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 howit 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. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
	☒ OUTPATIENT ☐ INPATIENT ☐ BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE MUNSON ARMY HEALTH CENTER TO RELEASE MY PATIENT INFORMATION TO:

(Name of Facility/TRICARE Health Plan)

a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION	b. ADDRESS *(Street, City, State and ZIP Code)*
SELF VSO: THOMAS AULT or ALLEN BARNES or N/A (Circle)	
c. TELEPHONE *(Include Area Code)*	**d. FAX** *(Include Area Code)*

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

☐ PERSONAL USE ☐ CONTINUED MEDICAL CARE ☐ SCHOOL ☐ OTHER *(Specify)*

☐ INSURANCE ☒ RETIREMENT/SEPARATION ☐ LEGAL

BRANCH OF SERVICE: (Circle)
ARMY AIR FORCE NAVY
MARINES USCG USPHS

8. INFORMATION TO BE RELEASED

ONE CD FOR SM and ONE FOR VA/VSO (IF REQUESTING DIGITAL SEND TO VSO THEN ONLY ONE DISK GIVEN TO SM)

BH_____(INITIAL) CHAPTER DATE_____ ETS DATE_____ RETIRE DATE_____

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.ss

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/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

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

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

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	
COMPLETION DATE_____	**SPONSOR NAME:**
	SPONSOR RANK:
EMAIL_____ (DoD Safe)	**FMP/SPONSOR SSN:**
MAIL_____ (ADDRESS IN BLOCK 6a ABOVE)	**BRANCH OF SERVICE:**
PICK UP_____	**PHONE NUMBER:**

DEFENSE HEALTH AGENCY
ARMY HEALTH CLINIC MUNSON LEAVENWORTH
550 POPE AVENUE
FORT LEAVENWORTH KS 66027-2332

REPLY TO
ATTENTION OF

MCXN-PAD-ROI

SUBJECT: Statement of Understanding for Retirements/ETS/Chapter Record Requests

IAW DHA-PM 6025.02 Volume 1, The Servicemember is entitled to a one time copy of the medical record to include the paper copy Service Treatment Record (if applicable) free of charge. This copy will come in a format of either a CD or electronically via DoD Safe. Additionally, we will provide one free of charge update to Servicemember upon request. This update will carry forward any health documentation inserted into Electronic Health Record from when first copy of records was created and received by Servicemember. **Any requests after the first update will result in a monetary charge from the Servicemember.**

Servicemember will receive either two CDs (if requested), **or** one CD and other copy electronically to VSO (if requested), **or** both copies electronically to SM and VSO (if requested). Electronic records are transmitted via DoD Safe. Both CD and electronic versions will be identical records. If a CD is for VSO then the seal cannot and should not be broken. The VA/VSO has confirmed that they are a paperless system and will only accept records in electronic format (CD or DoD Safe). No paper records will be accepted.

Each branch of service has policies that require the Servicemember to obtain a physical no earlier than 6 months before and no later than 1 month before the date of separation. If a VA Disability Claim is being filed, claims cannot be submitted more than 180 days prior to the actual separation date.

Please keep in mind that although it may take up to 30 days to receive a copy of the records from Munson Army Health Center, the records may be ready and available at any time within the 30 days. As HIPAA mandates that all requests for medical records must be completed within 30 calendar days, we are unable to accept DD Form 2870 requests for records to be completed outside of this timeframe. There are no exceptions.

_____ _____

SIGNATURE DATE

_____

PRINTED NAME