

**Authorization For Release of Medical Information  
(Black Lung Benefits)**

U. S. Department of Labor  
Office of Workers' Compensation  
Program  
Division of Coal Mine Workers'  
Compensation



OMB No. 1240-0034  
Expires: 03/31/2025

**MINER'S INFORMATION**

1. Miner's Full Name (First, Middle, Last)	2. Miner's Social Security Number:	3. DOL's Case ID Number:
4. Miner's Date of Birth (Month, Day, Year):	5. Miner's Date of Death (if applicable):	

**CONTACT INFORMATION FOR PERSON AUTHORIZING MEDICAL RELEASE**

6. Claimant's Name (First, Middle, Last):	7. Your Relationship to Miner: (e.g. self, spouse, guardian etc.)
8. Your Mailing Address (Number, Street, Apt. No., P.O. Box):	9. City, State, and Zip Code:
10. Your Email Address:	11. Your Telephone Number:

**LIST ALL MEDICAL FACILITIES OR CLINICS THAT HAVE TREATED THE MINER FOR A LUNG OR HEART CONDITION.**

**This includes all doctor's offices, medical clinics, urgent care facilities, and hospitalizations.**

**12. Medical Treatment Facility or Clinic**

a. Facility or Clinic Name:	b. Physician's Name:
c. Facility or Clinic Mailing Address (Number, Street, Apr., P.O. Box):	d. Facility or Clinic City, State, and Zip Code:
e. Facility or Clinic Phone Number:	f. Reason for treatment (Include description of any heart or lung studies performed):
g. Start Date of Treatment or Admission Date for Hospitalization:	i. Most Recent Date of Treatment or Discharge Date for Hospitalization:
j. Please provide any other identifying information (such as building, clinic, patient number, in-patient or out-patient, etc.):	

**13. Medical Treatment Facility or Clinic**

a. Facility or Clinic Name:	b. Physician's Name:
c. Facility or Clinic Mailing Address (Number, Street, Apr., P.O. Box):	d. Facility or Clinic City, State, and Zip Code:
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g. Start Date of Treatment or Admission Date for Hospitalization:	i. Most Recent Date of Treatment or Discharge Date for Hospitalization:
j. Please provide any other identifying information (such as building, clinic, patient number, in-patient or out-patient, etc.):	

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e. Facility or Clinic Phone Number:	f. Reason for treatment (Include description of any heart or lung studies performed):
g. Start Date of Treatment or Admission Date for Hospitalization:	i. Most Recent Date of Treatment/ Discharge Date:
j. Please provide any other identifying information (such as building, clinic, patient number, in-patient or out-patient, etc.)	
<b>15. Medical Treatment Facility or Clinic</b>	
a. Facility or Clinic Name:	b. Physician's Name:
c. Facility or Clinic Mailing Address (Number, Street, Apr., P.O. Box):	d. Facility or Clinic City, State, and Zip Code:
e. Facility or Clinic Phone Number:	f. Reason for treatment (Include description of any heart or lung studies performed):
g. Start Date of Treatment or Admission Date for Hospitalization:	i. Most Recent Date of Treatment/ Discharge Date:
j. Please provide any other identifying information (such as building, clinic, patient number, in-patient or out-patient, etc.)	
<b>16. Remarks</b> (You may use this space for explanations. If you need more space for additional facility or clinic information or to provide additional information, attach a separate sheet.)	
I hereby authorize any physician, hospital, agency, or other organization, including the National Institute of Occupational Safety and Health, (NIOSH), to disclose to the Office of Workers' Compensation Programs of the U.S. Department of Labor any medical records or other information about (my) or (the deceased miner's) medical condition(s) for the purpose of providing information related to my claim for benefits under the Black Lung Benefits Act.	
17. Signature of Claimant (or person on his/her behalf)	18. Date (month, day, year)

**TWO FILING OPTIONS:**

1. To file electronically, submit completed form to the COAL Mine Portal:  
<https://coalmine.dol.gov>
2. To file by mail, submit completed form to:  
 US Department of Labor  
 OWCP/DCMWC/CMR  
 Correspondence  
 PO Box 8307  
 London, KY 40742-8307  
 For further information call TOLL FREE: 1-800-347-2502

## Public Burden Statement

Public reporting burden for this collection of information is estimated to average 20 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is voluntary. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Coal Mine Workers' Compensation, 200 Constitution Avenue NW, Suite C3520-DCMWC, Washington, DC 20210  
**DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**

## Notice

If you have a disability, federal law gives you the right to receive help from the OWCP in the form of communication assistance, accommodation(s) and/or modification(s) to aid you in the OWCP claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments of changes to accommodate your disability. Please contact our office or your OWCP claims staff to ask about this assistance.

## Privacy Act Notice

The following information is provided in accordance with the Privacy Act of 1974, 5 U.S.C. 552a. (1) Collection of this information is authorized by the Black Lung Benefits Act, 30 U.S.C. 901 et seq., and 20 CFR 725.405. (2) The information in this form will be used to authorize medical treatment providers to release information about the miner to the Department of Labor pertinent to the black lung claim. (3) While you are not required to respond, your cooperation is needed to ensure that your claim is given full and proper consideration. Failure to provide the release of medical documentation may exclude relevant medical information from consideration in the black lung claim. (4) Information may be used by other agencies or persons handling matters relating, directly or indirectly to this claim, including liable coal mine operators and their insurance carriers; medical professionals in obtaining medical services or evaluations; contractors providing automated data processing or other services to the Department of Labor; representatives of the parties to the claim; and federal, state or local agencies. (5) Furnishing all requested information will facilitate accurate and timely processing of the black lung claim. (6) This information is included in a System of Records, DOL/ OWCP-2, published at 81 Federal Register 25765, 25858 (April 29, 2016), or as updated and republished.

## Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no person is required to respond to a collection of information unless such collection displays a valid OMB control number.

Collection of this information is authorized by the Black Lung Benefits Act (BLBA), 30 U.S.C. 901 et seq., and 20 CFR 725.621. The obligation to respond to this collection is mandatory/required to obtain or retain benefit. We estimate it takes about 12 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing the collection of information.

Please send comments regarding the burden estimate or any other aspect of this collection of information to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S3323, 200 Constitution Avenue NW, Washington, DC 20210, or email [suggs.anjanette@dol.gov](mailto:suggs.anjanette@dol.gov), and reference OMB control number 1240-0034.

**Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB number.**