

PEDIATRIC SPECIALTY LOAN REPAYMENT PROGRAM
PRIVACY ACT RELEASE AUTHORIZATION

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 the Health and Human Services, and/or its contractors, to disclose any information contained in its files relating to my application to participate in the Pediatric Specialty 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 date, 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)

For questions on how/where to submit this form, please contact the Customer Care Center at: 1-800-221-9393.

Public Burden Statement: The purpose of this information collection is to obtain information through the Pediatric Specialty Loan Repayment Program (PS LRP) that is used to assess a Loan Repayment Program applicant's eligibility and qualifications for the PS LRP and to obtain information for eligible facilities or sites. Clinicians interested in participating in the PS LRP must submit an application to the PS LRP through the My BHW online portal. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0906-0058 and it is valid until xx/xx/xxxx. This information collection is required to obtain or retain a benefit (Section 775 of the Public Health Service Act [42 USC § 295]). The information is protected by the Privacy Act, but it may be disclosed outside the U.S. Department of Health and Human Services, as permitted by the Privacy Act and Freedom of Information Act, to Congress, the National Archives, and the Government Accountability Office, and pursuant to court order and various routine uses as described in the System of Record Notice 09-15-0037. Public reporting burden for this collection of information is estimated to average xx hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 13N82, Rockville, Maryland, 20857.