

**QUESTIONNAIRE FOR  
 NATIONAL SECURITY POSITIONS**

**UNITED STATES OF AMERICA  
 AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION PURSUANT  
 TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

If you answered "Yes" to Question 21, carefully read this authorization to release information about you, then sign and date it in ink.

**Instructions for Completing this Release**

This is a release for the investigator to ask your health practitioner(s) the questions below concerning your mental health consultations. Your signature will allow the practitioner(s) to answer only these questions.

**Authorization**

I am seeking assignment to or retention in a national security position. As part of the clearance process, I hereby authorize the investigator, special agent, or duly accredited representative of the authorized Federal agency conducting my background investigation, to obtain the following information 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 the U.S. Office of Personnel Management. 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 release is for use by the Federal Government only for purposes provided in the Standard Form 86 and that it may be disclosed by the Government only as authorized by law, but will no longer be subject to the HIPAA privacy rule.

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 <i>(Sign in ink)</i>		Full name <i>(Type or print legibly)</i>			Date signed <i>(mm/dd/yyyy)</i>
Other names used					Social Security Number
Current street address	Apt. #	City <i>(Country)</i>	State	ZIP Code	Home 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 ability to properly safeguard classified national security information?  <input type="checkbox"/> Yes <input type="checkbox"/> No  If so, describe the nature of the condition and the extent and duration of the impairment or treatment.  What is the prognosis?		
Signature <i>(Sign in ink)</i>	Practitioner name	Date signed <i>(mm/dd/yyyy)</i>

Enter your Social Security Number before going to the next page 