REQUEST FOR MEDICAL/DENTAL RECORDS OR INFORMATION

REQUESTING ACTIVITY - Complete Items 1 through 10 *(Except 8b)*; also complete Item 19.

ADDRESSEE - Complete Items 8b, 11 to 14 or 15 to 18, as appropriate, final referrer shall return to requester.

DATE: Date of Request

1. PATIENT *(Last Name - First Name - Middle Name)*
Doe, John

2. ORGANIZATION AND PLACE OF TREATMENT
Current MTF
(Ft.Bliss) William Beaumont AMC

3. STATUS ☒ MILITARY ☐ VA BENEFICIARY ☐ DEPENDENT ☐ FEDERAL EMPLOYEE ☐ OTHER *(Specify)*

3a. NAME OF SPONSOR *(If dependent)*
Only name Sponsor here if request is for Dependants only

4. TO *(Include ZIP Code)*
Losing MTF
Example: Ft. Lewis
No need for an address we will fill it in and request it to the losing MTF.

5. IDENTIFYING INFORMATION
a. SERVICE NUMBER: leave blank
b. GRADE/RATE: E-5 SGT
c. SOCIAL SECURITY ACCOUNT NO.: 123-45-6789
d. VA CLAIM NUMBER: leave blank
e. DATE OF BIRTH *(If Federal employee)*: Sponsor's DOB

6. DATES OF TREATMENT *(Inclusive)*
Leave Blank

7. DISEASE OR INJURY
Leave Blank

8. a. RECORDS REQUESTED / b. RECORDS FORWARDED

	a. MIL	a. VA	b. MIL	b. VA
CLINICAL	☐	☐	☐	☐
OUTPATIENT	☒	☐	☐	☐
HEALTH RECORD	☒		☐	
DENTAL RECORD	☐	☐	☐	☐
X-RAY	☐	☐	☐	☐
MEDICAL REPORT CARDS, EMERGENCY MEDICAL TAGS, FIELD MEDICAL CARDS	☐		☐	
ABSTRACT OF RATING SHEET		☐		☐
REPORT OF PHYSICAL EXAMINATION	☐	☐	☐	☐
ALL AVAILABLE RECORDS *(Except X-rays unless specifically requested)*	☒		☐	
OTHERS *(List under remarks)*	☐	☐	☐	☐

9. REMARKS
If the Sponsor is listed in Box 1 and you are needing family member records as well, please list family members here and their dates of birth.

For Box 8 please X accordingly. We do not request Dental records. A separate request needs to be filled out and requested through the Dental facility.

10. SIGNATURE
Leave Blank, Records Room Clerk signs here

REPLY/REFERRAL

11. TO:
N/A

12. REMARKS
☐ RECORDS CHECKED IN 8b FORWARDED.
☐ NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.
☐ MORE INFORMATION NEEDED. FURNISH FOLLOWING:

13. SIGNATURE

14. DATE

REPLY/SECOND REFERRAL

15. TO:
N/A

16. REMARKS
☐ RECORDS CHECKED IN 8b FORWARDED.
☐ NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.
☐ MORE INFORMATION NEEDED. FURNISH FOLLOWING:

17. SIGNATURE

18. DATE

19. RETURN TO: *(Include ZIP Code)*
William Beaumont Army Medical Center
ATTN: Outpatient Medical Records
5005 N. Piedras St.
El Paso, TX 79920-5001
Fax: (915)-742-1960

REQUESTING ACTIVITY WILL ENTER COMPLETE ADDRESS TO WHICH RECORDS OR FINAL REPLY SHOULD BE MAILED.

DD FORM 877, SEP 67

REPLACES EDITION OF 1 JAN. 60. WHICH MAY BE USED.

Reset

Adobe Professional 7.0