

## Authorization to Release Information Form

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***(Print Name – First, Middle, Last)***

As a National Health Service Corps (NHSC) Loan Repayment Program (LRP) applicant, I, hereby authorize:

1. The Department of Health and Human Services (HHS), and/or its contractors, to release the following information to a consumer reporting agency (credit bureau) to obtain a credit report to assess my eligibility, creditworthiness and suitability to participate in the NHSC LRP and to verify my educational loans: my name, address(es), social security number, and other information necessary to identify me.
2. The HHS, and/or its contractors, to release the following information to the lenders/holders of my educational loans in order to obtain loan payoff balances, to determine my eligibility/qualifications to participate in the NHSC LRP, and to determine the eligibility of my educational loans for repayment under the NHSC LRP: my name, address(es), social security number, account number(s), account status, and other information necessary to identify me.
3. The HHS, and/or its contractors, to release my name, address(es) and social security number for the purpose of determining whether I appear on the Excluded Parties System List.
4. The HHS, and/or its contractors, to release my name, address(es) and social security number for the purpose of obtaining the National Health Practitioner Data Bank and Healthcare Integrity Protection Data Bank Reports to determine my eligibility requirement of satisfactory professional competence and conduct.
5. Any program to which I owe a health profession service obligation to release information relating to that obligation to HHS and/or its contractors.

This authorization will take effect on the date that I sign this release form. If I receive an NHSC Loan Repayment Program Amendment Contract, this authorization shall remain in effect until the date my NHSC Loan Repayment Program obligation has been fulfilled or this authorization is revoked by me in writing

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***(Signature of Applicant)***

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***(Date)***

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***(Please Print Name)***

(Revised 06/09 – DAA, BCRS, HRSA, DHHS)