Harvey Watt & Co.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, I, (Printed name) _____, hereby request and authorize **Harvey Watt & Company** and their staff to use, disclose, discuss and/or exchange protected health information (PHI) about me with **medical representatives of the U.S. Department of Transportation, Federal Aviation Administration (FAA)**. The use and/or disclosure of this PHI is to facilitate the process of obtaining or maintaining FAA airman medical certification.

By signing this form, I am consenting to Harvey Watt & Company's use and/or disclosure of the following PHI about me to assist in obtaining or maintaining FAA airman medical certification:

- all medical documentation in written form, including, if applicable, records related to mental health care and psychotherapy,
- additional medical documentation provided by me or by my treating health care providers to Harvey Watt & Company, and
- documentation from the Federal Aviation Administration (FAA) regarding my eligibility to meet airman medical certification standards.

With my consent, Harvey Watt & Company may communicate with me, at my home or other designated location, using any of the following methods in reference to any items that assist Harvey Watt & Company for the purpose of obtaining or maintaining FAA airman medical certification: phone calls, e-mail, mail, fax, and/or overnight delivery service.

I have the right to revoke my consent in writing except to the extent that it was previously relied upon to disclose PHI. Further, I have the right to request that Harvey Watt & Company restrict how it uses and/or discloses my PHI to facilitate obtaining or maintaining FAA airman medical certification. However, Harvey Watt & Company is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

If I do not sign this consent, Harvey Watt & Company may decline to provide service to me.

Requests to revoke my consent of this authorization and/or restrict the use or disclosure of my PHI must be submitted to Harvey Watt & Company at:

Harvey Watt & Company
Director of Claims Administration
P.O. Box 20787
Atlanta, GA 30320

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

_____ _____
Signature of Individual Named Above or Legal Guardian Date of Birth of Individual Named Above

_____
Date

✈ *Please mail or fax this completed and signed authorization to Harvey Watt & Company at the address below and save a copy for your personal records.* ✈

P.O. Box 20787 | Atlanta, GA 30320 | 1-800-241-6103 | FAX: 404-761-8326