Sensitive Diagnosis Only: Authorization to Release Information

Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by TRICARE East's Automated Information System and how your personal information will be used.

AUTHORITY: 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); 45 CFR Parts 160 and 164, HIPAA Privacy and Security Rules; and E.O. 9397 (SSN), as amended.

PURPOSE: This form is used to provide the military hospital or clinic or Dental Treatment Facility TRICARE Health Plan with a means to request the use and/or disclosure of an individuals protected health information.

ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, these records contained therein may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3). The DoD Blanket Routine Uses are published and visible at: https://dpcld.defense.gov/Privacy/ SORNsIndex/Blanket-Routine-Uses/. Collected information may be shared with the Departments of Health and Human Services, Homeland Security, and other federal, state, local, or foreign government agencies, private business entities, including entities under contract with the Department of Defense and individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, thirdparty liability, coordination of benefits, and civil or criminal litigation.

DISCLOSURE: Voluntary. Failure to complete and sign the form will result in the nonrelease of the PHI. 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.

APPLICABLE SORN: EDHA 07, Military Health Information System (June 15, 2020; 85 FR 36190) https://dpcld.defense.gov/Portals/49/Documents/Privacy/SORNs/DHA/EDHA-07.pdf

Beneficiary Name: _____

Sponsor ID: _____ DOB:_____

Address: _____

City: _____ State: ____ ZIP: _____

I hereby authorize the use or disclosure of the above-named beneficiary's PHI by TRICARE East and/or TRICARE Health Plan, as described below:

(Check only one box. Only one diagnosis is allowed per form.)

- ☐ Pregnancy and birth control records
- ☐ Acquired Immunodeficiency Syndrome HIV records
- ☐ STD records
- ☐ Abortion records
- ☐ Mental health records (excludes autism and/or ABA)
- ☐ Alcoholism records
- ☐ Sexual assault or domestic violence records
- ☐ Substance abuse records

This information may be disclosed to/used by the following:

Name: _____

Address: _____

Phone: _____

City: _____ State: ____ ZIP: _____

The information is being disclosed for the following purpose(s):

- ☐ Personal use
- ☐ Continued medical care
- ☐ Insurance claims
- ☐ Retirement
- ☐ School
- ☐ Legal
- ☐ Other (be specific:)

_____

_____

TRICARE EAST REGION

By signing below, the beneficiary or the beneficiary's representative agrees to the following statements:

1. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

2. I understand that I may see and copy the information described on this form if I ask for it, and that I may request a copy of this form after I sign it.

3. I understand that I may revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to the TRICARE East privacy office to the address below. I understand that the revocation will not apply to information that has already been released in response to the authorization.

4. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations. Exception: Re-disclosure of alcohol and substance use information is expressly prohibited without the written consent of the person to whom it pertains.

5. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR,Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations

This section must be completed for all authorizations:

I understand I may refuse to sign this authorization and TRICARE East may not condition treatment or payment on whether or not I sign this authorization. If no expiration date is specified, this authorization will expire one year from the date of signature.

Expiration Date (mm/dd/yyyy, cannot be indefinite):

_____

Beneficiary Signature:

_____

(The beneficiary must sign the form. If signed by the beneficiary's representative; additional documentation may be required.)

Relationship of signor to beneficiary:

_____

Signature/Parent/Guardian/Authorized Representative (when required)

Signature Date (mm/dd/yyyy): _____

TRICARE East will follow all federal and state laws and regulations that are more stringent.

Please return form by fax/mail to:

Fax
877-298-3407

Mail
TRICARE East Privacy Office
P.O. Box 740062
Louisville, KY 40201-7462

TRICARE® EAST REGION