AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carfolly. ADTHORTY: Public Law 104-191; EX. 0337 (SSAN), Do DO SOS 15.87. ADTHORTY: Public Law 104-191; EX. 0337 (SSAN), Do DO SOS 15.87. ADTHORTY: Public Law 104-191; EX. 0337 (SSAN), Do DO SOS 15.87. ADTHORTY: Fublic Law 104-191; EX. 0337 (SSAN), Do DO SOS 15.87. ADTHORTY: Public Law 104-191; EX. 0337 (SSAN), Do DO SOS 15.87. ADTHORTY: Public Law 104-191; EX. 0337 (SSAN), Do DO SOS 15.87. ADTHORTY: Fublic Law 104-191; EX. 0337 (SSAN), Do DO SOS 15.87. ADTHORTY: Fublic Law 2014 (Figure 104) and the part of the individual gen particle hadth information. ROUTINE USE(S): To any third party or the individual gen authorization for the disclose information from medical records or for authorization to be used for the authorization form records of an alcohol of drug abuse pratimin from medical records or for authorization to use of disclose psychotherapy notes. SECTION I - PATIENT DATA 1. NAME flast, Middle Initial 2. DATE OF BITH //YYYYMMDD) 3. SOCIAL SECURITY NUMBER 4. PENDO OF TREATMENT; FROM - TO /YYYYMMDD) 5. TYPE OF TREATMENT // Xonel ULIPATINT NATION TO INFORMATION TO INFORMATION TO: (Name of Febrily/TRICARE Health Plan) 6. IAUTHORIZE (Name of Febrily/TRICARE Health Plan) 6. ADDRESS IStreet, City, State and ZIP Codel 7. REASOR TOR REQUESTIVES OF MEDICAL INFORMATION IX A septembril 9. AUTHORIZE TO RECOMPLY AND ADD IN CA septembril 9. AUTHORIZE TO RETEMENT; EROM - TO (YYYYMMDD) 10. AUTHORIZE INFORMATION TO BE RELEASED 9. AUTHORIZE TO NOT TO (YYYYMMDD) 10. AUTHORIZE INFORMATION TO A septembril 9. ADDRESS IStreet, City, State and ZIP Codel 9. AUTHORIZEND START DATE (YYYYMMDD) 10. AUTHORIZEND 9. AUTHORIZEND START DATE (YYYYMMDD) 10. AUTHORIZEND 1	PRIVACEAC	I STATEMENT
PRINCIPAL PURPOSE[5]: This form is to provide the Military Treatment Facility/Dental Treatment Facility/IBCARE Health Plant ROUTINE USE[5]: To any third party or the individual upon authorization for the disclosure from the individual for: personal Disclosure from the upotected health information. This form will not be used for the authorization to disclose alcohol or drug abuse pratement program. In addition, any use as a nathorization to use or disclose psychotherapy notes. SECTION I - PATIENT DATA T. NAME (Lasr, Middle Initial 2. DATE OF BIRTH (VYYYMM00) 3. SOCIAL SECURITY NUMBER G. I AUTHORIZE INPATEENT INPATEENT BOTH G. I AUTHORIZE INPATEENT INPATEENT <td colspan="2">it will be used. Please read it carefully.</td>	it will be used. Please read it carefully.	
use: insurance: continued medical care; school: lega; retirement/separation; or other reasons. DBClCOSURE: Voluntary. Failure to sign the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose school in the non-release of the protected health information from records of an accord or authorization to disclose school in or disclose school and the abuse treatment program. In addition, any use as an authorization to disclose school and the abuse treatment program. In addition, any use as an authorization to disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes. SECTION II - PATIENT DATA 1. NAME (Last, Fest, Middle Initial) 2. DATE OF BIRTH //YYYMMDD) 3. SOCIAL SECURITY NUMBER 4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD) 5. TYPE OF TREATMENT (X one) 0. UTPATIENT INPATIENT BOTH 6. I AUTHORIZE INPACT TO (YYYYMMDD) 6. ADDRESS (Street, City, State and ZIP Code) 6. I AUTHORIZE INPACE INFORMATION TO: 1. NAME OF PHYSICIAN, FAGLITY, OR TRICARE Health Plent 1. ADDRESS (Street, City, State and ZIP Code) 6. TELEPHONE (Include Area Code) 6. TELEPHONE (Include Area Code) 6. TELEPHONE (Include Area Code) 7. REASON FOR REQUESTUSE OF MEDICAL INFORMATION (X as applicable) 9. AUTHORIZE INFORMATION TO BE RELEASED 9. AUTHORIZATION START DATE (YYYYMMDD) 10. AUTHORIZATION EXPIRATION 10. DATE (YYYYMMDD) 10. AUTHORIZATION START DATE (YYYYMMDD) 10. AUTHORIZATION EXPIRATION 11. RELEASE AUTHORIZATION 2. INFORMATION TO BE RELEASED 9. AUTHORIZATION START DATE (YYYYMMDD) 10. AUTHORIZATION EXPIRATION 11. RELEASE AUTHORIZATION 2. INFORMATION TO BE RELEASED 9. AUTHORIZATION START DATE (YYYYMMDD) 10. AUTHORIZATION EXPIRATION 11. RELEASE AUTHORIZATION 11. RELEASE AUTHORIZATION 12. INFORMATION TO BE RELEASED 13. AUTHORIZATION START DATE (YYYYMMDD) 14. AUTHORIZATION START DATE (YYYYMMDD) 15. REVORATION TO REGULASE AUTHORIZATION 2. INFORMATION TO BE RELEASED 15. AUTHORIZATION START DATE (YYYYMMDD) 16. AUTHORIZ	PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.	
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