AUTHORIZATION FOR RELEASE OF RECORDS

To: CENTERS FOR DISEASE CONTROL AND PREVENTION
1600 Clifton Road, NE
Mailstop D-54
Atlanta, Georgia 30333
Phone: (770) 488-6399; Fax: (404) 235-1852

Name: _____ Date of Birth: _____

If illness-related, please provide the State Identification Number (obtained from State Health Department) to assist us in our search for agency documents.

_____

Description of Illness or Injury:

_____

_____

I hereby authorize the Centers for Disease Control and Prevention to release any and all medical, confidential, employment, or other information regarding the above-named individual.

_____
Signature

_____
Date

NOTARY INSERT:

Privacy Act Statement:

In accordance with 45 CFR Section 5b.9, personal data sufficient to identify the individuals submitting requests for information covered under the Privacy Act of 1974, 5 USC Section 552a, is required. The primary use of this information is to verify the identity of the individual whose records have been requested and ensure that the records of individuals who are the subject of U.S. Department of Health and Human Services, Centers for Disease Control and Prevention systems of records are not wrongfully disclosed by the Department. Because other individuals may have the same name and birth date, the provision of a social security number will be used to facilitate the disclosure of accurate information and to help eliminate the possibility of misidentification of individuals. The information provided may be disclosed to CDC/ATSDR personnel conducting the records search in relation to the request. The information may also be disclosed to other federal agencies for the purpose of locating records related to the search. Requests will not be processed if this information is not furnished. False information on this form may subject the requester to criminal penalties under 18 USC Section 1001 and/or 5 USC Section 552a(i)(3). The use of this form is voluntary.