HIMS AME RELEASE OF INFORMATION FORM

This is a **comprehensive** and **all-inclusive** request for records.

By signing below, I hereby authorize any and all persons or organizations to release at any time any and all information related to my current or past physical and mental health, civil or criminal court records, educational records, and employment history including personnel records in written, electronic, verbal, or any other format to Dr. Mark K. Huntington, my HIMS AME. I authorize Dr. Huntington to discuss the material released hereby with the provider of the material as needed.

I recognize this release includes information normally protected by HIPAA legislation and other materials considered confidential by law or by tradition.

This release shall remain in effect unless or until it is revoked in writing.

Information may be sent to: Mark K. Huntington MD PhD FAAFP
Center for Family Medicine
1115 East 20th Street
Sioux Falls, SD 57105 USA
FAX 605.335.1006

I acknowledge that my interactions with the HIMS AME and the HIMS Program do not fall under the provisions of HIPAA; all information related to my participation in the HIMS program will be shared with the FAA.

Legibly printed name: _____ Signature:_____
Birthdate: _____
Date signed: _____

Witness/Notary: