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

1. **NAME** *(Last, First, Middle Initial)*

2. **DATE OF BIRTH** *(YYYYMMDD)*

3. **SSN:**

4. **PERIOD OF TREATMENT: FROM - TO** *(YYYYMMDD)*

5. **TYPE OF TREATMENT** *(X one/or more)*
☐ MEDICAL ☐ INPATIENT ☐ BOTH

SECTION II - DISCLOSURE

6. **I AUTHORIZE** 507th Medical Squadron Tinker AFB OK 73145 **TO RELEASE MY PATIENT INFORMATION TO:**
(Name of Facility/TRICARE Health Plan)

a. **PERSON/ORGANIZATION TO RECEIVE MY INFORMATION**

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

c. **TELEPHONE** *(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.
PATIENT'S E-MAIL : ____________________

PER AFI 41-210, YOU MAY RECEIVE ONE FULL COPY OF YOUR MEDICAL RECORD(S) WITH IN A CALENDAR YEAR OF COMPLETION.

9. **AUTHORIZATION START DATE** *(Today's Date)*

10. **AUTHORIZATION EXPIRATION**
☐ DATE *(YYYYMMDD)* ☐ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

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)*

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. **RECEIPT OF REQUESTED INFORMATION**

STAFF USE ONLY

DATE RECEIVED:____________ INITIALS:____________

DEPARTMENT OF THE AIR FORCE
507TH AIR REFUELING WING (AFRC)
TINKER AIR FORCE BASE OKLAHOMA

23 Mar 23

MEMORANDUM FOR RECORD

FROM: 507 MDS MEDICAL RECORDS

SUBJECT: Copy request for member's military health record

1. Per AFI 41-210, members may receive one full copy of your medical records within a calendar year of completion.

2. Member must complete ALL highlighted sections to prevent any delays in accomplishing request.

3. Request will be completed within 60 days upon receipt.
NOTE: We are currently minimally staffed. Please be aware this may result in a longer processing timeframe. We are working diligently to complete your request in the order it is received.

4. Request will be emailed using DoD Safe (encrypted). This is time sensitive and will expire in 7 days of being sent. Members will be contacted via phone before email is sent and will receive an additional email with the password needed to retrieve their records.

5. Your patience and understanding are appreciated. If you have any questions or concerns, please email me at london.russell@us.af.mil or you may contact me at 405-582-6736.

RUSSELL.LONDON.NYOMI.1381343622 Digitally signed by RUSSELL.LONDON.NYOMI.1381343622 Date: 2023.07.14 10:06:07 -05'00'

LONDON N. RUSSELL, MSgt, USAF
NCOIC, MEDICAL RECORDS