

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

**To: Lenders/Holders/Serviceers 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/serviceers 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/serviceer 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