**Privacy Act Release Authorization**

**PEDIATRIC SPECIALTY LOAN REPAYMENT PROGRAM**

**U.S. Department of Health & Human Services**

**Health Resources and Services Administration**

OMB #: 0906-0058

Expiration Date: xx/xx/xxxx

I, , residing at

, am an applicant/participant to the Pediatric Specialty Loan Repayment Program (42 U.S.C. 254l-1). I hereby authorize the Department of Health and Human Services, and/or its contractors, to disclose any information contained in its files relating to my application to participate in the PS Loan Repayment Program **to:**

**(Individual) (Relationship/Name of Firm)**

**(Address)**

**(City, State, Zip Code)**

This authority shall remain in effect one year from the date that the authorization is signed and dated, or until this authorization is revoked by me in writing, whichever occurs first.

I certify that I am the above-named applicant. I understand that the knowing and willful request for, or acquisition of, information pertaining to an individual from an agency under false pretenses is a criminal offense under the Privacy Act, subject to a $5,000 fine (5 U.S.C. 552a(i)(3)).

**(Signature of Applicant/Participant) (Date)**

I certify that I am the above-named individual, to whom the applicant has authorized disclosure. I understand that the knowing and willful request for, or acquisition of, information pertaining to an individual from an agency under false pretenses is a criminal offense under the Privacy Act, subject to a $5,000 fine (5 U.S.C. 552a(i)(3)).

**(Signature of Individual) (Date)**