

**AVIATION MEDICINE ADVISORY SERVICE
General Medical Release**

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Aviation Medicine Advisory Service (AMAS)** and its staff to use and/or disclose certain protected health information (PHI) about me to **the below named individuals/groups for purposes related to medical certification**. This disclosure is at my request. AMAS may communicate PHI to them or me by telephone, voice messaging systems and non-secure email.

Section 1 – AMAS may discuss my case with the following individuals/groups:

1. _____
2. _____
3. _____
4. _____
5. _____

This authorization permits **AMAS** to use and/or disclose the following individually identifiable health information about me: all medical records in written form, substance abuse evaluations (SAE), mental health and psychotherapy notes (if applicable), and all additional materials provided by me or by my treating health care providers to AMAS. Treating providers and/or Union representatives and other individuals/entities listed by me above may release the above information to representatives of AMAS.

The primary purpose of these disclosures is to facilitate AMAS advice regarding medical certification, protect individual privacy, and promote aviation safety. AMAS will interpret clinical results to determine if I am safe to return to work or not. Additional purposes of these disclosures may include determination of eligibility for Disability and Loss of License insurance benefits, communicating with healthcare personnel in providing appropriate medical evaluations and treatment and contributing to my care, facilitating union officials in providing representation rights with my employer and for my employer to make a return to work determination. The purposes are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire three (3) years from the date listed below. I have the right to revoke this authorization at any time except to the extent that the practice has acted in reliance upon this authorization.

AMAS will not receive payment or other remuneration from a 3rd party in exchange for using or disclosing the PHI. AMAS will not release, sell, or otherwise distribute any email addresses or personal contact information to any individual, company or organization for marketing purposes or secondary distribution.

I have had the opportunity to view the Notice of Privacy Policies that is posted at www.AviationMedicine.com (printed copy available upon request).

I do not have to sign this authorization in order to receive FAA Medical Certification advice from AMAS. In fact, I have the right to refuse to sign this authorization. Refusal to sign this authorization will prevent AMAS and its physicians from acting on the individual's behalf with other outside agencies, individuals, companies or organizations. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by AMAS Privacy Policies.

Notice to Recipient of Medical Records and Protected Health Information sent by Aviation Medicine Advisory Service:

This Protected Health Information has been disclosed to you from confidential records. There is no intent, either expressed or implied, that you may make further distribution of this information without the specific written consent of the undersigned.

Signed by: _____ Date _____
Signature of Individual or Legal Guardian

First Name MI Last Name DOB: _____