NSSP releases

National Supplemental Screening Program

Authorization for Release of NSSP Participant Information – Former Worker Program

NSSP Participant's Name: _____ Date of Birth: _____

You are receiving a DOE Former Worker Program health screening examination performed by the NSSP on behalf of a Regional Former Worker Program (FWP) project. In order to share your screening results with your regional project, we require your written consent. We have provided information below to help you identify which regional project(s) applies to you specifically. If you worked at more than one DOE site and are unsure which box to check, please call the NSSP toll-free at (866) 812-6703 for guidance.

I hereby authorize Oak Ridge Associated Universities (ORAU) to release the results of my National Supplemental Screening Program medical examination to the following regional FWP project(s) and Principal Investigator(s) (PI):

	If you worked at:	**Then your results will be sent to:**
☐	A gaseous diffusion plant (K-25, Paducah, Portsmouth), Idaho National Engineering Laboratory, Mound Plant, Y-12 Plant, Oak Ridge National Laboratory (X-10), Fernald, Brookhaven National Laboratory, Lawrence Livermore National Laboratory, Lawrence Berkeley National Laboratory, Sandia National Laboratory (in Livermore, California), Nevada Test Site, Yucca Mountain, and/or Waste Isolation Pilot Plant	The Worker Health Protection Program (Queens College) PI: Steven Markowitz, MD
☐	Los Alamos National Laboratory and/or Sandia National Laboratory (in New Mexico)	The Johns Hopkins University Program PI: Aisha Rivera Margarin, MD, MS
☐	Iowa Army Ammunition Plant and/or Ames Laboratory	The University of Iowa Program PI: Marek Mikulski, MD, MPH, PhD
☐	Pantex Plant	The University of Texas (Tyler) Program PI: Cynthia K. Ball, DO, MS, FACOEM

Oak Ridge Associated Universities may disclose all results and reports from exam date _____ to the principal investigator(s) indicated above.

This authorization is voluntary and I may rescind my authorization of this release in the future. I will personally receive a copy of the medical information that is to be disclosed to the Regional FWP project Principal Investigator. Any information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. There is no processing fee for this service. This authorization will expire one year from the date I sign this authorization unless I specify otherwise.

I may revoke this authorization at any time by notifying Oak Ridge Associated Universities. To revoke this authorization, I must do so in writing and the written revocation must be signed and dated. The revocation will not affect any actions taken before its receipt by Oak Ridge Associated Universities.

_____ _____

Signature of NSSP Participant or Representative Date

Printed Name of NSSP Participant or Representative: _____

_____ or _____

Representative Relationship to Patient Legal Authority (attach supporting documentation)