Standard Form 86-1
Revised July 2008
U.S. Office of Personnel Management
5 CFR Parts 731, 732, and 736

QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS

Form approved:
OMB. No. 3206 0005
NSN 7540-00-634-4036
86-111

UNITED STATES OF AMERICA

AUTHORIZATION FOR RELEASE OF INFORMATION

Carefully read this authorization to release information about you, then sign and date it in ink.

I Authorize any investigator, special agent, or other duly accredited representative of the authorized Federal agency conducting my background investigation, to obtain any information relating to my activities from individuals, schools, residential management agents, employers, criminal justice agencies, credit bureaus, consumer reporting agencies, collection agencies, retail business establishments, or other sources of information. This information may include, but is not limited to, my academic, residential, achievement, performance, attendance, disciplinary, employment history, criminal history record information, and financial and credit information. I authorize the Federal agency conducting my investigation to disclose the record of my background investigation to the requesting agency for the purpose of making a determination of suitability or eligibility for a national security position.

I Authorize the Social Security Administration (SSA) to verify my Social Security Number (to match my name, Social Security Number, and date of birth with information in SSA records and provide the results of the match) to the Office of Personnel Management (OPM) or other Federal agency requesting or conducting my investigation for the purposes outlined above. I authorize SSA to provide explanatory information to OPM, or to the other Federal agency requesting or conducting my investigation, in the event of a discrepancy.

I Understand that, for financial or lending institutions, medical institutions, hospitals, health care professionals, and other sources of information, separate specific release may be needed, and I may be contacted for such releases at a later date.

I Authorize any investigator, special agent, or other duly accredited representative of the OPM, the Federal Bureau of Investigation, the Department of Defense, the Department of State, and any other authorized Federal agency, to request criminal record information about me from criminal justice agencies for the purpose of determining my eligibility for assignment to, or retention in, a national security position, in accordance with 5 U.S.C. 9101. I understand that I may request a copy of such records as may be available to me under the law.

I Authorize custodians of records and other sources of information pertaining to me to release such information upon request of the investigator, special agent, or other duly accredited representative of any Federal agency authorized above regardless of any previous agreement to the contrary.

I Understand that the information released by records custodians and sources of information is for official use by the Federal Government only for the purposes provided in this Standard Form 86, and that it may be disclosed by the Government only as authorized by law.

Photocopies of this authorization that show my signature are valid. This authorization is valid for five(5) years from the date signed or upon the termination of my affiliation with the Federal Government, whichever is sooner.

Signature *(Sign in ink)*	Full Name *(Type or print legibly)*			Date Signed (mm/dd/yyyy)
Other Names Used			Date of Birth	Social Security Number
Current street address Apt.#	City (Country)	State	ZIP Code	Home Telephone Number

Enter your Social Security Number before going to the next page →

UNITED STATES OF AMERICA

CREDIT CHECK AUTHORIZATION

Fair Credit Reporting Act of 1970, as amended

PLEASE TAKE NOTICE THAT ONE OR MORE CONSUMER CREDIT REPORTS MAY BE OBTAINED FOR EMPLOYMENT PURPOSES PURSUANT TO THE FAIR CREDIT REPORTING ACT, AS AMENDED, 15 U. S. C., 1681, ET SEQ. SHOULD A DECISION TO TAKE ANY ADVERSE ACTION AGAINST YOU BE MADE, BASED EITHER IN WHOLE OR IN PART ON THE CONSUMER CREDIT REPORT, THE CONSUMER REPORTING AGENCY THAT PROVIDED THE REPORT PLAYED NO ROLE IN THE AGENCY'S DECISION TO TAKE SUCH ADVERSE ACTION.

Information provided by you on this form will be furnished to the consumer reporting agency in order to obtain information in connection with an investigation to determine your (1) fitness for Federal employment, (2) clearance to perform contractual service for the Federal Government, and/or (3) security clearance or access. The information obtained may be redisclosed to other Federal agencies for the above purposes and in fulfillment of official responsibilities to the extent that such disclosure is permitted by law.

I hereby authorize the United States Army National Guard to obtain such report(s) from any consumer/credit agency for employment purposes.

_____ (Print Name) _____ (SSN)

_____ (Signature) _____ (Date)

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UNITED STATES OF AMERICA

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

If you answered "Yes" to Question 21, carefully read this authorization to release information about you, then sign and date it in ink.

Instructions for Completing this Release

This is a release for the investigator to ask your health practitioner(s) the questions below concerning your mental health consultations. Your signature will allow the practitioner(s) to answer only these questions.

Authorization

I am seeking assignment to or retention in a national secuitry position. As part of the clearance process, I hereby authorize the investigator, special agent, or duly accredited representative of the authorized Federal agency conducting my background investigation, to obtain the following information relating to my mental health consultations.

In accordance with HIPAA, I understand that I have the right to revoke this authorization at any time by writing to the U.S. Office of Personnel Management. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Further, I understand that this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

I understand the information disclosed pursuant to this release is for use by the Federal Government only for purposes provided in the Standard Form 86 and that it may be disclosed by the Government only as authorized by law, but will no longer be subject to the HIPAA privacy rule.

Photocopies of this authorization with my signature are valid. This authorization is valid for one(1) year from the date signed or upon termination of my affiliation with the Federal Government, whichever is sooner.

Signature (Sign in ink)	Full Name (Type or Print Legibly)			Date Signed (mm/dd/yyyy)
Other Names Used				Social Security Number
Current street address Apt.#	City (Country)	State	ZIP Code	Home Telephone Number

For Use By Practitioner(s) Only

Does the person under investigation have a condidition that could impair his or her judgment, reliability, or ability to properly safeguard classified national security information?

☐ Yes ☐ No

If so, describe the nature of the condition and the extent and duration of the impairment or treatment.

What is the prognosis?

Signature (Sign in ink)	Practitioner name	Date Signed (mm/dd/yyyy)

Enter your Social Security Number before going to the next page →

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Certification

My statements on this form, and on any attachments to it, are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I have carefully read the foregoing instructions to complete this form. I understand that a knowing and willful false statement on this form can be punished by fine or imprisonment or both (18 U.S.C. 1001). I understand that intentionally withholding, misrepresenting, or falsifying information may have a negative effect on my security clearance, employment prospects, or job status, up to and including denial or revocation of my security clearance, or my removal and debarment from Federal service.

Signature	Date Signed (mm/dd/yyyy)

Enter your Social Security Number before going to the next page → 321-82-4542