Authorization for Use or Disclosure of Information
Requested by Armed Forces Retirement Home (AFRH)

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1. I hereby authorize__________________________________ to disclose the following information from the health records of:

Patient Name: ________________________________ Date of Birth: ______________________

Address: ___________________________________ Telephone: _______________________

City: ___________________________ State: ______________ Zip Code: ________________

Period of Disclosure: Previous 12 months of health care from the date of this authorization form.

2. This information will be disclosed to the Armed Force Retirement Home Medical Director for the purpose of determining eligibility for admission to the AFRH.

3. **Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to the contact office listed below. I understand that revocation of this authorization will not affect any action AFRH took in reliance on this authorization before you received my written notice or revocation.

Signature of Patient: ____________________________________ Date: ___________________

CONTACT OFFICE:
Armed Forces Retirement Home
Public Affairs Office #1305
3700 North Capitol Street, NW
Washington, DC 20011-8400
Fax: 202-730-3492