FORM 6-07
PRIVACY ACT AND HIPAA WAIVER

This authorization compiles with the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA).

SECTION I

Identification of Applicant/Student:

Name: _____
Date of Birth: _____
Student ID Number: _____
Phone: _____
Mailing Address: _____
Social Security Number (optional): _____

SECTION II

I, _____ (name of applicant/student), pursuant to 5 U.S.C. 552a(b) and 45 C.F.R. Parts 160 and 164, authorize **the U.S. Department of Labor, Office of Job Corps** to disclose all or a portion of my student or applicant file, including my protected health information if indicated below to:

Name of individual/ organization/ facility:
Phone: _____
E-mail: _____
Address: _____

Please send:

- ☐ Electronic copy to email address provided above
- ☐ Hard copy to mailing address provided above

SECTION III – INFORMATION SOUGHT: Student/Applicant File (not including health records)

- ☐ Include the entire contents of my student or applicant file.
- ☐ Include only the following information from my student or applicant file (describe):

_____

I declare under penalty of perjury that the foregoing is true and correct pursuant to 28 U.S.C. §1746 and that I am the applicant/student named above.

_____ _____
Name of Requestor Signature of Requestor

_____ Date: _____
Signature of Parent/Guardian if Requestor is a minor

SECTION IV – INFORMATION SOUGHT: Student/Applicant Health Records (please complete only if you are requesting health records)

1. **Health information to be disclosed (Check either A or B):**

A. ☐ Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, billing).

Psychotherapy notes and substance use disorder counseling notes (separate authorization required). IMPORTANT: Psychotherapy notes and substance use disorder counseling notes, if any, are kept separately from the medical record and require specific authorization.

☐ I authorize disclosure of psychotherapy notes.

☐ I authorize disclosure of substance use disorder notes.

OR

B. ☐ Disclose only portions of my health record (<u>check portions to be released</u>):

- ☐ Mental health records
  - ☐ Psychotherapy Notes (Psychotherapy notes are kept separately from the medical record and require specific authorization.)
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Alcohol/ drug abuse treatment records, including substance use records under 42 CFR part 2)
  - ☐ Substance Use Disorder Counseling Notes (Substance use disorder counseling notes are kept separately from the medical record and require specific authorization.)
- ☐ Genetic information
- ☐ Other (specify) _____

2. Purpose

The purpose or need for this disclosure of health records is:

_____

_____

3. Duration

This authorization is effective on the date it is signed and will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

If applicable, different expiration date or expiration event: _____

4. Signature

I, the undersigned, have read the above and understand that:

I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected.

I understand that if I requested my complete health record to be released, this release will include all records contained in my complete health record, including any records concerning alcohol use, mental health, substance use (including any records protected under the regulations of 42 CFR Part 2), psychotherapy or substance use disorder notes (if authorized), social work, and HIV/AIDS and any other communicable disease.

I understand that treatment, enrollment, eligibility for benefits or payment cannot be conditioned on my signing this authorization.

I understand that information subject to this authorization may be disclosed and/or re-disclosed in electronic form to experts and their agents, other health care providers, insurance companies, governmental agencies, and/or attorneys representing adverse parties, and I specifically authorize such disclosures and/or re-disclosures.

A copy of this authorization shall have the same force and effect as the signed original.

I have read this form and agree to the disclosures indicated above.

I declare under penalty of perjury that the foregoing is true and correct pursuant to 28 U.S.C. §1746 and that I am the applicant/student named above.

_____ _____

Name of Requestor Signature of Requestor

_____
Signature of Parent/Guardian if Requestor is a minor

Date: _____

If signing as Personal Representative, please state under what authority you are acting:

_____
_____