

Instructions for Completing the DD Form 2870, Authorization for Disclosure of Medical or Dental Information (Civilian Request)

1. The attached DD Form 2870, Authorization for Disclosure of Medical or Dental Information, authorizes Fox Army Health Center 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 being requested

Block 5: Mark all that apply

Block 6. Put the name and fax/telephone number of the civilian facility from which the records are being requested

Block 6a: N/A.....Already complete

Block 6b: N/A.....Already complete

Block 6c: N/A....Already complete

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 FAHC. If **all** information is to be released without any restrictions, then the words "All Applicable Medical Records" should be placed here. If the patient leaves Block 8 empty, FAHC will be authorized to receive **ALL** information from the person listed in Block 6.

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

Block 10: An expiration date is required for this authorization. The standard date for requesting information from another facility is at least three months from the submission completion date of this form; however, any date may be chosen.

Block 11: Patient (parent/guardian, if patient is under the age of 14) signs in this block.

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

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

Blocks 14-16: FOR STAFF USE ONLY; please leave blank

Block 17: Please provide the information requested for Sponsor Name, FMP, and Sponsor's Last Four SSN.

3. Once patient completes the form, they will turn it in at the Medical Records Window at Fox Army Health Center 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 your military ID or state driver' 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