BP-A0621
MAY 24

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

COMPLETE ALL SECTIONS, DATE, AND SIGN

I.	**(PRINT) Full Legal Name** *(Last, First, Middle)*:	**Register Number**	**Date of Birth**
	Other Names *(Maiden Name, Alias):*		

II. Pursuant to 5 U.S.C. Section 552a (b), I authorize the U.S. Department of Justice to:

☐ **Obtain information from** ***OR*** ☐ **Release information to**

Name of Person/Facility:_____ Phone: _____ Fax:_____

Address:_____ City/State/Zip Code: _____

III. Purpose of Disclosure: ☐ Continuing Care ☐ Disability Determination ☐ Legal ☐ Other: _____

IV. Information to be Released/Obtained: Copy of and/or information from my health record pertaining to my evaluation/treatment received from_____ to _____.

☐ Complete Record	☐ Laboratory Reports	☐ Pathology Reports	☐ Radiology Reports
☐ Consultations	☐ Medication List	☐ Pathology Slides	☐ Radiology Film/Imaging
☐ Discharge Summary	☐ Operative/Procedure	☐ Will be returned OR	☐ Will be returned OR
☐ History & Physical	☐ Progress Notes	☐ Duplicates accepted	☐ Duplicates accepted
☐ Immunization Record	☐ Other: _____		

I authorize the release of the following sensitive information relating to:

☐ Alcohol/Drug Treatment/Referral ☐ HIV/AIDS Treatment

☐ Behavioral/Mental Health *(Other than Psychotherapy Notes)* ☐ Sexually Transmitted Diseases

V. Privacy Act Statement. In accordance with 28 CFR Section 166.41(d) personal data sufficient to identify the individuals' submitting requests by mail under the Privacy Act of 1974, 5 U.S.C. Section 552a, is required. The purpose of this solicitation is to ensure that the records of individuals who are the subject of US Department of Justice systems of records are not wrongfully disclosed by the Department. Failure to furnish this information will result in no action being taken on the request. False information on this form may subject the requester to criminal penalties under 18 U.S.C. Section 1001 and/or 5 U.S.C. Section 552a (i)(3).

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. Section 1001 by a fine of not more than $10,000 or by imprisonment of not more than five years or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. 552a(i)(3) by a fine of not more than $5000.

I understand that authorizing the disclosure of this health information is voluntary and not a condition of treatment. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I understand that I may revoke this consent at any time by sending a written notice to the Supervisor of Medical Records. I understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. This authorization will automatically **expire 90 days** from the date of the signature.

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Signature of Patient:	**Date:**
Signature of Witness/Credentials ***(If required):***	**Date:**
(Print) Witness Name/Credentials:	

DEPARTMENT USE ONLY

Processed by: _____ Date: _____ Requested by: _____ ☐ No health records found

Mail or fax records to:

Instructions for Completing BOP Form BP-A0621

Authorization for Release of Medical Records

I. Print legibly in all fields using dark permanent ink.

II. **Section I** – print your name and other names used (alias, maiden name), and date of birth.

III. **Section II** – print the name, address, and phone/fax to the person or facility releasing to or obtaining the information.

IV. **Section III** – state the reason why the information is needed: continuing care, insurance/disability determination, legal, or other.

V. **Section IV:**

a. **Specify date range**, e.g., January 1, 2019, to December 31, 2020.

b. **Select the information** – check the appropriate box, discharge summary, history & physical, laboratory reports etc.

i. **Other** – describe the specific information you are requesting.

ii. **Entire Record** – complete record including, if authorized, the sensitive information (alcohol/drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and behavioral/mental health other than psychotherapy notes).

IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, SEXUALLY TRANSMITTED DISEASES, HIV/AIDS-RELATED TREATMENT, BEHAVIORAL/MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), **THE APPROPRIATE BOX OR BOXES MUST BE CHECKED BY THE PATIENT.**

VI. **Section V** – please read, sign and date.

A copy of the completed form will be scanned in your health record.

Note: A witness signature is not required by the Privacy Act of 1974 or the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It may be left blank or used as needed to meet State law.

VII. **Section Department Use Only:**

a. Processed by – staff member who completed this request

b. Requested by – provider requesting the information

c. Complete the date and address/fax number for receipt of records.