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. SSN or DOD

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
to	☐ BOTH ☐ INPATIENT ☐ OUTPATIENT

SECTION II - DISCLOSURE

6. I AUTHORIZE WILLIAM BEAUMONT AMC **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 ☐ *UPDATE* *FIRST COPY* ☐ YES ☐ NO

☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL *SEPARATION DATE*_____

8. INFORMATION TO BE RELEASED *(X as applicable to request updates only)*

☐ MEDICAL ☐ BEHAVIORAL HEALTH ☐ IMMUNIZATIONS ☐ LABS/RADS ☐ UPDATES

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:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
☐ AUTHORIZATION REVOKED		

17. I consent to receive a download link from DOD Secure Access File Exchange (SAFE) to the email address below.	SPONSOR NAME:
Initials: _____	SPONSOR RANK:
18. RECIPIENT EMAIL ADDRESS: *(Personal email, Non-DOD)*	FMP/SPONSOR SSN:
	BRANCH OF SERVICE:
	PHONE NUMBER:

Instructions for completing DD 2870 Authorization for Disclosure of Medical Information

This form allows beneficiaries to request copies of their medical records from WBAMC.

Key points

- **Completion:** All blocks must be completed in their entirety. Incomplete forms will be returned for correction.
- **Exclusions:** This form cannot be used to request psychotherapy notes, substance abuse information, or family advocacy program notes.
- **Turnaround Time:** The average turnaround time is up to 30 days, although this may vary.
- **Genesis Patient Portal:** Skip the wait and download your non- sensitive medical records at home in minutes or authorize your provider to access records directly! (Contact helpdesk for issues at (800) 600-9332.) https://myaccess.dmdc.osd.mil/identitymanagement/app/login
- **Confidential Documents:** Behavioral Health records may require additional time for review by a provider, and parts of these records may be excluded from release in accordance with DoDM 6025.18.
- **Submission:** Return the completed form to the WBAMC Release of Information Office (ROI) located on the 1st floor of the West Clinic, by fax, or send to our email address below.

To accurately complete the DD Form 2870, please follow the instructions below:

Block 1	Enter the beneficiary's full name.
Block 2	Enter the beneficiary's date of birth.
Block 3	Enter the beneficiary's full Social Security Number SSN or Department of Defense (DOD) ID.
Block 4	Enter the dates of treatment that the patient wants copied (or put “all time periods”)
Block 5	Select “Outpatient” for routine visits, select “Inpatient” for procedures or admissions, or “Both” to include all.
Block 6	Information already entered.
Block 6a-d	Enter the recipient’s name, address, phone and fax number (person or organization).
Block 7	Select the reason for the request.
Block 8	Select the information to be released or fill in a specific record type.
Block 9-10	Enter the start date for the request and either an expiration or until the request is completed.
Block 11	Sign via wet ink signature, digital stylus, or Common Access Card (CAC). Typed signatures are not authorized. Attach a copy of a state issued ID with a signature if not CAC signed.
Block 12	Enter “Self”, “Parent”, “Guardian”, “POA”, “NOK” and attach copy of POA authorizing release of records. Attach copy of death certificate and proof of Executor/Admin of Estate for deceased patients
Block 13	Enter the date the form is signed.
Block 17-18	Enter initials if you authorize WBAMC to send a secure download link to the designated email address in box 18. Enter Sponsors Name and full SSN if the patient is not the sponsor.

William Beaumont AMC
ATTN: ROI Box 817
18511 Highlander Medics
Fort Bliss, TX 79916

Phone: (915) 742-0661 Fax (915) 569-0710 ICE Comments: https://ice.disa.mil/
Email: usarmy.bliss.medcom-wbamc.mbx.pad-record-request@health.mil
Genesis Patient Portal: https://myaccess.dmdc.osd.mil/identitymanagement/app/login
https://william-beaumont.tricare.mil/Getting-Care/Patient-Administration-Services/