



DEPARTMENT OF INTERIOR

United States Park Police

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

DIRECTIONS: Complete all sections, date, and sign (Print legibly and use black or blue ink)

1. I, _____, hereby voluntarily authorize the disclosure of information from my health record.

2. This information is to be provided to:

Name:
Address:

Phone:
Email:

3. The purpose or need for disclosure is (check the applicable boxes):

USPP Physical Readiness Test

Physical Efficiency Battery

Applicant Eye Exam Report

Preplacement Medical Examination Report (USPP Form 130)

Other (specify) _____

4. Sensitive health information to be disclosed (check the applicable boxes):

Substance Related Disorder (Drug/Alcohol) Treatment/Referral

Mental Health History

5. Disclosure Authorization: Signature and Date (Authorization is incomplete without signature and date).

5A. Signature

5B. Date



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MENTAL HEALTH HISTORY QUESTIONNAIRE

DIRECTIONS: This Mental Health History Questionnaire must be completed to continue the application process. Please use the space at the bottom of the last page for details.

1A. NAME (Last, First, Middle)	1B. DOB (MM/DD/YYYY)	1C. SEX (M or F)	1D. SSN No.
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2A. Home Address (No. Street, City, State, Zip Code)	2B. Phone No.
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3A. Have you EVER been evaluated, diagnosed, and/or treated for any of the following?	3B. Treatment Dates (MM/YY):	3C. Please check if your treatment included any of the following:
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	Yes	No	Start	End	Hospitalized	Medication	Counseling
Depression							
Anxiety							
Work Burnout/Fatigue							
Bipolar Disorder							
Personality Disorder							
Post-Traumatic Stress Disorder							
Attention-Deficit/Hyperactivity Disorder							
Obsessive/Compulsive Disorder							
Suicidal Thoughts, Plan or Attempt							
Homicidal Thoughts, Plan or Attempt							
Hallucinations (Verbal or Auditory)							
Panic/Panic Attacks							
Substance Related Disorder (Drug/Alcohol)							
Any Other Mental Health Condition							

5. Please provide details on ALL checked boxes from the above table:

6. Please provide details on ALL CURRENT treatment not specified above:

7A. Signature	7B. Date
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