

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE LIMITS OF CONFIDENTIALITY AND INFORMED CONSENT TO CARE (BH CLINICS)

OTSG APPROVED (Date)
(YYYYMMDD)

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As part of your healthcare team, our goal is to provide you with quality care as well as protect the privacy of your personal information. The care we provide you may include, but is not limited to: assessment, referral, individual therapy, couples therapy, family therapy, group therapy, and psychiatric evaluation and medications.

As your providers, we will document information about your visits in your military health record (written and electronic) to ensure continuity of care. Your health record is maintained as the property of the U.S. Government. In the majority of cases, we will not disclose any of your personal information nor confirm/deny that we have met with you unless you provide us with written authorization to disclose your personal information. There are just a few exceptions, however, under which we may be required to release your personal information without obtaining your prior authorization. However, we will discuss these with you at the beginning of treatment and throughout treatment, whenever possible. For example:

1. **Safety** : If you threaten to harm yourself, we may seek hospitalization and/or contact others to ensure your safety. If you threaten serious bodily harm to another, we are required to take protective actions, such as contacting the victim, police, chain of command, or seeking hospitalization.
2. **Abuse** : If we believe that a child, spouse, or vulnerable adult is being abused, we may be required to file a report.
3. **Legal** : If you are involved in legal actions/proceedings, your records may be subject to subpoena or lawful directive from a court. Under the Uniform Code of Military Justice (UCMJ), we have a limited "privileged communication" that may prevent your records from being disclosed in legal proceedings. This privilege is not absolute and there may be situations involving some violations of the UCMJ or civil law where we may be required to divulge that information to the chain of command and/or other authorities. If you have any concerns related to this, please contact an attorney.
4. **Fitness for Duty/Command-Directed Referrals** : If you are command-referred, your chain of command will not be authorized to view your medical record, but is entitled to limited information pertinent to any duty limitation or restriction, security clearance, or treatment that might affect duty performance or jeopardize the safety of yourself or co-workers.
5. **Care Coordination** : Because we operate as a team with other healthcare staff to provide you the best possible services, other members of the military medical system are permitted access to your record. In most cases, your information will not be disclosed outside the clinic/hospital setting without your written permission.
6. **Quality Care Review** : Quality assurance personnel may review your record to ensure that care standards are being met. If this occurs, the reviewer is required to keep your identity confidential.

If you have any questions or concerns, please feel free to discuss it with us.

STATEMENT OF UNDERSTANDING/CONSENT TO ASSESSMENT and/or TREATMENT

I have read the above and understand that clinical information about me will be safeguarded within the limitations mentioned above and under the provisions of the Privacy Act - DD Form 2005 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

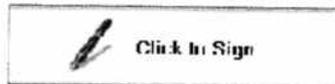
Patient/Caregiver Signature: _____

Date: _____

I have explained the nature of the assessment and treatment(s) including benefits and risks of proposed and alternatives treatments.

(Continue on reverse)

PREPARED BY (Signature & Title)



DEPARTMENT/SERVICE/CLINIC

DATE (YYYYMMDD)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

- | | |
|--|--|
| <input type="checkbox"/> HISTORY/PHYSICAL | <input type="checkbox"/> FLOW CHART |
| <input type="checkbox"/> OTHER EXAMINATION OR EVALUATION | <input type="checkbox"/> OTHER (Specify) |
| <input type="checkbox"/> DIAGNOSTIC STUDIES | |
| <input type="checkbox"/> TREATMENT | |