# QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS



## UNITED STATES OF AMERICA

### AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

If you answered "Yes" to Section 21 of the Standard Form 86 (SF-86), carefully read this authorization to release information about you, then sign and date it in ink.

This is an authorization for the investigator to ask your health practitioner(s) the questions below concerning your mental health consultations. The U.S. government recognizes the critical importance of mental health and advocates proactive management of mental health conditions to support the wellness and recovery of Federal employees and others. The government recognizes that mental health counseling and treatment may provide important support for those who have experienced traumatic events, as well as for those with other mental health conditions. While most individuals with mental health conditions do not present security risks, there may be times when such a condition can affect a person's eligibility for a security clearance. Seeking or receiving mental health care for personal wellness and recovery may contribute favorably to decisions about your eligibility. Your signature will allow the practitioner(s) to answer only those questions identified below.

**Authorization**

I am seeking assignment to or retention in a national security sensitive position. As part of the investigative process, I hereby authorize the investigator, special agent, or duly accredited representative of the authorized Federal agency conducting my background investigation, reinvestigation, or ongoing evaluation (i.e., continuous evaluation) of eligibility for access to classified information or eligibility to hold a national security sensitive position to request, and my health practitioner(s) to provide, the information requested below, 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 my health care provider/ entity. Revocation of this authorization is not effective until received by my health care provider/entity. 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 authorization for use by the Federal Government only for purposes provided in the Standard Form 86 will no longer be covered by the HIPAA Privacy Rule, and that the Federal Government may redisclose the information as authorized by law, subject to Privacy Act safeguards.

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.

| Full name *(Type or print legibly)* | | | | Social Security Number |
|---|---|---|---|---|
| FIRST_MIDDLE_LAST | | | | SSN |
| Signature *(Sign in ink)* This form was digitally signed by: **FIRST_MIDDLE_LAST** in accordance with the Electronic Signature Act 15 U.S.C. 7001, Public Law 105-277 the Uniform Electronic Transaction Act, and other regulations governing electronic signatures and access controlled U.S. Government systems. | | | | Date signed *(mm/dd/yyyy)* **SIGNED_ON** |
| Other names used | | | Date of birth | |
| OTHER_NAMES | | | DOB | |
| Current street address Apt. # | City *(Country)* | State | Zip Code | Telephone Number |
| STREET_ADDRESS | CITY_COUNTRY | STATE | ZIP_CODE | TELEPHONE |

**For Use By Practitioner(s) Only**

Does the person under investigation have a condition that could impair his or her judgment, reliability, or trustworthiness?

☐ **YES** ☐ **NO**

If so, describe the nature of the condition and the extent and duration of the impairment or treatment.

What is the prognosis?

Dates of treatment?

| Signature (Sign in ink) | Practitioner name | Date signed *(mm/dd/yyyy)* |
|---|---|---|
| | | |

**Enter your Social Security Number before going to the next page** →

SSN