

# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO SPECIAL PROGRAMS

## PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of this form and how it will be used. Please read it carefully.

**AUTHORITY:** Public Law 104-191; E.O. 9397 (SSAN); 42 CFR § Part 2; 45 CFR § 164.528.

**PRINCIPAL PURPOSE(S):** This form is to provide the Coast Guard Clinic with a means to request the use and/or disclosure of an individual's protected health information to appropriate military authorities for evaluation of fitness for initial and continued participation in the program named in box 5.

**USE OF ALCOHOL/SUBSTANCE ABUSE INFORMATION:** Alcohol and substance abuse information will only be used by appropriate military authorities in accordance with 42 U.S.C. § 290dd-2 for evaluation of fitness for initial and continued participation in the program named in box 5. No other use of this information is permitted.

**DISCLOSURE:** Voluntary.

## SECTION I – PATIENT DATA

1. NAME ( <i>Last, First, Middle Initial</i> )	2. DATE OF BIRTH (YYYYMMDD)	3. SOCIAL SECURITY NUMBER
4. DATES OF PROGRAM: FROM – TO (YYYYMMDD)	5. NAME AND ADDRESS OF PROGRAM	

## SECTION II – DISCLOSURE

6. I AUTHORIZE RELEASE OF MY PATIENT INFORMATION TO:

a. COMMAND OF PROGRAM IDENTIFIED IN (5) AND THE FOLLOWING ADDITIONAL PERSONS/ORGANIZATIONS: ( <i>optional</i> )	b. ADDRESS & TELEPHONE OF ADDITIONS ( <i>Street, City, State, and Zip Code</i> )
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### Disclosure Information

Disclosure of this information will be made to appropriate designated and appointed military authorities to be used to evaluate fitness for initial and continued participation in the program. Information on this use may be included or maintained in the office responsible for this program. The authorization applies to disclosure of medical, dental, and drug and alcohol abuse and treatment information related to participation in this program to appropriate designated and appointed military authorities. The disclosure shall only include documentation necessary to ascertain fitness to perform any particular mission, assignment, order or duty, including compliance with any actions required as a precondition to performance of such mission, assignment, order or duty related to the subject program. These data may be stored in electronic databases used for medical management of participants. Only representatives from the medical department and the offices responsible for the program will have access to the information.

**AUTHORIZATION START DATE** - the date that you sign this form authorizing the release of information.

**AUTHORIZATION EXPIRATION** - the date of your disenrollment from the program or the program's completion, whichever occurs first.

## SECTION III – RELEASE AUTHORIZATION

I understand that:

- 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. 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.
- 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 with the exception of alcohol or drug abuse patient information.
- 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. I request and authorize release of the information described above to the named individual/organization/program indicated.
- The Military Health System (which includes the TRICARE Health Plan and Coast Guard Health Services) may not condition treatment in Coast Guard medical facilities/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.

7. SIGNATURE OF PATIENT	8. DATE (YYYYMMDD)
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