U.S. Department of State

Office of Medical Services

RELEASE OF MEDICAL INFORMATION

I understand that the Office of Medical Clearances has an obligation to keep my personally identifiable information, including medical records, confidential. I also understand that I can choose to allow the Office of Medical Clearances to release medical and mental health aspects of my personal information to certain individuals. I understand that failure to sign this form will not affect my clearance status.

I, ______________________________ , MED ID Number ________________________ authorize the Office of Medical Clearances to share my medical clearance reports, labs and information needs with:

Who I want to have my information:

Name *(Last, First, MI)* ____________________ ____________________ ________

Relationship ______________________________

Phone Number ______________________________

The information may be shared *(Please check all that apply)* :

☐ In Person ☐ By Phone ☐ By Fax ☐ By Mail ☐ By E-Mail

☐ I understand that electronic mail *(e-mail)* is not confidential and can be intercepted and read by other people.

Please check the boxes below to indicate that you understand:

☐ That I do not have to sign a release form. I do not have to allow the Office of Medial Clearances to share my information. Signing a release form is completely voluntary. If I would like Medical Clearances to release information about me in the future, I will need to sign another written, time-limited release.

☐ That Medical Clearances may not be able to control what happens to my information once it has been released to the above person.

This release expires on ____________________ ____________________

Date *(mm-dd-yyyy)* Time

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

Printed Name ______________________________

Signature	Date *(mm-dd-yyyy)*

Witness ______________________________

Reaffirmation and Extension *(if additional time is necessary to meet the purpose of this release)* I confirm that this release is still valid, and I would like to extend the release until

____________________ ____________________

New Date *(mm-dd-yyyy)* New Time

Signature	Date *(mm-dd-yyyy)*

Witness ______________________________

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