

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR A US GOVERNMENT
BACKGROUND INVESTIGATION**

If you answered "Yes" to Question 21, carefully read this authorization to release information about you, then sign and date it in ink.

KEY: Sign and date this form in ink. Your investigation may not be able to proceed without the proper completion of this form.

Instructions for Completing this Release

This is a release for the investigator to ask your health practitioner(s) the questions below concerning your mental health consultations. **Your signature will allow the practitioner(s) to answer only these questions.**

Authorization

I am seeking assignment to or retention in a national security position. As part of the clearance process, I hereby authorize the investigator, special agent, or duly accredited representative of the authorized Federal agency conducting my background investigation, to obtain the following information relating to my mental health consultations.

In accordance with HIPAA, I understand that I have the right to revoke this authorization at any time by writing to the U.S. Office of Personnel Management. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Further, I understand that this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

I understand the information disclosed pursuant to this release is for use by the Federal Government only for purposes provided in the Standard Form 86 and that it may be disclosed by the Government only as authorized by law, but will no longer be subject to the HIPAA privacy rule.

Photocopies of this authorization with my signature are valid. This authorization is valid for one (1) year from the date signed or upon termination of my affiliation with the Federal Government, whichever is sooner.