

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION**PRIVACY ACT STATEMENT**

AUTHORITY: Public Law 104-191; Health Insurance Portability and Accountability Act of 1996; 10 U.S.C. Chapter 55, Medical and Dental Care; DoD Manual (DoDM) 6025.18, Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs; and E.O. 9397 (SSN).

PRINCIPAL PURPOSE(S): DD Form 2870 collects patient data and a patient's or their parent's or legal representative's, authorization for military treatment facility or dental treatment facility or DoD health plan to use or disclose an individual's protected health information.

ROUTINE USE(S): To third parties or individuals as per your written authorization.

APPLICABLE SORN: EDHA 07, Military Health Information System (June 15, 2020; 85 FR 36190). <https://dpcl.d.defense.gov/Portals/49/Documents/Privacy/SORNS/DHA/EDHA-07.pdf>

DISCLOSURE: Voluntary. If you choose not to provide your information, no penalty may be imposed and there will be a non-release of the protected health information. This form will not be used for the authorization to disclose substance abuse information or treatment, if any, within your medical records nor will it be used to authorize the use or disclosure of psychotherapy notes, if any, within your medical records.

SECTION I - PATIENT DATA

1. NAME (Last, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. DOD NUMBER OF PATIENT
4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD)	5. TYPE OF TREATMENT (X one) MUST SELECT ONE	
	<input type="checkbox"/> OUTPATIENT	<input type="checkbox"/> INPATIENT <input type="checkbox"/> BOTH

SECTION II - DISCLOSURE

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

a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION	b. EMAIL ADDRESS
c. TELEPHONE (Include Area Code)	d. FAX (Include Area Code)
7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION (X as applicable) MUST SELECT AT LEAST ONE	
<input type="checkbox"/> PERSONAL USE	<input type="checkbox"/> CONTINUED MEDICAL CARE
<input type="checkbox"/> INSURANCE	<input type="checkbox"/> RETIREMENT/SEPARATION
<input type="checkbox"/> SCHOOL	<input type="checkbox"/> OTHER (Specify)
<input type="checkbox"/> LEGAL	

8. INFORMATION TO BE RELEASED

If you would like the following to be included, please check mark below:

☐ Mental Health Clinical Records

☐ HIV/AIDS related information

9. AUTHORIZATION START DATE (YYYYMMDD)	10. AUTHORIZATION EXPIRATION
<input type="checkbox"/> DATE (YYYYMMDD)	<input type="checkbox"/> 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)
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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)
<input type="checkbox"/> AUTHORIZATION REVOKED		

NOTICE TO PATIENT OR REPRESENTATIVE: COPIES OF RECORDS WILL BE SENT YOU VIA DOD Safe TO THE E-MAIL ADDRESS IN BOX 6b. A LINK TO RETRIEVE YOUR RECORDS WILL BE PROVIDED and WILL ONLY ACTIVE FOR 7 DAYS.

Please check your junk mail if you don't see the DOD Safe email in your inbox.

COMPLETE SPONSOR INFORMATION ONLY IF PATIENT IS 17 & UNDER

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