AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS UNDER HIPAA

DATA REQUIRED BY THE PRIVACY ACT OF 1974
(5 U.S.C., Section 552a)

1. **AUTHORITY:** **The Federal Medical Recovery Act, 42 U.S.C., Section 2651-3, 10 U.S.C., Section 1095, 32 CFR, Part 220.12(I), 5 U.S.C., Section 301, 44 U.S.C., Section 3101.**

2. **PRINCIPAL PURPOSES:** **Authorization for release of medical records excerpts in order to document the claim of the United States Government against third parties for medical care recovery costs.**

3. **ROUTINE USES:** **Information may be disclosed to civilian attorneys, insurance companies and other agencies in order to settle claims, and/or to the Department of Justice for use in litigation, and may be furnished to other components of the Department of Defense as required by regulation.**

4. **MANDATORY OR VOLUNTARY DISCLOSURE:** **Voluntary. However, eligible recipients of Government sponsored medical treatment electing not to provide this information will be required to sign in writing any other claim against any other party as a result of the incident giving rise to the Government's claim for the recovery of medical care costs.**

Use of Medical Records

As evidenced by my signature below, I, _____, (name of patient, natural or legal guardian or estate representative) have read the attached explanation of my privacy rights under the Health Insurance Portability and Accountability Act (HIPAA). I hereby grant authority to the United States Army claims representatives to obtain, copy and release for review, protected information (PHI), including medical and dental records, whether civilian or military, for the purpose of evaluating the United States' claim for medical care expenses.

I understand that PHI in the possession of the Army claims representative may be copied and disclosed to other agencies, civilian entities, experts, or consultants for purpose of investigating and evaluating the claim.

A Photostatic copy of this document shall be valid as the original. This authorization will remain in effect until such time that a final resolution of the administrative claim for compensation has been determined.

_____ _____

Printed Name of Patient Patient's Social Security Number

_____ _____

Signature of Patient Patient's Date of Birth

(If Signed by a Legal Representative, List Relationship to Patient)

_____

Date Signed

Provided Medical Records of _____

Claim Number _____

1. Military Records:

Dates of Treatment	Name of Military Treatment Facility
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. Radiology films (MRI/CT Scans, slides or electronic images):

Dates of Treatment	Name of Military Treatment Facility
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

3. Civilian Records:

Dates of Treatment	Civilian Records
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Radiology films (MRI/CT Scans, slides or electronic images):

Date of Treatment	Name of Treatment Facility
_____	_____
_____	_____
_____	_____
_____	_____

(USE EXTRA SHEETS IF NECESSARY)