AUTHORIZATION FOR DoD TO DISCUSS MEDICAL/DENTAL INFORMATION/STATUS WITH APPOINTED INDIVIDUAL(S)

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, USC 133, 3012, 5031, 8013, and Executive Order 9397
PRINCIPAL PURPOSE: To determine medical acceptability or update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corp (ROTC) Scholarship Program, or the Uniformed Services University of the Health Sciences (USUHS) and other programs as assigned by the Assistant Secretary of Defense for Health Affairs.
ROUTINE USES: This information may be disclosed to the Coast Guard Academy and Merchant Marine Academy for applicants to their Academies.
DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy. Use of the Social Security Number (SSN) is used for positive identification of records.

Section I – Applicant Data

1) NAME (Last, First, Middle Initial)	2) Date of Birth (YYYY/MM/DD)	3) Social Security Number
Smith, Jonathan, B	2004/10/15	574-45-5441

Section II – Disclosure

I authorize the Department of Defense Medical Examination Review Board (DoDMERB) and other applicable Government agencies to release and/or discuss my personal medical information as it pertains to the processing of my application(s) to the United States Service Academy(ies), the Uniformed Services University of the Health Sciences, the Reserve Officer Training Corps Program(s) of the United States Armed Forces, or any other program(s) that DoDMERB determines the medical qualification with the following individuals:

Name: NA, DOB: NA, Relationship: NA
Name: NA, DOB: NA, Relationship: NA
Name: NA, DOB: NA, Relationship: NA
Name: NA, DOB: NA, Relationship: NA

NOTE: Please place an N/A in any unused lines above.

Section III – Release Authorization

I understand that:
a. I have the right to revoke this authorization at anytime. My revocation must be in writing and provided to DoDMERB. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protections, then such information may be re-disclosed and would no longer be protected.

I request and authorize DoDMERB and other applicable Government Agencies to release the information described above to the named individual(s) indicated above.

1) Signature of Applicant: 2) Date:

If there are any concerns with this written, signed, release, please feel free to contact me at the following phone number(s) and/or e-mail address:

Home Phone: 907 957-4800
Cell Phone: 907 957-4800
E-Mail Address: graham.smith2011@gmail.com