Instructions for Completing the DD Form 2870, Authorization for Disclosure of Medical or Dental Information

1. The attached DD Form 2870, Authorization for Disclosure of Medical or Dental Information, authorizes Fox Army Health Center (FACH) to release medical information to specific individuals other than the patient for purposes other than treatment, payment or healthcare operations.

2. To complete the DD Form 2870, please follow these instructions:

Block 1: Patient name

Block 2: Patient's date of birth

Block 3: Patient's SSN

Block 4: Indicate the date(s) of treatment patient wants another individual to have access to (i.e., write in "All time periods", or put in a specific time of your choice)

Block 5: Mark all that apply. If patient is authorizing only regular outpatient information to be released to/access by another individual, mark "Outpatient". If patient is authorizing behavioral/psychiatric type information to be released to/access by another individual, mark "BHD". "BHD" stands for "Behavioral Health Department".

Block 6a: Put the name of the third party (i.e., spouse, doctor, recruiter, etc.) who is authorized to receive/have access to the patient's medical information.

Block 6b: Address of individual(s) listed in Block 6a.

Block 6c: Phone number of the individual(s) listed in Block 6a.

Block 7: Patient may mark as appropriate or leave blank; patient's discretion.

Block 8: Patient must write out specifically what information is authorized to be released to a third party. If **all** information is to be released without any restrictions, then the words "No restrictions" should be placed here. If the patient leaves Block 8 empty, FAHC personnel will release **ALL** information to the person listed in Block 6a.

Block 9: Date the patient wants this authorization to become effective.

Block 10: Expiration date of this authorization (the standard date is one year from the completion date of this form, although patient may choose any date of his/her choice). However, FAHC will **NOT** accept the release without an expiration date.

Block 11: Patient signs in this block.

Block 12: As applicable; if you are the patient, please respond with "Self".

Block 13: Patient should date the form the same date as when they submit the form to FAHC.

Blocks 14-16: FOR STAFF ONLY

Block 17: Please provide the information requested for Patient Contact Number, Sponsor Name, FMP, and Sponsor's SSN.

3. Once patient completes the form, they will turn it in at the Medical Records Window at FAHC in person.

4**. If you – the patient who is authorizing this release – are unable to present the form in person, you may do one of the following:**

1. **Mail the hard copy original of the DD Form 2870 with a copy of military ID or state driver's license to the address listed below:**

   Fox Army Health Center
   MCXW-PAD (ROI)
   4100 Goss Road
   Redstone Arsenal, Alabama 35809-7000

2. **Fax the request to 256-842-0655 with a copy of your military ID or state driver's license.**

NO EXCEPTIONS. This allows us to verify your signature and ensure your patient confidentiality is protected at all times. If you do not have either of these identifications, please provide any other state or government issued photo ID for verification purposes.

6. If you have any questions/concerns, please do not hesitate to contact me at (256) 955-8888, Ext 1600.

//Signed//
VALERIA D. HILLS
Chief, Medical Records Department
HIPAA Privacy Officer