

## PILOT'S AUTHORIZATION TO RELEASE OR DISCLOSE DOCUMENTS

Pilot's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Request: \_\_\_\_\_

**As required by Privacy Regulations, Aviation Medicine Advisory Service (AMAS) may not release or disclose your protected health information without your authorization. This document will allow release or disclosure of your information to Harvey W. Watt & C. Inc. (Watt) within the guidelines of the Privacy Regulations.**

I, \_\_\_\_\_ hereby authorize AMAS to release or disclose "documents" to Watt as they relate to the Aeromedical Services.

Documents will include all records AMAS has in it's possession, including but not limited to:

- Patient Health Information such as, psychiatric information (but *excluding* psychotherapy notes), HIV or related information, Alcohol and/or drug use information, Lab test results, and general office notes from medical providers
- Other information (including information obtained from non-affiliated parties) related to the application for insurance and relied upon to make determination for coverage for a Pilot

**The authorization is effective for a period of six months from the date signed below.** This authorization will expire at the end of this specified period.

I understand that for reasons beyond the control of AMAS, the documents disclosed above, may be subject to re-disclosure with my authorization or as otherwise permitted or required by law and therefore, may no longer be protected.

I understand that Watt complies with state and federal laws and regulations enacted to protect my privacy. I understand that that I have the right to inspect a copy of the documents released or disclosed under federal law, to receive a copy of this authorization, to restrict what is disclosed with this authorization and to have knowledge of any remuneration involved due to any marketing activity as allowed by this authorization and as a result of this authorization. I also understand that I have the right to refuse to sign this authorization or to revoke this authorization by sending a written statement to Watt. A revocation of this authorization will only apply to the extent that it was previously relied upon to disclose documents.

I understand that failure to sign this authorization will not condition my enrollment in the Watt Aviation Medical Services program, but may impair Watt's ability to advise, monitor and/or assist with services provided under the program on my behalf.

\_\_\_\_\_  
Pilot's Printed Name:

\_\_\_\_\_  
Pilot's Signature:

\_\_\_\_\_  
Date:

Please mail completed form to both AMAS and Harvey Watt & Co. at the following:

Aviation Medicine Advisory Service  
14707 E. 2<sup>nd</sup>. Ave. Suite 200  
Aurora, CO 80011

Harvey Watt & Co.  
PO Box 20787  
Atlanta, GA 30320