

**P**SYCHIATRIC

**I**NTENSIVE

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**O**UTPATIENT

**P**ROGRAM

***INTAKE QUESTIONNAIRE***

*Please complete this form and return to Care Manager*

*Name* \_\_\_\_\_ *last 4* \_\_\_\_\_

*Care Manager* \_\_\_\_\_

*Date* \_\_\_\_\_

**Naval Medical Center Portsmouth, Directorate of Mental Health  
Limits to Privacy and Confidentiality and Informed Consent to Participate in Treatment**

It is important for you to know the limits to privacy and confidentiality regarding your appointments within the Directorate of Mental Health (DMH) at Naval Medical Center, Portsmouth. This notice is written in accordance with departmental policy, military guidelines, and regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the final Privacy Rule of 2000. Clinics within DMH are committed to compliance with HIPAA privacy regulations.

When you speak with a mental health provider, the notes and results of your initial evaluation and subsequent visits are entered into your electronic medical record (AHLTA) as maintained by the Department of Defense under your or your sponsor's social security number and will be designated as "sensitive", which offers the highest level of privacy available for this information. Access to portions of your electronic record by third parties is only allowed when required by law, regulations, or judicial proceedings. This is consistent with the Privacy Act Statement (DD Form 2005) maintained in your hard record and the HIPAA Notice of Privacy Practice.

As a rule, your mental health provider will disclose no information obtained from your contacts with them, or the fact that you are receiving care in this clinic, except with your written consent. However, there are some important exceptions to this confidentiality rule as described by the following or as otherwise specified by law.

- As general practice, we will use and disclose your protected health information to provide, coordinate, or manage your health care and related services as described in the HIPAA Notice of Privacy Practices.
- Contents of your record may also be reviewed by other health care providers for supervision, consultation and quality assurance.
- If you reveal information about child abuse or neglect, or physical abuse of elders or dependent adults, we are required to report it to civil authorities.
- If you report spousal/partner abuse or drug abuse, we are required to report it to military authorities.
- If you are judged to be suicidal or a threat to yourself, we are required to take what action is necessary to ensure your well being.
- If you are a threat to another person (for physical harm or death), we are required to warn the intended victim and the appropriate law enforcement agencies.
- If a court of law issues a legitimate subpoena, we are required to provide the information specifically described in the subpoena.
- If you report a violation of The Uniform Code of Military Justice (UCMJ) or civil law we may be required to report it to the appropriate authorities.
- If you are Active Duty, your command may be advised of conditions that impact your fitness or suitability for duty or mission readiness. This may include disclosure to the service member's CO, XO, relevant Medical Department Personnel, and work supervisors in the member's Chain of Command. However, your CO/XO can access your mental health record without your given consent.

**STATEMENT OF UNDERSTANDING AND INFORMED CONSENT**

I have been advised and understand that all information obtained as herein described will be used in confidence and in conformity with the Health Insurance Portability and Accountability Act (HIPAA) and/or other restrictions and protections required by any applicable law(s).

As a result of a Behavioral Health evaluation, I have been informed of and recommended to participate in a specified appropriate level of treatment based on my preliminary diagnosis. I have also been informed that my treatment may utilize a combination of assessment and treatment modalities to include, but not limited to: individual counseling or therapy, group therapy, pharmacotherapy, psychological testing, biofeedback treatment, and assessment using laboratory and/or radiological testing.

I have been informed that I may refuse any or all aspects of treatment at any time, but that this refusal might result in worsening of my mental health conditions. This consent form will be maintained in my medical record. I also understand that I may revoke this consent at any time, and that if I do so, by signed/dated revocation, it shall be made part of my medical record.

Please initial one of the following:

a. I consent to mental health treatment.  b. I do not consent to treatment at this time.

\_\_\_\_\_  
Patient/Parent/Guardian Signature                      SSN/ID                      Date                      Time

\_\_\_\_\_  
Staff Signature                      Date                      Time

|  |             |   |                       |
|--|-------------|---|-----------------------|
| HOSPITAL OR MEDICAL FACILITY<br>Naval Medical Center, Portsmouth | STATUS      | DEPART/SERVICE<br>Outpatient Psychiatry | RECORDS MAINTAINED AT |
| SPONSOR'S NAME   | SSN/ ID NO. | RELATIONSHIP TO SPONSOR                 |                       |

|  |              |          |
|--|--------------|----------|
| PATIENT'S IDENTIFICATION (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of birth; Rank/Grade.) | REGISTER NO. | WARD NO. |
|--|--------------|----------|

Name: \_\_\_\_\_  
SSN: \_\_\_\_\_  
DOB: \_\_\_\_\_

Department of Psychiatry  
Naval Medical Center Portsmouth  
620 John Paul Jones Circle, Bldg 215 3<sup>rd</sup> Floor  
Portsmouth, VA, 23708  
Office: (757) 953-7641

**CHRONOLOGICAL RECORD OF MEDICAL CARE**  
Medical Record  
**STANDARD FORM 600 (REV. 6-97)**  
Prescribed by GSA/ICMR  
FIRMR (41 CFR) 201-9.202-1

### Psychiatric Intensive Outpatient Program (PIOP) Contract

*Welcome to PIOP!* You have now begun what may be one of the most important learning experiences of your life. You will be expected to attend this group as scheduled on Monday through Fridays from 0730 - 1400. The purpose of this Program is to assist patients achieve the level of care recommended by their attending physician and the PIOP Treatment Team. For most, this program will serve as a therapeutic aid to regaining stability and improved coping skills in daily living and as an adjunct treatment to meet the Treatment Goals. Additional information and screening may be required from some patients to enter another modality of treatment upon completion of the PIOP

The duration of the program will be from 4 to 10 days, depending on the patient's progress in meeting treatment goals. During your enrollment in this program we expect the following:

1. Attendance to all group sessions and to any community support groups assigned (and be able to provide proof of attendance).
2. Abstinence from AOD (alcohol, drugs and over the counter herbal aids) that may be verified.
3. Arrival to group on time and appropriately groomed/attired.
4. Willingness to explore criteria and consequences of your diagnosis/es and incorporate appropriate group and staff feedback.
5. Meet with your individual Care Manager as scheduled and on an as needed basis each week. Complete individual treatment assignments on time.
6. Demonstrated respect for other group members and staff and interact appropriately.
7. That you maintain the confidentiality of the group.
8. That there is no exchange of materials, money, tobacco, snacks, drinks during group.
9. Compliance with such medications as prescribed by your physician.

Non-compliance with the requirements of this program as stated in 1-9 above is viewed as objective indication of lack of investment in your treatment and will be addressed as determined by the Treatment Team.

You are in this program at your request and with the recommendation of a Clinical Treatment Team. Unexcused absences, tardiness or lack of seriousness regarding the group modality cannot be tolerated. In the event you experience some event that requires your unavoidable absence from the group at the starting time, you must communicate this to your Care Manager or the contact below...prior to the absence.

As you know, the ultimate responsibility for successful quality of life rests in your hands. We hope this program will prove a valuable asset to you in that process and you may fully realize your own self worth. We will do our best to help you achieve this goal!

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Staff: \_\_\_\_\_ PIOP contact: 953-4877-leave message

### Psychiatric Intensive Outpatient Program (PIOP) Therapy Contract

PIOP is an intensive four to ten-day psycho-educational and behavioral treatment program serving the Tricare Prime population. The goal of the program is to promote immediate symptom reduction to achieve improved social and occupational functioning. A dynamic mixture of therapies is utilized:

- **Milieu Therapy:** Milieu therapy helps a patient to recover through manipulation of their environment in a clinical setting. Gaining insight and awareness, support, relearning and guidance play major roles.
- **Exposure Therapy:** Exposure therapy is suggested to be one of the best ways to overcome anxiety. To master something in life it is necessary first to think about it, and then actually practice doing it. Patients need to go into the situation and think about it in a different way, implement the other skills and knowledge to more effectively manage anxiety, and then reflect on how it went.
- **Cognitive Behavioral Therapy:** Cognitive-behavioral therapy is an action-oriented therapy that assumes that maladaptive, or faulty, thinking patterns cause maladaptive behavior and "negative" emotions. (Maladaptive behavior is behavior that is counter-productive or interferes with everyday living.) The treatment focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state.
- **Psycho-educational Therapy:** Psycho educational therapy provides education and/or training activities that develop information and guidance through informal and/or formal interventions targeting identified needs or knowledge deficits. Interventions may be at a group or individual level and can range from awareness groups to Drug and Alcohol education sessions.

PIOP strives to present challenging problems and situations for each patient to solve within group settings. This process fosters the development of improved communication and social skills. By the end of this course each patient can learn, or improve several life skills and actually practice them in a supportive yet challenging setting.

**Program Understanding:** The following statements must be read, understood and initialed to participate in PIOP:

1. \_\_\_\_\_ I am voluntarily entering PIOP for my own self awareness and am in no way ordered or coerced to attend.
2. \_\_\_\_\_ I understand that arrival to group on time is essential and tardiness will not be tolerated.
3. \_\_\_\_\_ I understand that my ability to get benefit from this program is dependent upon my willingness to express my honest thoughts and feelings right when they are happening.
4. \_\_\_\_\_ I understand that I am responsible for my own therapy and as such have to identify my own personal agenda for change.
5. \_\_\_\_\_ I understand that staff will ask me to express my thoughts and feelings and may occasionally interrupt me when I am speaking
6. \_\_\_\_\_ I understand that I am here to work on my own treatment goals and not to caretake others.
7. \_\_\_\_\_ I understand that I can be disenrolled from the program in the event my personal agenda is counter productive for the group's progress as a whole.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

NAVAL MEDICAL CENT PORTSMOUTH, VA  
PSYCHIATRIC INTENSIVE OUTPATIENT  
PATIENT PORTION OF INTAKE FORM

SAFETY CONTRACT

I, \_\_\_\_\_, will notify a staff member if I have any thoughts, plans, or intent to go UA, harm myself, harm others or damage property. If it is not possible to notify a staff member, I will go to the emergency room or notify the command's OOD. I will also notify a staff member if I have any knowledge of a peer who is experiencing any of the above thoughts as well.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

INFORMED CONSENT

I, \_\_\_\_\_, have been provided with information on the details of the Psychiatric Intensive Outpatient Program (PIOP) and am aware that this is a voluntary program.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

LIMITS OF PRIVACY AND CONFIDENTIALITY STATEMENT

It is important for you to know the limits of your privacy and confidentiality regarding the information disclosed by you to the mental health providers seen in this clinic. When you speak with a mental health provider, a private record, separate from the General Outpatient Medical Record, is kept in this clinic. A summary of each visit is made in that record.

While these records are considered private and kept in a locked cabinet accessible only to designated personnel, they are also considered property of the United States government and do not represent privileged communication. Access to this information by third parties is allowed when required by law, regulations, or judicial proceedings. You will be informed of such a request or release as soon as possible. This is consistent with the Privacy Act Release Form you signed.

There are also certain types of information, which must be reported by your mental health provider. These include suspected child or spouse abuse, illegal drug use and statements indicating likelihood of harm to self or others. Situations that involve a violation of the Uniform Code of Military Justice or civil law may also require disclosure to the proper authorities. In addition, if your mental health provider believes that you intend to harm yourself or someone else, that provider is required by law, to disclose and act upon that information.

If you have any questions about the limits of privacy and confidentiality, please ask your therapist or inquire at the appointment desk.

STATEMENT OF UNDERSTANDING

I have read the above information and understand that information disclosed about me will be safeguarded within the limits described above.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sponsor Social Security Number: \_\_\_\_\_

**Psychiatric Intensive Outpatient Program (PIOP)**

Define the specific series of events that led to your referral to PIOP:

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Define your most significant stressors:

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What are your goals as it relates to this program?

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List the things you would like to change within yourself. Be specific. Cite particular events or experiences where these traits or behaviors caused you problems.

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How may what you want to change within yourself impact your life?

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What do you believe will happen if you don't make any changes?

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If married, how long? \_\_\_\_\_ Spouse's age: \_\_\_\_\_ Is this the first marriage for both? \_\_\_\_\_ If not, please describe: \_\_\_\_\_

Length of dating before marriage? \_\_\_\_\_ Do you have any children? \_\_\_\_\_ If yes, how many? \_\_\_\_\_

What are their ages? \_\_\_\_\_ Do your children live with you? \_\_\_\_\_

Have you every had any difficulties in the military that resulted in a hearing, mast, trial and/or courts martial? \_\_\_\_\_

If yes, please give details, charges and the outcome: \_\_\_\_\_

What awards/decoration have you received in the military or civilian life? \_\_\_\_\_

My evaluations have averaged: \_\_\_\_\_

If you are on Active Duty, has your attitude changed since your enlistment? \_\_\_\_\_ If yes, in what way? \_\_\_\_\_

Are you working within rate? \_\_\_\_\_

How would you describe your strengths and weaknesses? \_\_\_\_\_

Has religion, faith, or spiritual beliefs been an important part of your life in the past? YES/NO Currently? YES/NO

If yes, please list your particular denomination or religious preference: \_\_\_\_\_

Patient's signature \_\_\_\_\_ Date: \_\_\_\_\_

By signing this, you agree that you have read and understood all documentation on these forms. You also agree that to the best of your knowledge, all personal answers and statements on these forms are correct and true.

What is your current caffeine/energy drink/supplement use? Please describe amount and types: \_\_\_\_\_

Do you use tobacco? YES/ NO How much? \_\_\_\_\_

**Personal History/Background:**

I mainly grew up in the City of or rural area near \_\_\_\_\_

My family's financial situation when I was growing up was (circle) upper, upper middle, middle, lower middle, lower income level.

I have \_\_\_\_\_ brothers and \_\_\_\_\_ sisters. I was born 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, other \_\_\_\_\_

Father's job: \_\_\_\_\_

How did you get along with your father? \_\_\_\_\_

Mother's job: \_\_\_\_\_

How did you get along with your mother? \_\_\_\_\_

My parents were never married, married, divorced, widowed. If divorced, how old were you? \_\_\_\_ Did anyone else live with you? \_\_\_\_\_

Discipline consisted of \_\_\_\_\_ in my family.

As a child I had no, few, many friends. Now I have no, few, many friends.

Number of school years you completed: \_\_\_\_\_ Age when completed: \_\_\_\_\_

How were your grades in school? \_\_\_\_\_

Were you in any special classes? If so, what types \_\_\_\_\_

With my teachers I got along very well, got along okay, did not get along.

With other students I got along very well, got along okay, did not get along.

List school activities/sports/favorite subjects: \_\_\_\_\_

Were you ever placed on probation, suspended, suspended or expelled from school? \_\_\_\_ If yes, please explain when, why and number of times. \_\_\_\_\_

Did you ever have problems with law enforcement agencies prior to enlistment? \_\_\_\_ If yes, please explain when and why: \_\_\_\_\_

What kinds of jobs did you have prior to joining the military? \_\_\_\_\_

Please place a check by any of the following that you may have experienced and note your age at the time:

|                              | Age |                        | Age |                   | Age |
|------------------------------|-----|------------------------|-----|-------------------|-----|
| Nail Biting                  |     | Anger control problems |     | Physical Abuse    |     |
| Sleep Walking                |     | Cruelty to Animals     |     | Verbal Abuse      |     |
| Bed Wetting                  |     | Stealing               |     | Sexual Abuse      |     |
| Bad Nightmares/Night terrors |     | Reckless Driving       |     | Running Away      |     |
| Hyperactivity                |     | Fire Setting           |     | Over/Under eating |     |

Do you have any current pain? If yes, please rate on a scale from 0 (no pain) to 10 (intense pain) and describe the location:

Pain level: \_\_\_\_\_ Location of pain: \_\_\_\_\_

### **Substance Use History:**

How often do you have a drink containing alcohol?

- 0 Never
- 1 Monthly or less
- 2 2-4 times a week
- 3 2-3 times a week
- 4 4 or more times a week

How many drinks containing alcohol do you have on a typical day when you are drinking?

- 0 1 or 2
- 1 3 or 4
- 2 5 or 6
- 3 7 to 9
- 4 10 or more

How often do you have six or more beers or drinks on one occasion?

- 0 Never
- 1 Less than monthly
- 2 Monthly
- 3 Weekly
- 4 Daily or almost daily

How often during the past year have you found that you were unable to stop drinking once you had started?

- 0 Never
- 1 Less than monthly
- 2 Monthly
- 3 Weekly
- 4 Daily or almost daily

How often during the past year have you failed to do what was normally expected from you, because of drinking?

- 0 Never
- 1 Less than monthly
- 2 Monthly
- 3 Weekly
- 4 Daily or almost daily

Have you ever used any illegal or illicit drugs? If yes, please list the drugs, frequency of use, and date of last use: \_\_\_\_\_

Have you ever attended alcohol and/or drug treatment? If yes, please list the dates and type of treatment: \_\_\_\_\_

How often during the past year have you needed a first drink in the morning to get yourself going after drinking the night before?

- 0 Never
- 1 Less than monthly
- 2 Monthly
- 3 Weekly
- 4 Daily or almost daily

How often during the past year have you had a feeling of guilt or remorse after drinking?

- 0 Never
- 1 Less than monthly
- 2 Monthly
- 3 Weekly
- 4 Daily or almost daily

How often in the past year have you been unable to remember what happened the night before because you had been drinking?

- 0 Never
- 1 Less than monthly
- 2 Monthly
- 3 Weekly
- 4 Daily or almost daily

Have you or someone else been injured as a result of your drinking?

- 0 No
- 2 Yes, but not in the last year
- 4 Yes, during the last year

Has a relative, friend, doctor, or other health worker been concerned about your drinking or suggested you cut down?

- 0 No
- 2 Yes, but not in the last year
- 4 Yes, during the last year

If applicable, did any injury received while you were deployed result in any of the following? (Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Being dazed, confused or seeing stars                     | <input type="checkbox"/> Losing consciousness for longer than 20 minutes                                      |
| <input type="checkbox"/> Not remembering the injury                                | <input type="checkbox"/> Having any symptoms of concussion afterward (headache, dizziness, irritability, etc) |
| <input type="checkbox"/> Losing consciousness (knocked out) for less than a minute | <input type="checkbox"/> Head injury  |
| <input type="checkbox"/> Losing consciousness for 1-20 minutes                     | <input type="checkbox"/> None of the above  |

Are you currently experiencing any of the following problems that you think might be related to a possible head injury or concussion? (Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Ringing in the ears  |
| <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Irritability         |
| <input type="checkbox"/> Memory Problems  | <input type="checkbox"/> Sleep problems       |
| <input type="checkbox"/> Balance problems | <input type="checkbox"/> Other specify: _____ |

**Mental Health History:**

Have you participated in any previous counseling or group therapy? If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Have you ever taken medication for mental health symptoms? If yes, please list the medications: \_\_\_\_\_

\_\_\_\_\_

Have you ever been hospitalized for mental health reasons? If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Is there any family history of mental health problems (nervous breakdown, suicide, substance abuse problems, etc)? If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

**Medical History:**

Do you have any current medical conditions? If yes, please list:

\_\_\_\_\_

List all Allergies: \_\_\_\_\_

Are you currently taking any medication (including herbal, supplements, and over the counter)? Is yes, please list:

\_\_\_\_\_

\_\_\_\_\_

| Have had any of these symptoms or experiences recently:                        |          | If Yes, length of time: |
|--|----------|-------------------------|
| Depressed mood   | Yes / No |                         |
| Big changes in appetite or weight (up or down)                                 | Yes / No |                         |
| Changes in sleep patterns or quality of sleep                                  | Yes / No |                         |
| Constant feelings of fatigue, tiredness or low energy                          | Yes / No |                         |
| Feelings of worthlessness or excessive guilt                                   | Yes / No |                         |
| Decreased ability to think or concentrate                                      | Yes / No |                         |
| Decreased interest in enjoyable activities                                     | Yes / No |                         |
| Constant anxiety or excessive worry  | Yes / No |                         |
| Avoidance of a specific object or situation                                    | Yes / No |                         |
| Intense memories of any previous traumatic events                              | Yes / No |                         |
| Unusual experiences that cause distress  | Yes / No |                         |
| Constantly on guard, watchful or easily startled                               | Yes / No |                         |
| Feelings of being numb or detached from others                                 | Yes / No |                         |
| Unpredictable mood swings  | Yes/ No  |                         |
| Thoughts of hurting yourself or someone else                                   | Yes / No |                         |
| Changes in the use of alcohol or other substances                              | Yes / No |                         |
| Recent or past incidents of family violence (domestic violence or child abuse) | Yes/ No  |                         |
| Legal or disciplinary issues (Civilian or Active Duty)                         | Yes/ No  |                         |

**Deployment History:**

Is this visit related to deployment in any way? Please describe: \_\_\_\_\_

How many times have you deployed? \_\_\_\_\_ When is your next deployment/underway? \_\_\_\_\_

Did you have any injury(ies) during your deployment from any of the following? (Check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> No injuries   | <input type="checkbox"/> Fall                                      |
| <input type="checkbox"/> Fragment <input type="checkbox"/> Bullet            | <input type="checkbox"/> Blast (IED, RPG, Land mine, Grenade, etc) |
| <input type="checkbox"/> Vehicular (any time of vehicle, including airplane) | <input type="checkbox"/> Other: specify _____                      |

**Directorate of Mental Health  
Intake Questionnaire**

Please answer the following questions to the best of your ability. Your answers will help us to better understand what concerns you may be having now. This will also help us focus on specific issues and more efficiently use your time with us.

**Today's Date:** \_\_\_\_\_

Name: \_\_\_\_\_ Sponsor's SSN#: \_\_\_\_\_  
Last, First, M.I.

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Ethnicity/Nationality: \_\_\_\_\_ DOB: \_\_\_\_\_

Marital Status (Circle): Single, Engaged, Married, Divorced, Remarried, Widowed

Rank/Rate: \_\_\_\_\_ Branch: \_\_\_\_\_ Status \_\_\_\_\_ Years of Active Duty Service \_\_\_\_\_ years and \_\_\_\_\_ months

EAOS \_\_\_\_\_ Time at present command \_\_\_\_\_ years \_\_\_\_\_ months

Command: \_\_\_\_\_ Base location: \_\_\_\_\_ Division: \_\_\_\_\_

Quarterdeck/ CQ ph #: \_\_\_\_\_ Medical: POC: \_\_\_\_\_ ph#: \_\_\_\_\_

Personal Address (Local):

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Who referred you to this Clinic? \_\_\_\_\_

If you were directed by your command, do you object to being seen here or being seen by a Mental Health Professional?  
(Please circle) YES NO

Did your command give you a letter ordering you to come to this evaluation?  
YES NO

What is your reason for being seen? What are your expectations?

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**PRIVACY ACT STATEMENT – HEALTH CARE RECORDS**

*THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.*

**1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)**

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.

**2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED**

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

**3. ROUTINE USES**

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

**4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION**

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but **CARE WILL NOT BE DENIED.**

This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF PATIENT OR SPONSOR

SSN OF MEMBER OR SPONSOR

DATE

