In order to fulfill your request, please complete the form as illustrated below.

Please note:
We are unable to process same day requests.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR [illegible]

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you [illegible] used. Please read it carefully.
AUTHORITY: [illegible] 6025.18-R
[illegible] Treatment Facility/Dental [illegible] protected health information [illegible] authorization for the disclosure [illegible] preparation; or other reason [illegible] form will result in the non-release of the protected health information. [illegible] alcohol or drug abuse patient information from medical records or for [illegible] of or drug abuse treatment program. In addition, any use as an [illegible] be combined with another authorization except one to use or disclose [illegible]

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)* — Print Patient's Full Name
2. DATE OF BIRTH *(YYYYMMDD)* — Patient's Birthdate
3. SOCIAL SECURITY NUMBER — Patient's SSN
4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)* — Specify the year and month of treatment.
5. TYPE OF TREATMENT *(X one)* OUTPATIENT INPATIENT — Check one of the boxes

SECTION II - DISCLOSURE

6. I AUTHORIZE ______ *(Name of Facility/TRICARE Health Plan)* TO RELEASE MY PATIENT INFORMATION TO:

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN — Person/Facility Authorized To Receive Information
b. ADDRESS *(Street, City, State and ZIP Code)* — Mailing address of where records will be mailed to.
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
What is the reason/purpose for the release?

8. INFORMATION TO BE RELEASED
Specify the information to be released –**NOTE: Specify psychiatric, substance abuse, HIV and STD**

9. AUTHORIZATION START DATE *(YYYYMMDD)* — Date authorization is signed
10. AUTHORIZATION EXPIRATION — Check ONE of the boxes below
DATE *(YYYYMMDD)* — Write the date if box is √'d
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/PARENT/LEGAL REPRESENTATIVE — Signature patient or legal representative
12. RELATIONSHIP TO PATIENT *(If applicable)* — Self for patient, "mother or father if parent
13. DATE *(YYYYMMDD)* — Date authorization is signed

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
SPONSOR NAME:
SPONSOR RANK:
FMP/SPONSOR SSN:
BRANCH OF SERVICE:
PHONE NUMBER:
Complete sponsor information

DD FORM 2870, DEC 2003