MEDICAL INFORMATION RELEASE FORM/ PRIVACY ACT WAIVER
(HIPAA RELEASE FORM)

Name:_____ **Date of Birth:** _____

Address: _____

In accordance with the Privacy Act of 1974: I, _____, authorize the U.S. Department of Labor, the Office of Workers' Compensation Programs, and the United States Postal Service to disclose to the National Association of Letter Carriers and/or _____ any information regarding my claim for compensation filed under the Federal Employees' Compensation Act, OWCP File No. _____.

RELEASE OF INFORMATION:

[✓] I authorize the release of information (*e.g., information relating to the diagnosis, examination, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number*) rendered to me and claims information. This information may be released to:

[✓] National Association of Letter Carriers (NALC),_____

The information is for the purpose of helping me to resolve claims, grievances, and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my signature below and shall remain in effect until terminated by me in writing.

A copy of this authorization shall have the same force and effect as the signed original.

I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization.

MESSAGES:

Please call [ ] my home [ ] my work [ ] my cell Number: _____
If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (*day*) _____between (*time*) _____

Signed: _____ Date: ____/____/_____