GENERAL INSTRUCTIONS

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION
(DD FORM 2870)

This form is used to allow a TRICARE beneficiary to authorize Health Net Federal Services, LLC (Health Net) to release protected information to a person or entity of the beneficiary's choosing. Completion of this form is voluntary. If this form is not completed in its entirety, your request will not be processed.
*This authorization will not apply to alcohol or substance abuse information

Sponsor Social Security Number (SSN): Please print the Sponsor's 9-digit SSN on the TOP LEFT of the form, above the word "Authorization".

Section I: Patient Data

- Complete the *beneficiary/patient's* information.
- Identify the date range and type of treatment information to be released.

Section II: Disclosure

This section identifies who may release information about the patient to an identified third party or authorized representative.

- **Item 6**: Please enter "Health Net/TRICARE".
- **Items 6a-6d**: Please complete the name and contact information of the authorized representative (for example: the name and contact information of your spouse or parent).
- **Item 7:** Identify why the information will be disclosed.
- **Item 8:** You may clarify information related to the date range and/or type of treatment that you wish to be disclosed.
- **Item 9:** The authorization will be effective the date the form is received.
- **Item 10:** ***If a calendar date is not provided, the authorization is incomplete and will be returned.***

Section III: Release Authorization

- Sign and Date the authorization.
- If a patient's representative signs the authorization, please attach documentation of the representative's authority (for example: Custody, Guardianship, Power of attorney, etc).

MAIL or FAX your completed form to:

TRICARE Correspondence PGBA, LLC P.O. Box 870141 Surfside Beach, SC 29587-9741
Fax: 1-888-225-3545

IMPORTANT:
This form grants permission for information disclosed by telephone or correspondence about authorizations/referrals, claims, and enrollment *only.* It does *NOT* permit the person to see your claims on our Web site, www.myTRICARE.com, or grant permission to make changes to your account. To grant permission for someone to see your claims information on the Web site, you must do so within your account on www.myTRICARE.com.

01/23/2014

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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)* ☐ OUTPATIENT ☐ INPATIENT ☐ BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

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)*
☐ PERSONAL USE ☐ CONTINUED MEDICAL CARE ☐ SCHOOL ☐ OTHER *(Specify)*
☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION ☐ DATE *(YYYYMMDD)* ☐ 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 *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE: ☐ 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:	

Reset