Standard Form 86
Revised November 2016
U.S. Office of Personnel Management
5 CFR Parts 731, 732, and 736

QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS

Form approved:
OMB No. 3206 0005

UNITED STATES OF AMERICA

AUTHORIZATION FOR RELEASE OF INFORMATION

Carefully read this authorization to release information about you, then sign and date it in ink.

I Authorize any investigator, special agent, or other duly accredited representative of the authorized Federal agency conducting my background investigation, reinvestigation, or ongoing evaluation (i.e. continuous evaluation) of my eligibility for access to classified information or, when applicable, eligibility to hold a national security sensitive position to obtain any information relating to my activities from individuals, schools, residential management agents, employers, criminal justice agencies, credit bureaus, consumer reporting agencies, collection agencies, retail business establishments, or other sources of information. This information may include, but is not limited to current and historic academic, residential, achievement, performance, attendance, disciplinary, employment, criminal, financial, and credit information, and publicly available social media information. I authorize the Federal agency conducting my investigation, reinvestigation, or ongoing evaluation (i.e. continuous evaluation) of eligibility to disclose the record of investigation or ongoing evaluation to the requesting agency for the purpose of making a determination of suitability, or initial or continued eligibility for a national security position or eligibility for access to classified information.

I Understand that, for these purposes, publicly available social media information includes any electronic social media information that has been published or broadcast for public consumption, is available on request to the public, is accessible on-line to the public, is available to the public by subscription or purchase, or is otherwise lawfully accessible to the public. I further understand that this authorization does not require me to provide passwords; log into a private account; or take any action that would disclose non-publicly available social media information.

I Authorize the Social Security Administration (SSA) to verify my Social Security Number (to match my name, Social Security Number, and date of birth with information in SSA records and provide the results of the match) to the United States Office of Personnel Management (OPM) or other Federal agency requesting or conducting my investigation for the purposes outlined above. I authorize SSA to provide explanatory information to OPM, or to the other Federal agency requesting or conducting my investigation, in the event of a discrepancy.

I Understand that, for financial or lending institutions, medical institutions, hospitals, health care professionals, and other sources of information, separate specific releases may be needed, and I may be contacted for such releases at a later date.

I Authorize any investigator, special agent, or other duly accredited representative of the OPM, the Federal Bureau of Investigation, the Department of Defense, the Department of Homeland Security, the Office of the Director of National Intelligence, the Department of State, and any other authorized Federal agency, to request criminal record information about me from criminal justice agencies for the purpose of determining my eligibility for assignment to, or retention in, a national security position, in accordance with 5 U.S.C. 9101. I understand that I may request a copy of such records as may be available to me under the law.

I Authorize custodians of records and other sources of information pertaining to me to release such information upon request of the investigator, special agent, or other duly accredited representative of any Federal agency authorized above regardless of any previous agreement to the contrary.

I Understand that the information released by records custodians and sources of information is for official use by the Federal Government only for the purposes provided in this Standard Form 86, and that it may be disclosed by the Government only as authorized by law.

I Authorize the information to be used to conduct officially sanctioned and approved personnel security-related studies and analyses, which will be maintained in accordance with the Privacy Act.

Photocopies of this authorization with my signature are valid. This authorization shall remain in effect so long as I occupy a national security sensitive position or require eligibility for access to classified information.

Signature *(Sign in ink)*	Full name *(Type or print legibly)*			Date signed *(mm/dd/yyyy)*
Other names used			Date of birth	Social Security Number
Current street address Apt. #	City *(Country)*	State	ZIP Code	Telephone number

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

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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.

Signature *(Sign in ink)*	Full name *(Type or print legibly)*			Date signed *(mm/dd/yyyy)*
Other names used				Social Security Number
Current street address Apt. #	City *(Country)*	State	ZIP Code	Telephone number

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 →

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FAIR CREDIT REPORTING DISCLOSURE AND AUTHORIZATION

Disclosure
One or more reports from consumer reporting agencies may be obtained for employment purposes pursuant to the Fair Credit Reporting Act, codified at 15 U.S.C. § 1681 et seq.

Purpose
The Federal government requires information from one or more consumer reporting agencies in order to obtain information in connection with a background investigation, reinvestigation, or ongoing evaluation (i.e. continuous evaluation) of eligibility for access to classified information, or when applicable, eligibility to hold a national security sensitive position. The information obtained may be disclosed to other Federal agencies for the above purposes in fulfillment of official responsibilities to the extent that such disclosure is permitted by law. Information from the consumer report will not be used in violation of any applicable Federal or state equal employment opportunity law or regulation.

Authorization
I hereby authorize any investigator, special agent, or other duly accredited representative of the authorized Federal agency conducting my initial background investigation, reinvestigation, or ongoing evaluation (i.e. continuous evaluation) of my eligibility for access to classified information, or when applicable, eligibility to hold a national security sensitive position to request, and any consumer reporting agency to provide, such reports for purposes described above.

Note: If you have a security freeze on your consumer or credit report file, we will not be able to access the information necessary to complete your investigation, which can adversely affect your eligibility for a national security position. To avoid such delays, you should expeditiously respond to any requests made to release the credit freeze for the purposes as described above.

Photocopies of this authorization with my signature are valid. This authorization shall remain in effect so long as I occupy a national security sensitive position or require eligibility for access to classified information.

Print Name	Social Security Number
Signature *(Sign in ink)*	Date signed *(mm/dd/yyyy)*

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