AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. PATIENT'S FULL *NAME (LAST, FIRST, MIDDLE INITIAL)* REQUIRED	2. PATIENT'S DATE OF BIRTH *(YYYY/MM/DD)* REQUIRED	3. PATIENT'S DoD ID # REQUIRED
4. PERIOD OF TREAT REQUESTED *(YYYY/MM - YYYY/MM)* REQUIRED	5. *TYPE OF TREATMENT* NOT REQUIRED ☐ OUTPATIENT ☐ INPATIENT ☐ BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE Walter Reed National Military Medical Center Bethesda TO RELEASE MY PATIENT INFORMATION TO:

a. NAME OF PERSON AUTHORIZED BY THE PATIENT ONLY TO BE COMPLETED BY THE PATIENT ONLY AND MUST ALSO COMPLETE BOXS #9 & #10	b. *PATIENT'S FULL MAILING ADDRESS* REQUIRED
c. *PATIENT'S TELEPHONE NUMBER* REQUIRED	d. FAX *(Include Area Code)*

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)* REQUIRED

☐ PERSONAL USE ☐ CONTINUED MEDICAL CARE ☐ SCHOOL ☐ OTHER *(Specify)*
☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL

8. INFORMATION TO BE RELEASED (What Radiology exam/s are you requesting that were done at Walter Reed NMMCB, please be specific)

REQUIRED

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION ☐ DATE *(YYYYMMDD)* ☐ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE (WITH DOCUMENTATION) REQUIRED PRINT FULL NAME / SIGNATURE REQUIRED	12. RELATIONSHIP TO PATIENT *(If you are WR Staff enter your offical title)* REQUIRED	13. DATE *(YYYY/MM/DD)* REQUIRED

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE: ☐ AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE NOT REQUIRED	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER: NOT REQUIRED IF THE PATIENT'S INFORMATION IS COMPLETELY FILLED IN

DD FORM 2870, DEC 2003

STAFF USE ONLY

Date Complete_____ ___ **Picked-up** ___ **US Mail** ___**FedEx** ___**UPS Shipping Date** _____