Authorization for Use and Disclosure of Protected Health Information

With my consent, I, (Printed Name): ____________________, hereby request and authorize: ____________________________located at ____
Phone number: __________________________ | Fax number: ___________________________
to use and/or disclose any and all protected health information (PHI) including FAA correspondence and previous FAA medicals about me with AV8RMED, LLC. 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 am consenting to AV8RMED, LLC's use and/or disclosure of my PHI with the FAA-OAM Aerospace Medical Certification Division (AMCD) to assist in determining my fitness for flight and medical certification.
This authorization will expire within two (2) years from the date listed below.

By signing this form, I am aware that submission of my case to the FAA **DOES NOT** guarantee FAA approval or additional information may be requested.

_________________	______________________________________	________________
Date	Signature	Date of Birth

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