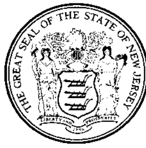

AUTHORIZATION TO DISCLOSE COASTGUARD INFORMATION

United States Coast Guard Headquarters
Commandant (G-MRI)
2100 2nd Street., S.W.
Washington, DC 20593-0001

Re: Name:
Address:
D.O.B.:
S.S. No.:

Please accept this authorization and provide the information below:

I hereby authorize the United States Coast Guard (the "Covered Entity") to release my information described below to:

New Jersey Maritime Pilot and Docking Pilot Commission
One Penn Plaza East
9th Floor
Newark, New Jersey 07105
(973) 491-7693

Purpose of Disclosure: The documents are being produced in connection with an Application for New Jersey State Docking Pilot license.

Documents/Information to be Released:

This authorization is limited to obtain applicant's Coast Guard license and records:

Information to be disclosed and provided:

___ Any and all information obtained during any investigation of this applicant;
___ Evidence of current first class pilot's license or a first class pilot endorsement license issued by the United States Coast Guard;
___ Evidence of current unlimited radar observer's certificate;
___ Evidence of participation in a United States Department of Transportation required drug screening and testing program;
___ Evidence of a current physical examination by a licensed physician in a manner prescribed by the United States Coast Guard;

I understand that the information to be disclosed includes my identity, diagnosis and treatment including but not limited to, ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS AND HIV information, as applicable.

I understand that the terms of this Authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA"). I understand that I have the right to revoke this Authorization, at any time prior to the Covered Entity's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in the Covered Entity's Notice of Privacy Practice. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature and that I should send it to:

The New Jersey Maritime Pilot
& Docking Pilot Commission
One Penn Plaza East, 9th Floor
Newark, NJ 07105

I understand that I am not required to sign this Authorization and that the Covered Entity may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

This Authorization expires upon the Covered Entity's release of the information described above or 90 days after the Date of Authorization, as set forth below, whichever comes first.

I hereby acknowledge receipt of a copy of this Authorization.

____
Print Name

____
Signature of Individual or Personal Representative

____
U.S. Coastguard Representative Title

____
Date of Authorization