MedicalDirection, LLC
Workplace Health + Safety Consultants

Authorization for Use and Disclosure of Protected Health Information

With my consent, I, (Printed name) _____, hereby request and authorize **Medical Direction, LLC** and their staff to use and/or disclose protected health information (PHI) about me with **medical representatives of the Federal Aviation Administration (FAA).** Use and/or disclosure of this PHI is to facilitate in obtaining or maintaining FAA airman medical certification.

By signing this form, I am consenting to Medical Direction, LLC's use and/or disclosure of the following PHI about me to assist in obtaining or maintaining FAA medical certification:

- all medical documentation in written form, including, if applicable, records related to mental health care and psychotherapy,
- additional medical documentation provided by me or by my treating health care providers to Medical Direction, LLC, and
- documentation from the Federal Aviation Administration (FAA) regarding my eligibility to meet airman medical certification standards.

With my consent, Medical Direction, LLC may communicate with me, at my home or other designated location, using any of the following methods in reference to any items that assist Medical Direction, LLC for the purpose of obtaining or maintaining FAA medical certification: phone calls, e-mail, mail, fax, and/or overnight delivery service.

I have the right to revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. Further, I have the right to request that Medical Direction, LLC restrict how it uses and/or discloses my PHI to facilitate obtaining or maintaining FAA medical certification. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

If I do not sign this consent, Medical Direction, LLC may decline to provide service to me.

Requests to revoke my consent of this authorization and/or restrict the use or disclosure of my PHI must be submitted to the Medical Direction, LLC Privacy Officer at:

Privacy Officer
Medical Direction, LLC
P.O. Box 4088,
Peachtree City, Georgia 30268-8088

This authorization will expire within two (2) years from the date listed below.

_____ _____
Signature of Individual named above or Legal Guardian Date of Birth of Individual named above

_____
Date

Please mail or fax this completed and signed authorization to Medical Direction, LLC at the address below and save a copy of for your personal records.