OMB No: 0915-0146
Expiration Date: xx/xx/xxxx
Bureau of Health Workforce
U.S. Department of Health and Human Services Health Resources and Services Administration

National Health Service Corps Scholarship Program

AUTHORIZATION TO RELEASE INFORMATION FORM

If I become a participant in the National Heath Service Corps (NHSC) Scholarship Program, I

_____ , hereby authorize:
(Print Name - Last, First, Middle Initial)

1) The school where I am/was enrolled while participating in the NHSC Scholarship Program to disclose information pertaining to my school enrollment to the Department of Health and Human Services (DHHS), and/or its contractors. Information pertaining to my school enrollment includes, but is not limited to, my transcripts and grades, academic standing, enrollment and degree status, curriculum and examination requirements for graduation, tuition and fees, leave-of-absence, withdrawal, or dismissal from school. This information will be used by DHHS to determine my eligibility to continue to receive scholarship benefits and the amount of those benefits.

2) If applicable, I hereby authorize any postgraduate training program(s), for which I receive a deferment (i.e., approval) from DHHS to complete, to disclose to DHHS, and/or its contractors, information pertaining to my participation in the postgraduate training program(s) including, but not limited to, my curriculum and examination requirements, status in the program, completion date, leave-of-absence, withdrawal or dismissal from the program.

3) The entity/entities where I am/was approved to provide service in satisfaction of my NHSC Scholarship Program obligation to disclose to DHHS, and/or its contractors, information pertaining to my compliance with the NHSC scholarship service requirements. Such information includes, but is not limited to, my practice location(s), practice responsibilities, work schedule or other documentation indicating the hours that I worked and the hours I was away from the site, records relating to my work performance and (if applicable) the circumstances relating to the termination of my employment at the service location.

The above authorizations take effect on the date that I become a participant in the NHSC Scholarship Program and shall remain in effect until the date my NHSC scholarship commitment has been fulfilled.

In addition, I hereby authorize the DHHS, and/or its contractors, to release my name, address(es) and social security number to see if I appear on the Excluded Parties List System. This authorization takes effect on the date I sign this release form. If I do not become a participant, this authorization shall remain in effect until September 30, 202x.

These authorizations may be revoked by me in writing at any time.

_____ _____
(Signature of Individual) (Date)

Please upload the completed and signed form to the NHSC SP Online Application: **My BHW Account**

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