

PATIENT'S AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(USAF NONAPPROPRIATED FUND WORKERS' COMPENSATION PROGRAM)

(THIS FORM IS AFFECTED BY THE PRIVACY ACT OF 1974)

AUTHORITY: 33 U.S.C. 903, Longshoremen's and Harbor Workers' Compensation Act; 10 U.S.C. 8013; and 44 U.S.C. 3101.

PRINCIPAL PURPOSE: To obtain information on present and past injuries and illnesses of employees.

ROUTINE USES: Used to determine what benefits, if any, may be due an employee under the Longshoremen's and Harbor Workers' Compensation Act as extended by the Nonappropriated Fund Instrumentalities Act (5 U.S.C. 8171). Information furnished may be disclosed to any DOD component or part thereof, and upon request, to other Federal, state and local government agencies in the pursuit of their official duties and to the Department of Labor. The information may also be used for other lawful purposes including those indicated below, law enforcement and or litigation.

DISCLOSURE IS MANDATORY: Failure to provide the information may result in reduction and/or delay of potential benefits.

1. I authorize and direct any physician who has examined and/or treated me or who may examine and/or treat me after the date of signature on this authorization or any medical facility where I have been examined and/or treated or at which I may be examined and/or treated after the date of signature on this authorization to provide to any authorized representative of the United States Air Force any information regarding my physical condition and/or treatment rendered, and to allow said representative to inspect, review and/or make copies of any and all medical records concerning my condition.

2. I authorize and direct any of my prior employers who may have records of my physical condition or insurance carriers which may have received and processed my prior claims for benefits to provide such records for inspection, review and/or copying by said representative.

3. I authorize my current employer to release information on my claim to any claim index bureau or similar organization which maintains such information for historical, analytical, and/or investigative purposes.

4. A copy of this authorization may be accepted and honored as if it were the original.

CASE NUMBER	EMPLOYEE'S NAME (Print or type)
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DATE	EMPLOYEE'S SIGNATURE
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AF IMT 786, 19981101, V2

PREVIOUS EDITION IS OBSOLETE.

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