DEFENSE HEALTH AGENCY
KELLER ARMY COMMUNITY HOSPITAL
900 WASHINGTON ROAD
WEST POINT, NEW YORK 10996-1197

AUTHORIZATION TO RELEASE MEDICAL RECORDS PHI
FOR USE OF THIS FORM SEE KACH REGULATION NO.40-6

I hereby authorize the custodian of my health treatment record to release PHI (Protected Health Information) to

_____ _____ _____
Print name of person to release to | Signature | Date

When he/she is in possession of a copy of my valid ID. I understand that DoD medical records are the property of the U.S. Government and this authorization is only intended to facilitate delivery of medical record information in the event that I am unable to do it myself or in the event of an emergency only.

_____
Print name of patient, FMP, and Sponsors last 4

_____ _____
Signature of patient | Date

EXPIRATION DATE _____
(Can be canceled at any time)

Special Conditions & Limitations Pertaining to PHI Release

If no expiration date is written, this form will expire one year from the date it is signed.

A DD2870 must be completed for each request. A valid government issued photo ID for both the patient and individual authorized above to receive the health treatment records must be present at the time of request.

Information to be released

(Check all that apply)

- o All Records
- o Labs Reports
- o Radiology Reports
- o Inpatient Records
- o Outpatient Records
- o Medication Lists
- o Other_____

Information Patient does not want released: _____

_____

Patient Initials: _____ PAD Representatives Initials: _____