DEPARTMENT OF HOMELAND SECURITY
Transportation Security Administration

# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION PURSUANT TO HIPAA

**INSTRUCTIONS:** Complete Section I, II, and III of this form and return to Transportation Security Administration (TSA) Chief Counsel at 6595 Springfield Center Drive Springfield, VA 20598-6002.

## SECTION I – PATIENT DATA

| 1. Patient Name: | 2. Date of Birth: | 3. Social Security Number: |
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**4. Patient Address:**

## SECTION II – RELEASE AUTHORIZATION

**5. Information to be disclosed [45 C.F.R. § 164.508(c)(1)(i)]:**

This includes information on the diagnosis or treatment of human immunodeficiency virus infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

**6. Person(s) or Organization(s) Authorized to make the disclosure [45 C.F.R. § 164.508(c)(1)(ii)]:**
Any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf ("my Providers").

**7. Person or Organization to whom the disclosure may be made [45 C.F.R. § 164.508(c)(1)(iii)]:**
Any person acting on behalf of the Chief Counsel or the Claims, Outreach and Debt Branch, Transportation Security Administration, U.S. Department of Homeland Security, 6595 Springfield Center Drive Springfield, VA 20598-6002.

**8. Purpose for the use or disclosure of information [45 C.F.R. § 164.508(c)(1)(iv)]:**
To permit TSA (a) to investigate and evaluate my administrative claim under the Federal Tort Claims Act; (b) to engage fully and openly in discussions with my Providers to whatever extent necessary or convenient properly to investigate my claim; and (c) to engage fully and openly in discussions with any person or public or private agency concerning any matter relevant to my economic or health background or history and/or health needs or conditions, to whatever extent necessary to obtain information that will be used to evaluate and determine my claim.

**9. This authorization expires [45 C.F.R. § 164.508(c)(1)(v)]:**
When TSA has finally adjudicated my claim or when I exercise my right under 28 U.S.C. § 2675(a) to sue the United States upon my claim, whichever is earlier.

## SECTION III – REVOCATION, PATIENT RIGHTS, & AUTHORIZATION FOR RELEASE

I understand that:

(a) I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the TSA Chief Counsel (TSA-2), Transportation Security Administration, 6595 Springfield Center Drive Springfield, VA 20598-6002. I am aware that a revocation is not effective to the extent that any of my Providers or TSA have already relied on this authorization to disclose information about me. 45 C.F.R. § 164.508(c)(2)(i).

(b) My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization, TSA may be unable to obtain sufficient information to pay my claim. 45 C.F.R. § 164.508(c)(2)(ii).

(c) If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected. 45 C.F.R. § 164.508(c)(2)(iii).

I request and authorize my Providers to release the information described above to TSA without restriction, and to discuss any of that information with TSA. **A copy of this authorization is as valid as the original.**

| **10. Signature of Patient/Parent/Legal Representative [45 C.F.R. § 164.508(c)(1)(vi)]:** | **11. Relationship to Patient (if applicable):** | **12. Date:** |
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| | | |

In accordance with the Privacy Act of 1974, 5 U.S.C. § 552a(e)(3), this notice informs you of the purpose of this form and how it will be used. Please read it carefully.

**PRIVACY ACT STATEMENT: Authority:** The Federal Tort Claims Act and implementing regulations , 28 U.S.C. § 2672; 28 C.F.R. § 14.4. The Health Insurance Portability and Accountability Act of 1996 and implementing regulations, Public Law 104-191, § 264 (110 Stat. 1936, 2033); 45 C.F.R. § 164.508. **Principal Purpose(s):** To facilitate the investigation and adjustment of your federal tort claim by providing the Transportation Security Administration with a means to request the use and/or disclosure of an individual's protected health information. **Use(s):** This form will be given to individuals and entities having information relevant to your claim, as proof of your permission to release that information to TSA. The information will be used to evaluate your federal tort claim, and may be disclosed to other parties who may have knowledge of your claim or to consultants, to the extent necessary to obtain information that will be used to evaluate, settle, refer, pay, or adjudicate your claim. **Disclosure:** Voluntary, but failure to provide the requested information, including your Social Security number, may cause delay in processing your claim or denial of payment.

**Paperwork Reduction Act Statement of Public Burden**: TSA is collecting this information because a determination has been made regarding your tort claim against the agency that payment is warranted; therefore TSA needs certain information to facilitate payment. The public burden for this collection of information is estimated to be approximately 2 minutes. This is a voluntary collection of information; however, failure to provide this information may delay or hinder the processing of your claim payment. An agency may not conduct or sponsor, and persons are not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number assigned to this collection is 1652-0039, which expires 03/31/2025.