Walter Reed National Military Medical Center

Radiology Archives Office
Department of Radiology
Walter Reed National Military Medical Center
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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.

PATIENT INFORMATION

FULL NAME: _____
DATE OF BIRTH: _____
PATIENT'S 10 DIGIT DOD ID #: _____
PHONE #: _____
FULL MAILING ADDRESS:
_____
_____

REQUESTED IMAGING INFORMATION

DATE RANGE OF REQUESTED EXAMS: _____

SPECIFIC RADIOLOGY IMAGING REQUESTED:

_____
_____
_____
_____
_____
_____

☐ ENCRYPTED (PC COMPATIBLE) ☐ UNENCRYPTED (PC & MAC ver. 10.14 & BELOW COMPATIBLE)

RELEASE AUTHORIZATION

I UNDERSTAND THAT:

a. This authorization is for this imaging disc request only, and any future request will require a new release authorization form.
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 ss 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.

REQUESTOR INFORMATION

☐ PATIENT

PRINT: _____

SIGN: _____

☐ WALTER REED NMMC STAFF (VALID STAFF ID BADGE REQUIRED)

JOB TITLE: _____

PRINT: _____

SIGN: _____

☐ OTHER (Written consent and/ or Legal documentation required along with copies of both, patient and requestor's valid ID Cards – DoD ID, VA ID, State ID, or Passport)

RELATIONSHIP: _____

PRINT: _____

SIGN: _____

RADIOLOGY STAFF USE ONLY:

Completed By (PRINT): _____

☐ Picked-Up ☐ US Mail ☐ FedEx Date: _____