REQUEST AND RELEASE OF MEDICAL INFORMATION TO COMMUNICATIONS MEDIA

For use of this form see AR 40-66; the proponent agency is the Office of The Surgeon General.

PRIVACY ACT STATEMENT

AUTHORITY: Section 3012, title 10, United States Code.

PRINCIPAL PURPOSE(S): This form provides for patient/parent/guardian consent to release requested personal medical information to news publication or broadcast.

ROUTINE USES: The requested information will be released on this form to the communications media. It will be used for news publication or broadcast.

MANDATORY OR VOLUNTARY DISCLOSURE: The release of this information is voluntary. There is no effect on the individual not providing the requested information.

SECTION I - PATIENT IDENTIFICATION

NAME (Last, First, Middle)		ADDRESS
AGE	STATUS	NAME OF MEDICAL TREATMENT FACILITY

SECTION II - TO BE COMPLETED BY REQUESTOR

I certify that I represent _____

(Name and Address of Communications Media)

_____ and that medical information on the above identified patient is requested for news publication or broadcast.

List specific information requested below:

DATE *(YYYYMMDD)*	SIGNATURE OF PUBLIC AFFAIRS OFFICER	SIGNATURE OF MEDIA REPRESENTATIVE

SECTION III - TO BE COMPLETED BY PATIENT/PARENT/LEGAL REPRESENTATIVE

Authorization Date *(YYYYMMDD)*:	Authorization Expiration: ☐ Date *(YYYYMMDD)* _____ ☐ Action Completed
_____	

I, _____, hereby request and authorize the release of the requested information concerning my illness or injury and hospital treatment (complete when other than patient gives consent-the illness or injury and hospital treatment of (_____) while a patient in the medical treatment facility, to the above mentioned communications media. I hereby agree to hold the hospital, its physicians, and its staff free and harmless from any, and all liabilities or ill effecfts which might arise from the publication or broadcast of such information.

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. 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 recieve 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.

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.

SIGNATURE OF PATIENT/PARENT/GUARDIAN	Relationship to Patient *(If applicable)*	DATE *(YYYYMMDD)*
SIGNATURE OF WITNESS		DATE *(YYYYMMDD)*

SECTION IV - TO BE COMPLETED BY ATTENDING PHYSICIAN

Information as requested and authorized is hereby furnished:

DATE *(YYYYMMDD)*	SIGNATURE OF ATTENDING PHYSICIAN

SECTION V - TO BE COMPLETED BY PATIENT AND ADMINISTRATION DIVISION

Section I through IV have been reviewed and is ☐ Approved ☐ Disapproved for release

DATE *(YYYYMMDD)*	SIGNATURE OF CHIEF, PATIENT ADMINISTRATION DIVISION *(or designated representative)*

Upon completion of this form, a copy will be placed in the patient's medical record and a copy will be returned to the Public Affairs Officer for release of the requested information to the media representative.