UNITED STATES POSTAL SERVICE™

Authorization for Medical Report

Name & Address	Social Security Number	VA Number
	Date of Birth	Date of Injury

Service Record

Branch of Service	Rank	Military Service Number	
☐ USA ☐ USMC ☐ USCG ☐ USN ☐ USAF		Date Entered Service	Date Released from Service

Postal Medical Officer

Name	Mailing Address

Authorization

I, the undersigned, authorize the following hospitals and/or doctors to furnish the above mentioned postal medical officer all medical information concerning the following problems. It is understood that this/these report(s) will be furnished without cost to the US Postal Service. A photostat of this authorization will be as valid and effective as the original.

Signature	Witness Signature	
Printed or Typed Name	Printed or Typed Name of Witness	Date

Authorized Doctors/Hospitals

Medical Problems

Privacy Act Statement

The collection of this information is authorized by 39 USC 401, 1001. Completion of this form is voluntary. This information will be used to secure outside medical information necessary to process medical records which are kept on each postal employee. As a routine use, this information may be disclosed to the Civil Service Commission, Public Health Services, HHS, and to officials of other federal agencies responsible for federal benefit programs. In addition, this information may be disclosed to an appropriate law enforcement agency for investigative or prosecutorial purposes, to a congressional office at your request, or where pertinent, in a legal proceeding to which the Postal Service is a party, to OMB for review or private relief regulation, to a labor organization as required by the NLRA, or to an agency where relevant to hiring, contracting, or licensing procedures. Your failure to provide this information may result in your not receiving full consideration for a position.