Defense Counterintelligence and Security Agency (DCSA)

SPECIFIC AUTHORIZATION FOR RELEASE OF BEHAVIORAL HEALTH AND RELATED MEDICAL INFORMATION

OMB No.
OMB approval expires

PRIVACY ACT STATEMENT

Authorities: DCSA is authorized to seek this information based on section 925 of Public Law 115-91; and, Executive Order 13467, as amended by Executive Order 13869.

Principal Purpose(s): To obtain records for investigating and determining an individual's initial or continued: eligibility for access to classified national security information or assignment to positions with sensitive duties; suitability for enlistment or appointment into military service; suitability or, for employees in positions not subject to suitability, fitness for Federal employment; fitness for assignment to work under contract for or on behalf of the U.S. Government; or eligibility for physical or logical access to U.S. Government systems or facilities.

Routine Use(s): The information collected may be disclosed to DCSA personnel and shared externally with other authorized government agency personnel, including those working for the agency requesting the investigation, as a routine use when necessary and relevant to personnel vetting investigations, determinations, and adjudications; and, for other purposes permitted under subsection (b) of the Privacy Act of 1974, as amended (5 USC §552a). Information obtained will also be released to the person being investigated upon their request unless otherwise exempt. A complete list of the routine uses can be found in the system of records notice for the Department of Defense Personnel Vetting Records System, "DUSDI 02-DoD" at: https://www.federalregister.gov/documents/2018/10/17/2018-22508/privacy-act-of-1974-system-of-records.

Voluntariness: Your consent to this release is voluntary and the addressee's disclosure of information is voluntary. Failure to consent or failure to provide DCSA access to the requested information may result in DCSA's inability to conduct a thorough investigation and may prevent the government from making a determination or adjudication regarding the qualifications, suitability, eligibility or fitness of the person being investigated.

This is a release for any physician, mental health care professional, hospital, clinic, medical facility, or other health care provider that has provided treatment or services to me for mental health conditions or substance use disorders. This release may be presented to the addressee by a duly accredited investigator or other duly accredited representative of the Defense Counterintelligence and Security Agency (DCSA), conducting my background investigation. **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. I have read and fully understand the Privacy Act Statement above and the Statement of Understanding on the next page of this form.

I, hereby authorize the addressee or designee thereof, noted below, to furnish full and complete information within their knowledge or records under their control pertaining to the identity, diagnosis, prognosis, or treatment, provided at any time, of my mental health conditions and substance use disorders, including any co-occurring disorders or medical conditions. My authorization includes the release for examination and reproduction of all related medical, psychiatric, psychosocial, and addiction treatment records, including, but not limited to, reports, notes, histories, doctor's orders, diagnoses, prognoses, and medical opinions, labs/medical tests (including drug screens), prescribed medications, attendance records, admissions notes, discharge summaries, and discharge information sheets. **This also includes information and records pertaining to inpatient, residential, or outpatient treatment, as well as partial or full hospitalizations. I acknowledge that the material authorized for release may contain alcohol, chemical dependency, or psychiatric information.** I specifically request that any healthcare providers associated with this addressee, with knowledge of my care, freely furnish their evaluations and opinions.

ORGANIZATION (referred to in this release as "addressee"):	ADDRESS:

SIGNATURE (handwritten or digital*)	FULL NAME	DATE SIGNED

OTHER NAMES USED	DATE OF BIRTH	SOCIAL SECURITY NUMBER

CURRENT STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER

(*) *A valid digital signature complies with the Electronic Signature Act 15 U.S.C. 7001, Public Law 105-277 the Uniform Electronic Transaction Act, and other regulations governing electronic signatures and access-controlled U.S. Government systems.*

Controlled By: DCSA
Controlled By: BI
CUI Category: PRVCY
LDC:
POC: [redacted]

DCSA Form 344

STATEMENT OF UNDERSTANDING

This form authorizes release of information in compliance with the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 and 164; Federal Confidentiality Rules, 42 CFR Part 2; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332. In accordance with HIPAA, I understand that I have the right to revoke this authorization at any time by writing to the addressee noted herein. 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.

As the person signing this release, I understand that I am giving my permission to the above-named provider to disclose my confidential health care records that may include medical, psychiatric, HIV/AIDS and substance use/abuse information. This authorization is subject to the restrictions imposed by the Genetic Information Nondiscrimination Act of 2008 (GINA). To comply with this law, I am instructing you not to provide any genetic information when responding to this release for medical information.

I hereby release any individual, including record custodians, from any and all liability for damages of any nature on account of compliance, or any attempts to comply, with this authorization.

I understand the information disclosed pursuant to this authorization is for use by the Federal Government only for purposes and authorities stated above and that it may be disclosed by the Federal Government only as authorized by the Privacy Act of 1974, as amended, 5 U.S.C. 552a. To the extent the information disclosed is from records protected by Federal Confidentiality Rules (42 CFR Part 2), the Federal Confidentiality Rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by my written consent or as otherwise permitted by 42 CFR Part 2.

I am aware that this release is valid only when presented to the addressee or a designee thereof. The authorization is valid for one (1) year from the date signed or upon termination of my affiliation with the Federal Government, whichever is sooner. My signature herein, either handwritten or digital, is valid and should be accepted by the addressee. Photocopies of this authorization, with my signature, are valid. If further confirmation is required, I can be reached at the phone number provided on this release.