Department of the Navy

Nuclear Weapons Personnel Reliability Program

Authorization for Disclosure of Medical and Dental Information[1]

PRIVACY ACT STATEMENT

AUTHORITY: 5 U.S.C. 552 (a) (Privacy Act of 1974: Records Maintained on Individuals); 10 U.S.C. 113 (Authority of the Secretary of Defense); 10 U.S.C. 5013 (Authority of the Secretary of the Navy); 42 U.S.C. 290dd-2 (Alcohol, Drug Abuse and Mental Health Reorganization Act (ADAMHRA), Confidentiality of Records); 45 C.F.R. Parts 160 and 164 (Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules); 42 CFR 2.31 (consent to disclosure of alcohol/drug abuse records); DoDI 1010.1 (Military Personnel Drug Abuse Testing Program); DoD 6025.18-R (Defense Health Information Privacy Regulation); E.O. 12564 (as amended, Drug Testing Program for DoD Employees in Sensitive Positions); and E.O. 9397 (as amended, for SSN collection).

PRINCIPAL PURPOSE(S): To manage and administer the Nuclear Weapons Personnel Reliability Program (PRP) within the Department of the Navy. The PRP policy requires review of medical and dental histories and records to determine and monitor qualification and suitability for PRP assignment.

ROUTINE USE(S): Disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, including the "Blanket Routine Uses" set forth therein.

DISCLOSURE: Voluntary. However, failure to disclose may prevent certification into the PRP.

I, _____, seek initial and continued assignment in the Nuclear Weapons Personnel Reliability Program (PRP). As part of the PRP screening and certification process, I hereby authorize competent medical authorities, other trained and designated PRP medical personnel, reviewing officials, and certifying officials to obtain and view my medical and dental histories and records for the purpose of determining my physical and mental condition and qualification under the standards of the PRP. Additionally, I authorize designated PRP inspectors to obtain and view my medical and dental histories and records for the purpose of reviewing and evaluating the Command PRP. I understand that my personal health information (PHI) disclosed from my medical and dental histories and records determines my fitness for duty to include making qualifying and disqualifying determinations regarding my continuous ability to perform PRP duties. By my execution of this authorization, I hereby permit full access to my PHI for the purposes stated above.

I further authorize custodians of records and sources of information pertaining to me, to release such information upon request of the competent medical authority, other trained and designated PRP medical personnel, reviewing official, certifying official, and/or designated inspectors. Copies of this authorization are as valid as the original.

I understand that once information contained in my medical and dental histories and records is disclosed pursuant to this release for use by the Department of the Navy (DON) only for purposes provided by PRP policy, it may be further disclosed by the DON only as authorized by law. Once information is disclosed from my medical and dental histories and records, it is no longer subject to protection as PHI under the HIPAA Privacy Rule as implemented by the DoD Health Information Privacy Regulation, DoD 6025.18-R. It remains subject to protection as personally identifiable information (PII) under the Privacy Act of 1974 as implemented by DoD 5400.11-R.

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I understand that in certain circumstances I may have the right to revoke this authorization at any time by writing to my Command PRP certifying official. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization, or as otherwise limited by applicable law or regulation. 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, but my eligibility under the PRP is conditioned on my continued authorization of this disclosure. Therefore, my revocation of this authorization may result in termination of my eligibility under the PRP.

This authorization expires upon the termination of my affiliation with the DON PRP.

Signature *(Sign in Ink)*:	Full Name *(Type or Print Legibly)*:	Date signed:
Other Names Used:	Date of birth:	
Current Address *(Street, City)*:	State: Zip Code:	Home Telephone Number: *(Include Area Code)*

[1]This authorization satisfies the requirements under HIPAA and the DoD Health Information Privacy Regulation, DoD 6025.18-R, permitting disclosure of medical and/or dental histories and records by a military treatment facility or other component of the Military Health System, or other provider or health plan. A HIPAA-compliant authorization is not applicable to release of such records for Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission. See Section C7.11.1 of DoD 6025.18-R. Although the PRP falls within this exception to the HIPAA authorization requirement concerning Armed Forces personnel, this document is separately required for all personnel, in order to comply with provisions of the Privacy Act of 1974 and, if applicable, the requirements for written consent to release of Federal alcohol or drug abuse treatment program information under ADAMHRA (42 CFR 2.31). Note that authorization for use or disclosure of psychotherapy notes may, based on applicable law or regulation, require a separate authorization.

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