DEPARTMENT OF THE ARMY
US ARMY MEDICAL DEPARTMENT ACTIVITY
PO BOX 105109
FT IRWIN, CA 92310-5109

MCXK-PAD-OPR

October 14, 2022

MEMORANDUM FOR RECORD

SUBJECT: REQUEST FOR COPY OF MEDICAL RECORDS

1. Requests for a copy of medical records will take at least **30 days** due to a high level of requests. The request for Behavioral Health, Family Advocacy Program (FAP), Substance Use Disorder Clinical Care (SUDCC), and Embedded Behavioral Health (EBH), records may take longer (up to or more than 45 days) due to required release approval from those departments. **Initials**_____

2. Each requester is allowed only **one** complimentary copy of their medical record for life. It is the Soldier's responsibility to provide a copy to the VA. You may also request updates from the day your last copy is ready at no cost. Additional full copies requested will incur a fee IAW with the fee schedule listed in AR 25-55, chapter 6 of $13.25 payable to the UBO, Uniform Billing Office, on the second floor. **Initials**_____

3. Upon completion of the records request, the requester will receive notification via telephone call and or e-mail to inform the patient to pick up the CD or that an e-mail containing the requester's records has been sent through the DoD SAFE Site (safe.apps.mil). It is incumbent upon the requester to access the files on the site within seven (7) days. If the requester fails to open the e-mail after the seventh day a processing fee of 13.25 will be applied in order to resend the record. **Initials** _____

4. **Dental exams available in MHS Genesis will be included with the records copy. If you have a hard copy dental record, you will request them from the Shuttleworth Dental Clinic.**

PRINT: _____ DATE: _____

SIGNATURE: _____ PCS/ETS DATE: _____

PHONE #: _____

STAFF ONLY

Form received by_____ (Initials)

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 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.

SECTION I - PATIENT DATA

(SPONSOR SSN)

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
All Treatment Periods	[ ] OUTPATIENT [ ] INPATIENT [X] BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE WEED ARMY COMMUNITY HOSPITAL TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME	b. ADDRESS *(Street, City, State and ZIP Code)*

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	

8. INFORMATION TO BE RELEASED
Initial in the boxes: [ ] ALL MEDICAL RECORDS [ ] ALL BEHAVIORAL HEALTH

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION
	[ ] 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.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*
X	SELF/GUARDIAN	

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
[ ] AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	
	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER: