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

[redacted]
SIGNED / HANDWRITTEN AREA REDACTED
Original document preserved for authorized verification.