AV8RMED
SERVING THE PROFESSIONAL PILOT

Authorization for Use and Disclosure of Protected Health Information

With my consent, I, (Printed name): _____, hereby request and authorize:

_____

located at: **Address:**_____

Phone Number:_____ **FAX Number:**_____

Relationship to Patient_____to use and/or disclose any and all protected health information (PHI) including FAA correspondence and previous FAA medicals about me with **Thomas B. Faulkner, MD, 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 document, I hereby grant my consent for Thomas B. Faulkner, MD, LLC to utilize and/or disclose my Protected Health Information (PHI) to the FAA-OAM Aerospace Medical Certification Division (AMCD) and the individual specified above. This will aid in evaluating my fitness for flight and the process of medical certification.

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

Please mail or fax this completed and signed authorization to AV8RMED, LLC at the address below and save a copy of for your personal records.

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