

Joseph William Korzen
[REDACTED]

December 20, 2025

VIA USPS REGISTERED MAIL

MedStar Health

10980 Grantchester Way, 7th Floor
Columbia, MD 21044
Attention: MMG Admin Team

RE: Formal HIPAA Request for Complete Medical Records – CICIP Case No. CICIP [REDACTED]

Patient: Joseph William Korzen, DOB: [REDACTED]

Date Range: January 1, 2020 – Present

Dear MMG Admin Team,

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 C.F.R. § 164.524), I am formally requesting a complete copy of my medical records for all treatment received within the MedStar Health system from January 1, 2020, to the present.

Request for Fee Waiver:

As these records are being requested exclusively for submission to a government compensation program (Countermeasures Injury Compensation Program - CICIP), I respectfully request that all fees be waived in accordance with standard practice for government claims.

This request includes all records for the specified date range, with particular attention to all visits, consultations, and diagnostic studies related to neurological symptoms and movement disorders. Specifically, I am requesting:

- Office visit notes
- Consultation reports
- Diagnostic imaging reports and images
- Laboratory results
- Medication lists
- Treatment plans
- All correspondence related to my care

Purpose:

These records are required for an official injury claim with the Countermeasures Injury Compensation Program (CICP Case No. CICP [REDACTED]).

Delivery Instructions:

Please send the complete set of records directly to:

Health Resources and Services Administration
Countermeasures Injury Compensation Program
5600 Fishers Lane, Room 14W-18
Rockville, MD 20857
Fax: 301-443-5502

No copy is required to be sent to my home address.

Under HIPAA, you are required to act within 30 days of receipt of this request. If for any reason fees cannot be waived, please contact me at [REDACTED] with a fee estimate before proceeding.

Thank you for your prompt attention to this matter.

Sincerely,

(Signature)

Jordan William Korzen

HANDWRITTEN SIGNATURE REDACTED

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
Countermeasures Injury Compensation Program

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PLEASE COMPLETE ALL APPLICABLE SECTIONS, SIGN, AND DATE

I. PATIENT IDENTIFICATION (<i>Injured Countermeasure Recipient</i>) Joseph William Korzen		FOR OFFICIAL CICP USE ONLY CICP No. _____	
NAME (Last) korzen		(First) joseph	(MI) W
ADDRESS [REDACTED]		DATE OF BIRTH [REDACTED]	
II. _____ Personal Representative, if applicable, for injured countermeasure recipient/ patient in section I (e.g. parent of a minor or guardian, administrator for estate)			
III. The information is to be disclosed by:		And is to be provided to:	
Name of Facility/Provider MedStar Health		U.S. Department of Health and Human Services Health Resources and Services Administration Countermeasures Injury Compensation Program 5600 Fishers Lane, Room 8W-25A Rockville, MD 20857	
Address 10980 Grantchester Way, 7th floor			
City/State/Zip Code Columbia, MD 21044			
IV. The information to be disclosed from the patient's, as identified in section I, health record (<i>check appropriate box(es)</i>). ☒ Entire medical records from <u>01/17/2020</u> to the present (<i>see instructions for appropriate date</i>) ☐ Only information (e.g. medical records) related to (<i>specify injury or cause of death</i>) _____ ☐ Other (<i>specify, e.g., insurance coverage, billing, etc.</i>) _____ The purpose or need for this disclosure is to determine eligibility for benefits from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Countermeasures Injury Compensation Program (CICP). This information may be used for certain medical research purposes when consistent with the purposes for which the CICP was formed, e.g., gathering and sharing de-identified data regarding countermeasures adverse events.			
V. I understand that I may revoke this authorization in writing at any time by contacting my facility/provider, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. _____ (<i>Enter Date of Termination or Expiration if different from one year after date below</i>)			
VI. SIGNATURE OF PATIENT		DATE 12/23/25	
VII. SIGNATURE OF PERSONAL REPRESENTATIVE (if applicable) PATIENT SIGNATURE REDACTED		DATE	
VIII. SIGNATURE OF WITNESS (if signature is thumbprint or mark, or if required by State law)		DATE 12/23/25	
Consenting to this authorization of disclosure of records is voluntary and health provider(s) shall not condition treatment upon the individual's signature. This information is subject to release for the purposes stated in Section IV and may not be used by the recipient for any other purpose unless permitted by federal law. I understand that information disclosed by this authorization, except for alcohol and drug abuse patient records as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Part 164), and the Privacy Act of 1974 (5 USC 552a).			

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
Countermeasures Injury Compensation Program

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PRIVACY ACT STATEMENT

Section 319F-4 of the Public Health Service Act (PHS Act), Public Law 109-148 (42 U.S.C. 247d-6e), and the Debt Collection Improvement Act of 1996 authorize collection of this information. It will be used to determine your eligibility to receive benefits. This information will be disclosed to the U.S. Department of Health and Human Services and its consultants; and Federal, State, or local law enforcement agencies, if the Government becomes aware of a possible violation of civil or criminal law; and for certain medical research purposes when consistent with the purposes for which the Program was formed, i.e., to make determinations concerning alleged covered countermeasure injury associations and to provide compensation to individuals injured by covered countermeasures. Furnishing the information on this Form, including the social security number, is voluntary, but failure to do so may delay or prevent the receipt of a payment. The information collected will be maintained confidentially pursuant to the Privacy Act, 5 USC Section 552a, as amended.

PUBLIC BURDEN STATEMENT

The purpose of this data collection is to gather information to allow the Secretary of Health and Human Services to determine if requesters are eligible for Countermeasure Injury Compensation Program (CICP) benefits. Requesters (or their representatives) must submit appropriate documentation forms and relevant medical records as specified in Section 42 CFR 110.50-110.53 to the CICP. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0334 and it is valid until 4/30/2026. This information collection is required to obtain or retain a benefit (42 CFR Part 110). Access to these records is strictly limited to authorized users who are aware of their responsibilities under the Privacy Act and who are required to maintain Privacy Act safeguards with respect to such records. The System of Records Notice for Injury Compensation Programs, HHS/HRSA/HSB, System No. 09-15-0056, identifies authorized users. Public reporting burden for this collection of information is estimated to average 5.1 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov. Please do not send documents related to an individual claim to paperwork@hrsa.gov.

Instructions for Completing HRSA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Type or print legibly in all fields using dark ink.

Section I – Provide the name, address, and date of birth of the injured countermeasure recipient.

Section II – Provide the name of the personal representative such as a parent of a minor, or a guardian, or an attorney, if applicable. If there is no personal representative then section II should be left blank.

Section III – Provide the name and address of the facility or provider releasing the information. This is the facility or provider of health care services to the injured countermeasure recipient.

Section IV – Check the appropriate box as applicable. The CICP will provide direction as to which records are needed.

- 1. Entire Medical Record – the complete medical record from the identified facility or provider from one (1) year prior to administration or use of the covered countermeasure that may have caused the injury. Please enter this date.**
- 2. Only information related to – specify diagnosis, injury, operations special therapies, etc. within a specific date range. (Only complete this section if instructed to do so by the CICP).**
- 3. Other (specify) – e.g., insurance coverage, billing, etc. (Only complete this section if instructed to do so by the CICP).**

Section V – The requester may revoke this authorization at any time by notifying the Health Information Management (Health Records) Department of the facility/provider in Section III, in writing. If a different expiration date is desired, specify a new date. You may consider providing a date longer than one year if you have an ongoing CICP covered injury that has not resolved or may not be resolved soon.

Section VI – Patient (i.e., the injured countermeasure recipient) signs and dates the form here.

Section VII – A personal representative (e.g., parent, legal guardian, power of attorney etc.), if one has been designated, signs and dates the form here.

Section VIII – A witness signs and dates the form here, if necessary (e.g., if the patient signature is a thumbprint or mark or if required by State law).

Send a copy of the completed form to the facility/provider identified, and, at the same time, also mail a copy of the completed form to the CICP at the address below:

Health Resources and Services Administration
Countermeasures Injury Compensation
Program 5600 Fishers Lane, Room 8W-25A
Rockville, MD 20857

If you have questions contact the CICP at:

1-855-266-2427 (855-266-CICP); or
www.hrsa.gov/CICP; or
CICP@HRSA.gov



Health Resources & Services Administration

Health Systems Bureau

Countermeasures Injury Compensation Program

5600 Fishers Lane

Rockville, MD 20857



December 3, 2025

Joseph Korzen
[REDACTED]

Case Number: CICP [REDACTED]

Dear Joseph Korzen:

Thank you for submitting a Request for Benefits form to the Countermeasures Injury Compensation Program (CICP). In addition to the form, you are required to submit: 1) records sufficient to demonstrate that you used or were administered a covered countermeasure; 2) records sufficient to demonstrate that you sustained a covered injury; and 3) a copy of each signed Authorization for Health Information Form authorizing the release of records to the Program that you sent to each of your healthcare providers instructing that your records be submitted directly to the Program. 42 C.F.R. §110.51(a).

You must arrange to have your providers submit the following medical records:

- (1) All medical records documenting medical visits, procedures, consultations, and test results that occurred on or after the date of administration or use of the covered countermeasure; and
- (2) All hospital records, including the admission history and physical examination, the discharge summary, all physician subspecialty consultation reports, all physician and nursing progress notes, and all test results that occurred on or after the date of administration or use of the covered countermeasure; and
- (3) All medical records for one year prior to administration or use of the covered countermeasure as necessary to indicate an injured countermeasure recipient's pre-existing medical history.
- (4) Proof of vaccination.

42 C.F.R. §110.50(a).

To date, the CICP has received copies of the signed "Authorization for Use or Disclosure of Health Information" form(s) **but has not received** the necessary medical records from your providers.

Please complete the steps outlined below to ensure that the CICP receives your medical records and the Request for Benefits can be processed and evaluated for CICP medical eligibility.

1. Complete an "Authorization for Use or Disclosure of Health Information" form for each healthcare provider that the requester visited, requesting records from the year prior to the use or administration of the countermeasure to the present. For example, if the requester received the covered countermeasure on January 1, 2021, please request the records for the time period between January 1, 2020, and the present date. If necessary, you can download additional "Authorization for Use or Disclosure of Health Information" forms from the CICP website: <https://www.hrsa.gov/cicp/filing-benefits>.
2. Submit the completed "Authorization for Use or Disclosure of Health Information" form(s) to requester's healthcare provider(s) so that they can send us the records AND mail a copy of each completed "Authorization for Use or Disclosure of Health Information" form(s) that you submitted to the CICP either online at this link: cicpsubmit.hrsa.gov, or to the following address:

Health Resources and Services Administration
Countermeasures Injury Compensation Program
5600 Fishers Lane, 14W-18
Rockville, MD 20857

If you have questions, please call 1-855-266-2427 or email the CICP at: CICP@HRSa.gov.

Very Respectfully,

Director
Division of Injury Compensation Program