

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Resources and Services Administration
Bureau of Health Professions
Rockville, MD 20857

To: Lenders/holders/Service providers Participating in the Health Education Assistance Loan (HEAL) Program

**Subject: Amendment to HEAL Total & Permanent Disability Procedures
Lender Policy Memorandum L-2003-7**

The purpose of this policy memorandum is to notify HEAL lenders/holders/service providers that the Department of Health and Human Services (DHHS) is amending the procedures to determine the total and permanent disability status of a borrower. To obtain a decision regarding a request to have HEAL loans discharged for permanent and total disability, a lender/holder/service provider must submit certain specified documentation to the Department of Health and Human Services. This documentation is outlined in Lender Policy Memoranda L-1995-10, L-1996-8, and L-1998-13.

Due to a new procedure for reviewing disability claim requests by the DHHS, we are implementing the use of a consent for medical release form (enclosed) to be included in each claim package. This form may also be obtained from our web site at <http://bhpr.hrsa.gov/scholarshipsloans/heal/index.html> and click on Forms. The medical release consent form is required and must be submitted with each disability package. This signed consent will permit the DHHS to contact the borrower's physician directly for additional, pertinent information that will enable the DHHS to perform a more complete review in a timely manner.

Documentation for disability discharge must be submitted to the Division of Health Careers Diversity and Development, Campus Based Branch, Parklawn Building, Room 8-34, 5600 Fishers Lane, Rockville, Maryland 20857.

If you have any further questions concerning this policy memorandum, please contact Ms. Terri Ehrenfeld of the HEAL Branch at (301) 443-5594 or Ms. Lorraine Evans of the Campus Based Branch at (301) 443-0785.

Henry Lopez, Jr.
Director
Division of Health Careers Diversity
and Development

Enclosure:
Medical Release Consent Form

Department of Health and Human Services

Program Support Center
Federal Occupational Health Service
4350 East West Highway, Third Floor
Bethesda, MD 20814

MEDICAL RELEASE

HHS/Health Resources and Services Administration
Division of Health Careers Diversity and Development

I, _____ authorize a Federal Occupational Health (FOH) designated physician to contact my physician, _____ to receive medical records and discuss my medical condition. I understand that the information discussed is to be confidential. Relevant information may, however, be shared with supervisors/managers concerned with work restrictions and/or accommodations, personnel who may provide first aid and emergency treatment, and government officials investigating compliance with the ADA.

Name

Date

Witness

Date