REQUEST FOR PRIVATE MEDICAL INFORMATION For use of this form, see AR 40-66; the proponent agency is the OTSG	1. Date *(YYYYMMDD)*
2. Patient's Name and SSN.	3. Medical Treatment Facility *(Name and Location)*
4. Reason for Request.	
5. Private Medical Information Sought (*Specify dates of hospitalization or clinic visits and diagnosis, if known)*	
6. Requestor's Name, Title, Organization and SSN.	
FOR USE OF MEDICAL TREATMENT FACILITY ONLY	
7. Check applicable box. ☐ Approved ☐ Disapproved *(State reason for disapproval)*	
8. Summary of Private Medical Information Released.	
9. Signature of Approving Official.	10. Date *(YYYYMMDD)*