FORM APPROVED: OMB NO. Expiration Date:
*See OMB Statement on Reverse.*

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
Countermeasures Injury Compensation Program

# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

**COMPLETE ALL SECTIONS, DATE, AND SIGN**

| I. PATIENT IDENTIFICATION *(Injured Countermeasure Recipient)* | | |
|---|---|---|
| NAME (*Last)* | *(First)* | *(MI)* |
| ADDRESS | | |
| CITY/STATE/ZIPCODE | DATE OF BIRTH | |

II. **I, _____, or _____**
***(Name of Patient)*** ***( Name of Parent or Representative)***
**authorize the disclosure of the above named individual's health records.**

| III. The information is to be disclosed by: | And is to be provided to: |
|---|---|
| Name of Facility/Provider | U.S. Department of Health and Human Services<br>Health Resources and Services Administration<br>Countermeasures Injury Compensation Program<br>5600 Fishers Lane, Room 11C-26<br>Rockville, MD 20857 |
| Address | |
| City/State/Zip Code | |

IV. The purpose or need for this disclosure is to apply for benefits with the U.S. Department of Health and Human Services, Health Resources and Services Administration, Countermeasures Injury Compensation Program (CICP). In some instances the information may be used for certain medical research purposes when consistent with the purposes for which the CICP was formed, e.g., gathering data regarding countermeasures adverse events.

V. The information to be disclosed from the above named individual's health record *(check appropriate box(es)).*

Entire record from _____ *(see instructions for appropriate date)*

Only information related to *(specify)*_____

Other *(specify,* e.g., insurance coverage, billing, etc.)_____

**VI. I understand that I may revoke this authorization in writing at any time to the Health Information Management (Health Records) Department of my facility/provider, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.**

_____
***(Enter if different from one year after date below)***

| VII. SIGNATURE OF PATIENT | DATE |
|---|---|
| SIGNATURE OF PERSONAL REPRESENTATIVE (state relationship to patient, e.g., parent) or WITNESS (if signature is thumbprint or mark) | DATE |

This information is to be released for the purposes stated above and may not be used by the recipient for any other purpose.

VIII. FOR OFFICIAL CICP USE ONLY
CICP No. _____

# Instructions for Completing HRSA Form ###
# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Type or print legibly in all fields using dark ink.

Section I **–** Provide the name, address, and date of birth of the injured countermeasure recipient.

Section II **–** Provide the name of the person authorizing the information to be released.

Section III **–** Provide the name and address of the facility or provider releasing the information. This is the facility or provider of health care services to the injured countermeasure recipient.

Section V **–** Check the appropriate box as applicable. The CICP will provide direction as to which records are needed.

1. **Entire Record – the complete record from the identified facility or provider from one (1) year prior to administration or use of the covered countermeasure that may have caused the injury. Please enter this date.**
2. **Only information related to – specify diagnosis, injury, operations special therapies, etc. within a specific date range. (Only complete this section if instructed to do so by the CICP).**
3. **Other (specify) – e.g., insurance coverage, billing, etc. (Only complete this section if instructed to do so by the CICP).**

Section VI **–** The requester may revoke this authorization at any time by notifying the Health Information Management (Health Records) Department of the facility/provider in Section III, in writing. If a different expiration date is desired, specify a new date. You may consider providing a date longer than one year if you have an ongoing CICP covered injury that has not resolved or may not be resolved soon.

Section VII **–** Patient (i.e., the injured countermeasure recipient) or personal representative (e.g., parent, legal guardian, power of attorney etc.) must sign and date.

Send a copy of the completed form to the facility/provider identified, and, **at the same time, also mail or fax a copy of the completed form to the CICP at the address below:**

Health Resources and Services Administration
Countermeasures Injury Compensation Program
5600 Fishers Lane, Room 11C-26
Rockville, MD 20857
Fax: (301) 443-8196

If you have questions contact the CICP at:

1-888-ASK-HRSA (1-888-275-3772); or
www.hrsa.gov/countermeasurescomp