Joseph William Korzen
[redacted]

December 20, 2025

Health Information Management Division
NIH Clinical Center
10 Center Drive, MSC 1192
Building 10, Room B1L400
Bethesda, MD 20892-1192

RE: Formal Request for Complete Medical Records – CICP Case No. [redacted]
Patient: Joseph William Korzen, DOB: [redacted]
Providers: Dr. Debra Ehrlich, Dr. Oday K. Halhouli, Zhen Ni, PhD, and associated staff
Protocol: 93-N-0202
Date Range: January 17, 2020 – Present (Specifically including all visits in 2023)

Dear Medical Records Custodian,

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 C.F.R. § 164.524), I hereby formally request a complete copy of my medical record for all care received at the NIH Clinical Center.

Request for Fee Waiver:
As these records are being requested exclusively for submission to a government compensation program, I respectfully request that all fees be waived in accordance with standard practice for government claims.

This request includes all records from January 17, 2020, to the present, with a specific emphasis on capturing all visits during the 2023 calendar year.

Specific records must include, but are not limited to:

- All records from my neurophysiology study at the Parkinson's Disease Clinic and Movement Disorders Unit on December 5, 2023.
- The complete neurophysiology report (EMG/EEG study) conducted on that date.
- All records related to Protocol 93-N-0202.
- All clinical notes, reports, and test results from Dr. Debra Ehrlich, Dr. Oday K. Halhouli, and Zhen Ni, PhD.
- Any and all records from my prior visit(s) with the movement disorders study team in 2023 (specific date unknown).

- Nursing notes, diagnostic imaging reports, laboratory results, and 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. [redacted]).

Delivery Instructions:
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

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

I have completed the required NIH-527 "Authorization for Release of Medical Information" form and included it with this request. 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 the fee estimate before proceeding.

Sincerely,

(Signature)
Joseph 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 *(Injured Countermeasure Recipient)* Joseph William Korzen	***FOR OFFICIAL CICP USE ONLY*** **CICP No.** _____	
NAME *(Last)* korzen	*(First)* joseph	*(MI)* w
ADDRESS [redacted]		
CITY/STATE/ZIPCODE [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 National Institutes of Health (NIH)	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 10 Center Drive, MSC 1192 Building 10, Room B1L400	
City/State/Zip Code Bethesda, MD 20892-1192	

IV. The information to be disclosed from the patient's, as identified in section I, health record *(check appropriate box(es)).*

☒ Entire medical records from 01/17/2020 to the present *(see instructions for appropriate date)*
☐ Only information (e.g. medical records) related to *(specify injury or cause of death)*_____
☐ Other *(specify,* e.g., insurance coverage, billing, etc.) _____

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.

_____
(Enter Date of Termination or Expiration if different from one year after date below)

VI. SIGNATURE OF PATIENT	DATE 12/23/25
VII. SIGNATURE OF PI[illegible]e) PATIENT SIGNATURE REDACTED	DATE
VIII. SIGNATURE OF WITNESS (if signature is [illegible]rint or mark, or if required by State law) PRIVATE WITNESS SIGNATURE REDACTED	DATE 12/23/25

Consenting to this authorization [illegible] th provider(s) shall not condition treatment upon the individual's signature of such authorization for use or disclosure of health information. 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).

OMB Control Number: 0915-0334
Expiration Date: 4/30/2026

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.

OMB Control Number: 0915-0334
Expiration Date: 4/30/2026

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

MEDICAL RECORD

Authorization for the Release of Medical Information

National Institutes of Health, Clinical Center
Health Information Management Division
10 Center Drive, MSC 1192
Building 10, Room B1L400
Bethesda, MD 20892-1192

Phone: (888) 790-2133 or (301) 496-3331
FAX: (301) 480-9982

INSTRUCTIONS: This form must be completed in its **entirety**, each section must be completed or the form could be returned as invalid.

For more information or to submit this form electronically, please visit our website:
https://www.cc.nih.gov/dcri/medical-record-request

Please complete a separate form for each requestor

1. PATIENT INFORMATION:

Patient Name:	Phone Number:	Date of Birth:
joseph korzen	[redacted]	[redacted]

2. ACTION: Up to two outside care providers can have permanent authorization to obtain copies of medical records. This authorization may be revoked at any time upon your request. If the below named individual is not a healthcare provider, please skip this step.

- (●) **Add New Care Provider** - Please give the below named care provider access to my medical records.
- ( ) **Replace Authorized Care Provider** - Replace existing care provider _____ with the below named care provider.
- ( ) **Remove Authorized Care Provider** - Please remove the below named care provider's access.

3. RELEASE INFORMATION TO: Who do you want to receive the requested records - **Full Mailing Address Required**. Phone and fax are optional. All other fields are required

Name:	Phone #:
HRSA Countermeasures Injury Compensation Program	
Address:	**Fax #:**
5600 Fishers Lane, Room 14W-18	301-443-5502

City:	State:	Zip Code:	Country:
Rockville, MD 20857			

4. INFORMATION TO BE RELEASED: *Review options and check appropriate box(es):*

DATES OF SERVICE TO BE RELEASED: From 01/17/2021 to Preasent

- [x] **Clinical Notes**
- [x] **Radiology Reports**
- [x] **Radiology Images** (will be released on a CD)
- [x] **Pathology Reports**
- [x] **Lab results**
- [x] **Other Diagnostic Test Results** (Cardiac, Pulmonary Function, Neurological Testing, etc.)
- [x] **Other (Please Specify)** :

everything you have

5. THE PURPOSE OR NEED FOR DISCLOSURE (Continued Care, Personal Use,etc):

6. AUTHORIZATION: Permission is hereby granted to the National Institutes of Health Clinical Center to release medical information to the individual/organization as identified above. I certify by signing and submitting this form that I am the individual who I claim to be. I understand that a request for records other than those about me (or those of whom I have legal authority to obtain, e.g., my minor child) is a criminal offense under the Privacy Act subject to a $5,000 fine. *Note: submission of this form authorizes future disclosures to the same individual and/or entity within* ***one year*** *from date of signature.*

Patient/Authorized Signature	Print Name	Date
PATIENT SIGNATURE REDACTED	PATIENT HANDWRITING REDACTED	12/23/25

Patient Identification *(Staff Use Only)*

HRSA
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: [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