



Form D - AUTHORIZATION TO RELEASE INFORMATION

As a participant to the Native Hawaiian Health Scholarship Program (NHHSP),

I, (print)	First Name	Middle Initial	Last Name
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hereby authorize the College/University where I am/was enrolled, to disclose information to NHHSP, Papa Ola Lokahi, Inc. (POL) and the U.S. Department of Health and Human Services (HHS), pertaining to my enrollment while participating in NHHSP. "Information pertaining to my school enrollment" includes, but not limited to, my college transcript and grades, academic standing, enrollment and degree status, curriculum and examination requirements for graduation, tuition and fees, and leave-of-absence, withdrawal, or dismissal from school.

By becoming a NHHSP participant, I also authorize any post-degree training program for which I received a deferment from the NHHSP to disclose to POL and DHHS information pertaining to my participation in the post-degree program including, but not limited to, my curriculum, status in the program, completion date, examination requirements, and my leave- of-absence, withdrawal or dismissal from the program.

The above authorizations take effect on the date indicated below with my signature.

In addition, I hereby authorize POL and DHHS, to release my name, addresses 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 an NHHSP participant, this **authorization shall remain in effect until contract is signed by HRSA {Insert Date}**.

If I become an NHHSP participant, all of the above authorizations shall remain in effect until the date my NHHSP scholarship commitment has been fulfilled or these authorizations have been revoked by me in writing.

Public Burden Statement: The purpose of this information collection is to obtain information through the Native Hawaiian Health Scholarship Program that is used to assess a scholarship applicant's eligibility and qualifications for the NHHSP. Clinicians interested in participating in the NHHSP must submit an application to the Native Hawaiian Health Scholarship Program. 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 0915-0146 and it is valid until xx/xx/xxxx. This information collection is required to obtain or retain a benefit (The Native Hawaiian Health Care Improvement Act of 1992, as amended [42 U.S.C. 11709]). 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 14NWH04, Rockville, Maryland, 20857.



Native Hawaiian Health Scholarship Program
U.S. Department of Health and Human Services
Health Resources and Services Administration
OMB No: 0915-0146
Expiration Date: xx/xx/xxxx

Applicants' Signature

Date

**For questions on how/where to submit this form please contact the NHHSP at:
nhhsp@papaolalokahi.org.**

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