

## 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: <small>(Name of Facility/TRICARE Health Plan)</small>	
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 <input type="checkbox"/> DATE (YYYYMMDD) <input type="checkbox"/> 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 <small>(If applicable)</small>	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:	

C5.1.2.2.2. Permitted by section C7.1., pertaining to uses and disclosures required by law; or

C5.1.2.2.3. Permitted by section C7.4., pertaining to uses and disclosures for health oversight activities, with respect to the oversight of the originator of the psychotherapy notes; or

C5.1.2.2.4. Permitted by section C7.7., pertaining to uses and disclosures about decedents to coroners and medical examiners; or

C5.1.2.2.5. Permitted by subparagraph C7.10.1.1., pertaining to uses and disclosures to avert a serious and imminent threat to health or safety of a person or the public, which may include a serious and imminent threat to military personnel or members of the public or a serious or imminent threat to a specific military mission or national security under circumstances which in turn create a serious and imminent threat to a person or the public.

#### C5.1.3. Authorization Required: Marketing

C5.1.3.1. Notwithstanding any provision of this Chapter, other than the transition provisions in Chapter 14, a covered entity must obtain an authorization for any use or disclosure of protected health information for marketing, except if the communication is in the form of:

C5.1.3.1.1. A face-to-face communication made by a covered entity to an individual; or

C5.1.3.1.2. A promotional gift of nominal value provided by the covered entity.

C5.1.3.2. If the marketing involves direct or indirect remuneration to the covered entity from a third party, the authorization must state that such remuneration is involved.

### C5.2. IMPLEMENTATION SPECIFICATIONS: GENERAL REQUIREMENTS

#### C5.2.1. Valid Authorizations

C5.2.1.1. A valid authorization is a document that contains the elements listed in subparagraph C5.1.3.2., paragraphs C5.3.1. and C5.3.2., as applicable.

C5.2.1.2. A valid authorization may contain elements or information in addition to the elements required by this section, if such additional elements or information are not inconsistent with the elements required by this section.

C5.2.2. Defective Authorizations. An authorization is not valid, if the document submitted has any of the following defects:

C5.2.2.1. The expiration date has passed or the expiration event is known by the covered entity to have occurred.

C5.2.2.2. The authorization has not been filled out completely, with respect to an element described by section C5.3., if applicable.

C5.2.2.3. The authorization is known by the covered entity to have been revoked.

C5.2.2.4. The authorization violates paragraphs C5.2.3. or C5.2.4., if applicable.

C5.2.2.5. Any material information in the authorization is known by the covered entity to be false.

C5.2.3. Compound Authorizations. An authorization for use or disclosure of protected health information may not be combined with any other document to create a compound authorization, except as follows:

C5.2.3.1. An authorization for the use or disclosure of protected health information for a research study may be combined with any other type of written permission for the same research study, including another authorization for the use or disclosure of protected health information for such research or a consent to participate in such research.

C5.2.3.2. An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes.

C5.2.3.3. An authorization under this section, other than an authorization for a use or disclosure of psychotherapy notes, may be combined with any other such authorization under this section, except when a covered entity has conditioned the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits under paragraph C5.2.4. on the provision of one of the authorizations.

**C5.2.4. Prohibition on Conditioning of Authorizations.** A covered entity may not condition the provision to an individual of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization, except:

C5.2.4.1. A covered healthcare provider may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information under this Chapter.

C5.2.4.2. A covered entity may condition the provision of healthcare that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party. Examples of this include physical exams performed in order for a family member to participate in a school's extracurricular activities.

**C5.2.5. Revocation of Authorizations.** An individual may revoke an authorization provided under this section at any time, if the revocation is in writing, except if:

C5.2.5.1. The covered entity has taken action in reliance thereon; or

C5.2.5.2. The authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

**C5.2.6. Documentation.** A covered entity shall document and retain any signed authorization and/or revocation under this section as required by section C14.10.

**C5.2.7. Review of Authorizations.** A covered entity shall review on a periodic basis any authorization provided under this section. If the review discloses any question over the authorization's continuing validity, the covered entity shall contact the individual who provided the authorization to clarify/verify contents of the authorization.

**C5.2.8. Processing of Authorizations.** Authorizations involving use or disclosure of protected health information in the possession of an MTF, should be directed to the Privacy Officer of the MTF involved. Authorizations involving the use or disclosure of protected health information in the possession of the health plan should be directed to the TRICARE Management Activity Privacy Officer.

C5.3. IMPLEMENTATION SPECIFICATIONS: CORE ELEMENTS AND REQUIREMENTS

C5.3.1. Core Elements. A valid authorization under this section shall contain at least the following elements:

C5.3.1.1. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.

C5.3.1.2. The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.

C5.3.1.3. The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure.

C5.3.1.4. A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

C5.3.1.5. An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository.

C5.3.1.6. Signature of the individual and date. If a personal representative of the individual signs the authorization, a description of such representative's authority to act for the individual shall also be provided.

C5.3.2. Required Statements. In addition to the core elements, the authorization shall contain statements adequate to place the individual on notice of all of the following:

C5.3.2.1. The individual's right to revoke the authorization in writing, and either:

C5.3.2.1.1. The exceptions to the right to revoke and a description of how the individual may revoke the authorization; or

C5.3.2.1.2. The information in subparagraph C5.3.2.1.1. is included in the notice required by Chapter 9, a reference to the covered entity's notice.

C5.3.2.2. The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization, by stating either:

C5.3.2.2.1. The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations in paragraph C5.2.4. applies; or

C5.3.2.2.2. The consequences to the individual of a refusal to sign the authorization when, in accordance with paragraph C5.2.4., the covered entity can condition treatment, enrollment in the health plan, or eligibility for benefits on failure to obtain such authorization.

C5.3.2.3. The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by this rule.

C5.3.3. Plain Language Requirement. The authorization shall be written in plain language.

C5.3.4. Copy to the Individual. If a covered entity seeks an authorization from an individual for a use or disclosure of protected health information, the covered entity must provide the individual with a copy of the signed authorization.

#### C5.4. AUTHORIZATION REQUIRED UNDER SPECIAL RULES FOR ALCOHOL AND DRUG ABUSE PROGRAM PATIENT RECORDS

An authorization is generally required for uses and disclosures of alcohol and drug abuse program patient records under special rules discussed in section C8.9.