AVIATION MEDICINE ADVISORY SERVICE
FAA 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 **Federal Aviation Administration (FAA) medical representatives**. I also authorize representatives of the FAA to release PHI to representatives of AMAS. This disclosure is at my request. AMAS may communicate PHI to them or me by telephone, voice messaging systems and non-secure email. Additionally, AMAS may disclose PHI to the following individuals and/or organizations specified below:

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

1. _____

2. _____

This authorization permits **AMAS** to use and/or disclose the following individually identifiable health information about me: all medical records in written form, including mental health and psychotherapy notes (if applicable), and all additional materials provided by me or by my treating health care providers to AMAS. FAA medical 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 obtaining FAA medical qualification determinations, though AMAS does not guarantee FAA decisions either expressed or implied.

Additional purposes of these disclosures may include determination of eligibility for Disability and Loss of License insurance benefits, Department of Labor / OWCP 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 one (1) year 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 the FAA or 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.

I understand that AMAS will retain PHI and other information about me in its files in accordance with AMAS's Document Retention and Destruction Policy.

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: _____ _____
Signature of Individual or Legal Guardian Date

_____ _____
First Name MI Last Name DOB: