

ADMINISTRATIVE REMARKS

NAVPERS 1070/613 (REV. 10-09)
SN 0106-LF-010-6991
SHIP OR STATION

E-32

NAVAL MEDICAL CENTER SAN DIEGO

PRIVACY ACT STATEMENT

I UNDERSTAND THE FOLLOWING:

-I UNDERSTAND IF THERE IS A SHADED BOX MARKED "YES" ON THE NAVMED 1300/1 QUESTIONS 13-20 OF MY PAPERWORK OR ANY MY DEPENDENTS PAPERWORK, THAT IT MAY AFFECT MY TRANSFER DATE, REPORT NO LATER THAN DATE, OR LEAVE PERIOD. MY SCREENING IS NOT COMPLETE UNTIL SCREENER'S RECEIVED FEEDBACK FROM GAINING COMMAND. THE GAINING COMMAND HAS SEVEN BUSINESS DAYS TO RESPOND FROM INITIAL DATE SENT.

-ADVISE THE SERVICE MEMBER THAT ORDERS MAY BE HELD IN ABEYANCE UNTIL SCREENING IS COMPLETED AND DELAYS MAY AFFECT THE AMOUNT OF LEAVE IN TRANSIT." -BUMEDINST 1300.2A

-ENSURE EACH SERVICE AND FAMILY MEMBER IS SCREENED WITHIN 30 DAYS OF RECEIPT OF TRANSFER ORDERS. SERVICE AND FAMILY MEMBERS WILL NOT TRANSFER UNTIL SATISFACTORY COMPLETION OF ALL ASPECTS OF THE SUITABILITY SCREENING PROCESS." -BUMEDINST 1300.2A

-MY SCREENING IS VALID FOR 12 MONTHS FROM DATE OF COMPLETION UNLESS CHANGE OF ORDERS, OR SIGNIFICANT CHANGE OF MEDICAL STATUS (IE.PREGNANCY, CAR ACCIDENT).

-Medical, dental and educational suitability screening is valid for 12 months from the date of completion if there were no significant changes in health or educational status of the service or family member. The service member must notify his or her commanding officer or officer in charge of any change in medical status (including pregnancy) of either or any family members." -BUMEDINST 1300.2A

-Service members must be cautioned that healthcare (including mental health care) received by family members from non-military providers must be brought to the attention of the screening authority, and failure to divulge disqualifying information or failure to notify screening authority of possible changes in screening status, may result in disciplinary action under Uniform Code of Military Justice (UCMJ), ARTICLE 107. Individual identifiable health information is protected under the Health Insurance Portability and Accountability Act (HIPAA) and cannot be divulged by the MTF to the transferring command without the express written consent of the service or family members." -OPNAVINST 1300.14D

SERVICE MEMBER SIGNATURE _____ DATE _____

SCREENER SIGNATURE _____ DATE _____

LAST, FIRST MI	SSN	BRANCH OF CLASS
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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. SOCIAL SECURITY NUMBER
4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD)	5. TYPE OF TREATMENT (X one)	
	<input type="checkbox"/> OUTPATIENT	<input type="checkbox"/> INPATIENT <input type="checkbox"/> BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO:

(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	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)

<input type="checkbox"/> PERSONAL USE	<input type="checkbox"/> CONTINUED MEDICAL CARE	<input type="checkbox"/> SCHOOL	<input type="checkbox"/> OTHER (Specify)
<input type="checkbox"/> INSURANCE	<input type="checkbox"/> RETIREMENT/SEPARATION	<input type="checkbox"/> 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.

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 <i>(If applicable)</i>	13. DATE (YYYYMMDD)
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SECTION IV - FOR STAFF USE ONLY (To be completed only upon receipt of written revocation)

14. X IF APPLICABLE: <input type="checkbox"/> 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: