Form No: CICP-2

OMB Control Number: 0915-0334
Expiration Date: 9/30/2013

Instructions for Completing
HRSA 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 personal representative such as a parent of a minor, or a guardian, or an attorney, if applicable. If there is no personal representative then section II should be left blank.

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

1. **Entire Medical Record – the complete medical 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 V **–** 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 VI **–** Patient (i.e., the injured countermeasure recipient) signs and dates the form here.

Section VII – A personal representative (e.g., parent, legal guardian, power of attorney etc.), if one has been designated, signs and dates the form here.

Section VIII – A witness signs and dates the form here, if necessary (e.g., if the patient signature is a thumbprint or mark or if required by State law).

Send a copy of the completed form to the facility/provider identified, and, at the same time, also mail 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-06
Rockville, MD 20857

If you have questions contact the CICP at:

1-855-266-2427 (855-266-CICP); or
www.hrsa.gov/countermeasurescomp