United States Department of Justice
Immigration and Naturalization Service

INS Health Care Program Authorization for Disclosure of Information

(Pursuant to the Privacy Act of 1974, Public Law 93-579)

To:

_____
Name

_____
Street Address

_____
City, State, ZIP

INS Location *(please circle):*

AGUADILLA, BATAVIA, EL CENTRO, EL PASO, FLORENCE

KROME, PORT ISABEL, SAN PEDRO, VARICK

OTHER: _____

You are hereby authorized to furnish information from my record/ the record of:

Detainee's Name: _____ A# _____

in the medical record system of your facility to :

Requester's Name: _____

Requester's Address: _____
Street Address *City, State* *ZIP*

Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal Agency under false pretenses shall be guilty of a misdemeanor and fined not more than $5000 (5 U.S.C. 552a(i)(3)) and in the case of alcohol and drug abuse patient records a falsified authorization of disclosure is prohibited under 42 CFR 2.31(d) and is punishable by a fine of not more than $500 for a first offense or a fine of not more than $5000 for a subsequent offense with 42 CFR 2.14.

Purpose or need for the disclosure:	Specify extent and nature of information to be disclosed for each purpose or need indicated (include inclusive dates of treatment.)
__ Further Medical Care	_____
__ Attorney	_____
__ Other (Specify)	_____

Duration of Consent (Period of time or the circumstance(s) during which disclosures may be made pursuant to this autnorization.)

From: _____ Until: _____

_____
Signature of Detainee (Applicant)

Address of Detainee (Applicant):

_____
Street

_____
City, State, ZIP

IMPRINT OF DETAINEE ID PLATE OR COMPUTER LABEL OR COMPLETE THE FOLLOWING:

1. Name *(Last, First)*

2. DOB:

3. A#

4. Nationality: