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 how

it 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

SECTION I - PATIENT DATA 1. NAME (Last, First, Middle Initial) 2. DATE OF BIRTH (YYYMMDD) 3. DOD NUMBER OF PATIENT 4. PERIOD OF TREATMENT: FROM - TO (YYYMMDD) 5. TYPE OF TREATMENT (X one) OUTPATIENT INPATIENT BOTH SECTION II - DISCLOSURE 6. I AUTHORIZE (Name of Focility/TRICARE Health Plan) 7. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION 7. REASON FOR REQUESTIVES OF MEDICAL INFORMATION (X as applicable) PERSONAL USE CONTINUED MEDICAL CARE SCHOOL OTHER (Specify) INSURANCE RETIREMENT/SEPARATION LEGAL 8. INFORMATION TO BE RELEASED SECTION II - RELEASE AUTHORIZATION DATE (YYYMMDD) 10. AUTHORIZATION EXPIRATION DATE (YYYMMDD) ACTION COMPLETED SECTION III - RELEASE AUTHORIZATION 1 Understand that: 1 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 OTHER Phane (Section Provided Information on the basis of this submirization inclination in the basis of this submirization in provided to the facility where my medical records are kept or to the OTHER Phane (Section Provided Information on the basis of this submirization in provided to the facility where my medical records are kept or to the OTHER Phane (Section Provided Information on the basis of this submirization in provided to the facility of the Phane (Section Provided Information on the basis of this submirization in provided to the facility of the Phane (Section Provided Information on the basis of this submirization, the person(s) I herein name to the provided Provid	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.												
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