**U.S. PROBATION OFFICE**

**EASTERN DISTRICT OF VIRGINIA**

**HEALTH INSURANCE PORTABILITY AND**

**ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION FORM**

I,       hereby authorize use or disclosure of protected health information about me as described below:

1. The following specific person or class of persons or facility is authorized to make the requested use or disclosure:       .

2. The following person may receive disclosure of protected health information about me:

United States Probation Officer

3. The specific information to be disclosed is:

4. I understand the information used or disclosed may be subject to re-disclosure by the person or class of persons receiving it, and would then no longer be protected by Federal privacy regulations.

5. I may revoke this authorization by notifying       , OR upon occurrence of the following event that related to me or to the purpose of the intended use or disclosure of information about me      .

**THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING**

Signature Date Date of Birth

Witness - United States Probation Officer Date