

**REQUEST FOR PRIVATE MEDICAL INFORMATION**  
For use of this form, see AR 40-66; the proponent agency is the OTSG

1. Date (YYYYMMDD)

2. Patient's Name and SSN.

3. Medical Treatment Facility (*Name and Location*)

4. Reason for Request.

5. Private Medical Information Sought (*Specify dates of hospitalization or clinic visits and diagnosis, if known*)

6. Requestor's Name, Title, Organization and SSN.

*FOR USE OF MEDICAL TREATMENT FACILITY ONLY*

7. Check applicable box.

Approved       Disapproved (*State reason for disapproval*)

8. Summary of Private Medical Information Released.

9. Signature of Approving Official.

10. Date (YYYYMMDD)