Instructions for Completing DD Form 2870 to Request Copies of Records

1. The attached DD Form 2870, Authorization for Disclosure of Medical or Dental Information, serves as the mechanism for beneficiaries to request copies of their medical record. All blocks must be completed in their entirety.
2. To complete the DD Form 2870, please follow the below instructions:

   Block 1: Patient's name
   Block 2: Patient's Date of Birth
   Block 3: Sponsor's SSN or DoD ID number
   Block 4: Indicate the dates of treatment that the patient wants copied
   Block 5: Mark the block for what the patient is requesting
   Block 6: Navy Medicine Record Activity
   Block 6a: Name of the individual authorized to access medical record (can be the patient, or another person named by the patient)
   Block 6b: Mailing address of individual listed in Block 6a
   Block 6c: Phone number of individual listed in Block 6a
   Block 7: Mark as appropriate
   Block 8: List desired documents for receipt (Immunizations, Physical assessments, entrance/separation physicals). If an entire copy of the regular outpatient medical record is required, write, "Copy entire medical record." If drug and/or alcohol abuse and/or treatment is requested to go to a third party, please complete the additional form provided addressing release of sensitive information.
   Note: sensitive information will not be provided if it is not specified
   Block 9: Authorization start date will be the date form completed
   Block 10: Authorization expiration – same date as Block 9 plus 1 year unless you mark action completed
   Block 11: Patient signs in this block
   Block 12: Either put "self" if you are the patient, or whatever your relationship is to the patient
   Block 13: Date the form the day it is brought, sent, or mailed

3. After completing this form(s), please mail to:
   Navy Medicine Records Activity
   Attn: Release of Information
   4300 Goodfellow Blvd, Bldg 103
   St. Louis, MO 63120

4. Your requested information will be mailed to you on a password protected CD and the password for the CD will be mailed separately.

5. If you have any questions or concerns, please contact the Navy Medicine Records Activity at 314-260-8120.

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)*
	☐ OUTPATIENT ☐ INPATIENT ☐ BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE Bureau of Medicine and Surgery NMRA 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)*

☐ PERSONAL USE ☐ CONTINUED MEDICAL CARE ☐ SCHOOL ☐ OTHER *(Specify)*
☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ 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 Planor eligibili ty 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. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:

Reset

Adobe Professional 8.0

AUTHORIZATION FOR DISCLOSURE OF SUBSTANCE ABUSE RELATED RECORDS

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.
AUHORITY: 42 CFR Part 2; 42 U.S.C 290dd-2; E.O. 9397 (SSAN); DoD 1010.4; Public Law 104-191; DoD 6025.18-R.
PRINCIPLE PURPOSE(S): This form is to provide the Military Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information with respect to Substance Abuse related records.
ROUTINE USES: To any third party or the individual upon authorization for the disclosure from the individual for: legal; continued medical care; security clearance check; personal use; or for other reason.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2; 42 U.S.C 290dd-2) prohibit you from making further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Section 1 – Patient Data

1. NAME (Last, First, Middle Initial)	2. Sponsor's SSN	3. Date of Birth *(YYYYMMDD)*:

4. Patient's Address (Street, City, State, ZIP Code)	5. Patient's Telephone Number

Section 2 – Disclosure

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

a. NAME OR TITLE OF PERSON OR ORGANIZATION	b. ADDRESS (Street, City, State, ZIP Code)
c. TELEPHONE (Include Area Code)	d. FAX (Include Area Code)

7. Purpose or Need for the Information

	Legal		Continued Medical Care		Security Clearance Check		Personal Use (COPY OF MY RECORD)		Other (Specify):

8. Information to be Released (or Copied for Personal Use):

9. Start Date *(YYYYMMDD)*:	10: Expiration Date: Or Action Completed ☐

Section 3 – Release Authorization (I understand that):

a. I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on this authorization. My revocation must be in writing and provided to the facility where my 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/DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used my protected health information on the basis of this authorization.
b. 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.
c. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment, payment, enrollment or eligibility on the failure to obtain this authorization.

11. Signature of Patient or Legal Representative:	Relationship to Patient:	Date *(YYYYMMDD)*:

12. Signature of Witness (If required by State Law):	Date *(YYYYMMDD)*:

Section 4 – FOR STAFF USE ONLY (To be completed only upon receipt of written revocation)

13. Authorization Revoked	14. Revocation completed by	15. Signature	Date *(YYYYMMDD)*: