

**AUTHORIZATION FOR DISCLOSURE OF MEDICAL
INFORMATION**

Authorization "Public Law 104-191" Health Insurance Portability and Accountability Act (HIPAA) "August 21, 1996.

I authorize _____ and other medical representatives of Naval Health Clinic Quantico associated with my care to receive and release my medical information to those persons deemed necessary and appropriate: (1) in the determination and coordination of my treatment, both medical and psychological; (2) to make recommendations on the availability of care; and (3) assist with the coordination of resources available. I further authorize the medical representatives to discuss medical information relating to the medical suitability screening and/or Exceptional Family Member Program process in the presence of my spouse/sponsor.

This receipt and/or release of information may be verbal, email (including scan) or written communication. This release and receipt applies to my sponsor's command and other service agencies as deemed necessary and appropriate in the coordination and determination of my care, safety and quality of life.

I understand that I have the right to revoke this authority at anytime. My revocation must be in writing and provided to Naval Health Clinic Quantico VA.

This authorization is in effect for the period of one year unless otherwise stipulated in writing. This information will be used for verification purposes.

My signature below will grant my approval for the release of my medical information as stipulated above.

PRINT NAME

SPONSOR'S SSN

PATIENT'S SSN

SIGNATURE

WITNESS SIGNATURE

DATE