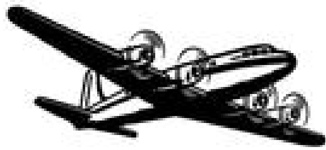

Dr. Robert J. Gordon, D.O.
Senior/HIMS AME
Aeromedical Consultant
Cell: (734)718-7607
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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, I, (Printed name) ________________________________ ______, hereby request and authorize representatives of **Robert J. Gordon, D.O. AME #21056,** to use, disclose, discuss and/or exchange protected health information (PHI) about me with **medical representatives of the U.S. Department of Transportation (DOT), Federal Aviation Administration (FAA)**. The use and/or disclosure of this PHI isto facilitate the process of obtaining or maintaining FAA airman medical certification.
By signing this form, I am consenting Dr. Gordon to use, disclosure, release and/or exchange of the following PHI about me to assist in obtaining or maintaining FAA airman medical certification:
□ all medical documentation in written form, including, if applicable, records related to mental health care and psychotherapy,
□ additional medical documentation provided by me or by my treating health care providers to Watt, and
□ all documentation from the Federal Aviation Administration (FAA) regarding my eligibility to meet airman medical certification standards, including FAA forms, telephone action records, letters of authorization, denial, Special Issuance, requests for additional information, memos, statements of demonstrated ability, airman medical file, and airman medical certificates.

With my consent, Dr. Gordon may communicate with me, my employer, my physician (s), the DOT and/or the FAA, at my home or other designated manner or location, using any of the following methods in reference to any items that assist Watt for the purpose of obtaining or maintaining FAA airman medical certification: phone calls, e-mail, mail, fax, and/or overnight delivery service.
I have the right to revoke my consent in writing except to the extent that it was previously relied upon to disclose PHI. Further, I have the right to request that Dr. Gordon restrict how it uses and/or discloses my PHI to facilitate obtaining or maintaining FAA airman medical certification. However, Dr. Gordon is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
If I do not sign this consent, Dr. Gordon may decline to provide service to me.
Requests to revoke my consent of this authorization and/or restrict the use or disclosure of my PHI must be submitted to Watt at:

Robert J. Gordon, D.O,
4801 Emma Browning Ave.
Austin, Texas 78179

This authorization will expire within two (2) years from the date listed below.

____ ________________________________
Signature of Individual Named Above or Legal Guardian Date of Birth of Individual Named Above

____
Date