Instructions for Completing the DD Form 2870, Authorization for Disclosure of Medical or Dental Information (Copy of Medical Record(s))

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.

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), if applicable.

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 individual authorized to pick up the medical record. It can be the patient or another person named by the patient (or it can be a parent/guardian if the patient is under 14 years of age).

Block 6b: Put the address of the person listed in Block 6a; however, if the copy is being picked up in person, rather than mailed, please write "Will pick up" in this block.

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

Block 7: Mark as applicable

Block 8: Mark as applicable. If requesting a copy of the entire medical record, please mark "complete copy of medical record". If requesting anything less, please specify in Block 4 the exact dates needed. However, if any type of behavioral health medical information is needed, you MUST select "copy of behavioral health documentation(s)". **NOTE: BHD information will be included in a general record copy unless specified. NO EXCEPTIONS.**

Block 9 and 10: N/A

Block 11: Patient (parent/guardian if patient is under 14 years of age) 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. After completing the form, please turn it in at the Medical Records Customer Service Desk at Fox Army Health Center **by the requesting beneficiary.**

4. **The copying of a complete medical record could take up to 60 business days for completion The record copy will be provided on a CD in a PDF format. NOTE: The CD will be automatically mailed to the address listed in Block 6b, unless otherwise specified.**

5. 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