Authorization for Disclosure of Medical Records (DD Form 2870 NOV 2023)

It is used to authorize Keller Army Community Hospital to obtain from a network hospital and/or release your Protected Health Information (PHI) to a person or entity of your choosing. You may be specific as to who may obtain or to whom the PHI may be released to.

You do not have to sign this form as it is voluntary. If you choose not to sign the authorization form, your PHI will not be released.

This authorization will not apply to sensitive PHI, unless you specifically authorize their release. Any Behavioral Health/Psychotherapy notes are also subject to Provider authorization for release (even if you authorize, the Provider has to agree to the release). You are encouraged to be specific to the encounter or time period to which you are comfortable. You have the right to revoke the authority for release at any time. Revocation does not cover PHI that has already been released.

SECTION I:

Blocks 1-3: your complete personally identifiable information.

Blocks 4-5: the dates that you are authorizing your PHI to be released. You can be as broad (all records) or as narrow as you are comfortable with (1 date, and even to 1 specific encounter). ***Remember to be specific***. For Behavioral Health records, indicate that with BH annotation in Block 8.

SECTION II:

Block 6: Who you are authorizing to release. This would be the facility where you received your care, and the record created from that care (e.g., Keller Army Community Hospital).

a,b,c,d – Who you are authorizing the information to be released to and the contact information.

Block 7: Mark box that best applies to your reason for release. Continuing medical care and Legal usually best suit your situation. NOTE: if your report is unrestricted, Only the records pertaining to the incident/examination may be released to CID as part of the investigation.

Block 8: Write out specifically what information you want to be released. You can be very specific, such as the date and time of the visit, or you can be general, such as all information from this date to this date (e.g., "Only information on date of incident"). Indicate BH, SUDCC or Family Advocacy Records if applicable.

Block 9: Enter the date that you wish the authorization to start. **Do not leave blank**.

Block 10: Enter an expiration date for this authorization or "Action Completed". **Do not leave blank**.

SECTION III: READ THOROUGHLY.

Blocks 11 – 13: Your signature (wet or digital) and date that you signed the release.

SECTION IV: Revocation section.

Blocks 14 – 17: LEAVE BLANK. If you choose to revoke your authorization for release you can come in and complete this section or you can contact the Outpatient Records Department and submit a written statement revoking your authorization. Please remember that information that has already been released cannot be included. This section covers any future release. P.O.C.: HIPAA Privacy Officer, Keller Army Hospital 315-774-8606.

***Complete the Sponsor's name, rank, FMP/Sponsor SSN, Branch of Service and Phone Number**.

Documents must be encrypted when sending back to us

CUI/PII/PHI must be encrypted when transmitted electronically. If you are unable to send via encrypted e-mail, you can utilize the Department of Defense Safe Access File Exchange (DoD SAFE) website https://safe.apps.mil/ to provide your response in a secure manner.

For any assistance needed with arranging a DoD SAFE Drop-Off, please contact KACH Outpatient Records at 315-774-8600 or the HIPAA Privacy Officer at 315-774-8606.

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 a 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://dpcld.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 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. SOCIAL SECURITY NUMBER
4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)* ☐ BOTH ☐ INPATIENT ☐ OUTPATIENT	

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. 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

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.ss
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)*

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

14. X IF APPLICABLE: ☐ AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:	