Print Form

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
NHCCHASNINST 6150.2	20110422
LOCAL FORM TITLE *(Optional)*	
RECORDS RELEASE	

RECORDS RELEASE

Record/medical information is requested from: _____

Name of facility or physician: _____

Address: _____

City, State, and Zip Code: _____

Record/medical information is requested on:

Patient's Name: _____ DOB _____

Sponsor's Name: _____ SSN _____

Treatment and date(s): _____

I hereby request and authorize medical information to be released to Naval Health Clinic Charleston at the address below (please include all information that you have on file):

COMMANDING OFFICER
CODE 09OA (ATTN: RELEASE OF INFO)
NAVAL HEALTH CLINIC CHARLESTON
110 NNPTC CIRCLE
GOOSE CREEK SC 29445

_____	_____	_____
Patient/Guardian Signature	Date	Witness' Name and Signature

Upon receipt by Naval Health Clinic Charleston, I want the following to be done (select one of the following)

_____ File the information in my record.
_____ Forward the information to me at _____.
_____ Notify me upon receipt of the information at telephone number:_____.
_____ Forward the information to Dr._____.

This information is protected by the Privacy Act of 1974 (PL-93-579) and the health Insurance Portability and Accountability Act (PL 104-191)

NHCCHASN 6150/8 Exception to NAVMED 6000/5 (09-2008)

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

Authorization Start Date:	Authorization Expiration Date:	Action Completed Date:

RELEASE AUTHORIZATION

PLEASE READ AND SIGN BELOW:

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 protect 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.

For Staff Use only – (To Be Completed only Upon Receipt of Written Revocation)

Authorization Revoked:	Revocation completed by:	Date:

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