

# Authorization for Release of Medical Information



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I hereby authorize the Aircraft Owners and Pilots Association to conduct by phone, in writing, or personal visit inquiries regarding my medical history and medical certificate application records with the FAA Aerospace Medical Certification Division, FAA Regional Flight Surgeons, FAA Office of Aerospace Medicine, Office of the Federal Air Surgeon, and any other parties as necessary.

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*Print your name EXACTLY as it appears on your FAA medical application*

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature** \_\_\_\_\_ **AOPA Member Number** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**FAA PI or MID Number (if available)** \_\_\_\_\_

**Date of most recent information sent to FAA** \_\_\_\_\_

**What Class of Medical are you applying for?** \_\_\_\_\_

**Medical condition(s) being reviewed by the FAA** \_\_\_\_\_

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**Submit this form to:**

**AOPA Medical Certification Services**

421 Aviation Way  
Frederick, MD 21701

**Email** [filereview@aopa.org](mailto:filereview@aopa.org)

**Fax** 240-712-5051

**Any questions? Give our Medical Certification Specialists a call at: 1 (800) 872-2672 (choose option 3)**