Authorization for Use and Disclosure of Protected Health Information

With my consent, I, (Printed Name): _____, hereby request and authorize the office of:

AV8RMED, LLC
100 Hartsfield Centre Parkway, Suite 340
Atlanta, GA 30354

to use and/or disclose any and all protected health information about me with the

Federal Aviation Administration – Office of Aerospace Medicine

Use and/or disclosure of this PHI is to assist in my efforts for initial or continued medical certification through the Federal Aviation Administration – Office of Aerospace Medicine (FAA- OAM) Aerospace Medical Certification Division.

By signing this form, I consent to AV8RMED, LLC's use and/or disclosure of my PHI with the FAA-OAM Aerospace Medical Certification Division (AMCD) and other treating providers to assist in determining my fitness for flight and medical certification.

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

_____ _____ _____

Date Signature Date of Birth

_____

PI #