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:

NOTE: Form MUST be handwritten by the patient authorizing release/disclosure.

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 Customer Service Desk at FAHC IN PERSON.

4. If you have any questions/concerns, please do not hesitate to contact me at (256) 955-8888, Ext 1615.

//Signed//
VALERIA D. HILLS
Chief, Patient Administration
HIPAA Privacy Officer