AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

IAW 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 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 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 the 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

SPONSOR'S LAST NAME ONLY	Sponsor SSN:
	Were you seen under a different sponsor's Social?
Period of treatment (YYYYMMDD-YYYYMMDD) last 3 years will be copied if no period is noted.	*Treatment:* ___Mental Health Record ___Outpatient ___Inpatient Operative Rpt

SECTION II - DISCLOSURE

I authorize Blanchfield Hosp, Corres, 650 Joel Dr, FT Campbell, KY 42223 to copy my medical records and release them to the address below.

Mailing Address - PRINT CLEARLY

Name: Barbara Aquino Pediatrics I #
Street: 881 Professional Park Drive
City, St, Zip Clarksville, TN 37040
phone

 # 2-ALSO PRINT ADDRESS ON MAILING LABEL

Reason for request/use of Medical Information

___Continued Medical Care
___Personal Use ___Retirement/Separation
___School ___Other (please specify)

Print *Name, DOB, & SSN, for all* BELOW:

For Staff Use Only
Authorization Start Date (YYYYMMDD:

Authorization Expiration: Initials of processor _____
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.
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.

Signature (PRINT & SIGN) X	CIRCLE Relationship to Patient Self, Birth Parent or Legal guardian (*MUST present guardianship papers*)	Date(YYYYMMDD)

If you have received this or another's PHI in error, please notify this office at once. Then return or destroy any copies you have.

Sponsor's name:

SECTION IV - For Staff Use Only (To Be Completed only upon Receipt of Written Revocation)

AUTHORIZATION REVOKED Revocation completed by _____ Date ___/___/___

DD FORM 2870, DEC 2003 **COPY RECORD**