Department of Health and Human Services
Administration for Children and Families
Office for Refugee Assistance

Repatriation Program
Consent Form

I, _____, authorize the
(Print)
Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Office or Refugee Resettlement (ORR), Repatriation Program (Program), to collect and have access to my protected health information (PHI)and to disclose my PHI to appropriate Program contractor/s, partner/s for the purpose of making Program Financial Decisions (PFD). PFD includes but is not limited to waivers and loan collection decisions.

Authorizing HHS/ACF/ORR/Program to collect, have access to and disclose your PHI information is volunteer. However, without your authorization, HHS/ACF/ORR/Program may be unable to proceed with your request and/or make a PFD decision regarding your case. We collect this information under the Privacy Rule authority issued pursuant to the Health Insurance Portability and Accountability Act of 1996.