Instructions

This form is supplemental to the SF 85P, Questionnaire for Public Trust Positions. This form has the same purposes, authorities, and Privacy Act Routine Uses, described on the SF 85P. The agency which gave you this form will tell you which questions to answer.

Instructions for completing this form are the same as the SF 85P. Type or legibly print your answers in ink (if the form is not legible, it will not be accepted). Be sure to sign and date the certification statement at the bottom of this page.

PUBLIC BURDEN INFORMATION: Public burden reporting for this collection is 20 minutes, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to OPM Forms Officer, U.S. Office of Personnel Management, 1900 E Street, N.W., Washington DC 20415. Do not send your completed form to this address, send it to the office that provided you the form. The OMB clearance number, 3206-0005, is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

5 USE OF ALCOHOL Respond for the timeframe of the last 7 years. YES NO a Has your use of alcohol had a negative impact on your work performance, your professional or personal relationships, your finances, or resulted in intervention by law enforcement/public safety personnel? (<i>If</i> "Yes," <i>explain</i> .) Image: the second seco	1 IDENTIFICATION INFORMATION											
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Signature (Sign in ink) Date (mm/dd/vvvv)	including my removal and debarment from Federal service.											

QUESTIONNAIRE FOR SELECTED POSITIONS

UNITED STATES OF AMERICA AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

If you answered "Yes" to Question 3, carefully read this authorization to release information about you, then sign and date it in ink.

Instructions for Completing this Release

This is a release for the investigator to ask your health practitioner(s) the questions below concerning your mental health consultations. Your signature will allow the practitioner(s) to answer only these questions.

Authorization

I am seeking assignment to or retention in a position of public trust with the Federal Government. As part of the clearance process, I hereby authorize the investigator, special agent, or duly accredited representative of the authorized Federal agency conducting my background investigation, to obtain the following information relating to my mental health consultations.

In accordance with HIPAA, I understand that I have the right to revoke this authorization at any time by writing to the U.S. Office of Personnel Management. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Further, I understand that this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

I understand the information disclosed pursuant to this release is for use by the Federal Government only for purposes provided in the Standard Form 85PS and that it may be disclosed by the Government only as authorized by law, but will no longer be subject to the HIPAA privacy rule.

Photocopies of this authorization with my signature are valid. This authorization is valid for one (1) year from the date signed or upon termination of my affiliation with the Federal Government, whichever is sooner.

Signature (Sign in ink)		Full name (Type or print le	gibly)		Date signed (mm/dd/yyyy)
Other names used					Social Security Number
Current street address	Apt. #	City (Country)	State	ZIP Code	Home telephone number

For Use By Practitioner(s) Only

 Does the person under investigation have a condition that could impair his or her judgment or reliability?

 If so, describe the nature of the condition and the extent and duration of the impairment or treatment.

 What is the prognosis?

 Signature (Sign in ink)
 Practitioner name

 Date signed (mm/dd/yyyy)