

Instructions for Completing DD Form 2870, Third Party Authorization

1. The attached DD Form 2870, Authorization for Disclosure of Medical or Dental Information, authorizes Fox Army Health Center (FAHC) to release medical information to specific individuals other than yourself.

2. To complete the DD Form 2870, please follow these instructions carefully:

Block 1: Patient's name in this block.

Block 2: Patient's date of birth in this block.

Block 3: Patient's complete social security number in this block.

Block 4: Indicate the date(s) of treatment you (the patient) wants released. You can write "all time periods" or you can put a specific time of your choice.

Block 5: If you are authorizing only regular outpatient information to be released, mark the block for "Outpatient". If you are authorizing regular outpatient and behavioral health/psychiatric type information to be released, mark the block for "Both", then put the letters "BHD" beside the block. "BHD" stands for Behavioral Health Division.

Block 6: This block is already completed.

Block 6a: Put the name of the individual(s) that you (the patient) wishes Fox to release medical information to.

Block 6b: Put the address of the individual(s) listed in Block 6a.

Block 6c: Put the phone number of the individual(s) listed in Block 6a.

Block 7: Mark as appropriate.

Block 8: Write out specifically what information you want released. You (the patient) can be very specific, to include date and time of the visit, or you can give generalized instructions such as "all medical information from this date to that date, provided by Dr. Jones." If this block is left empty, FAHC will automatically release **ALL** medical information to the individual listed in Block 6a.

Block 9: Put the date you wish this authorization to become effective. Do not leave blank.

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Block 10: Put an expiration date of this authorization. Do not leave this blank.

Block 11: You, the patient, signs this block.

Block 12: Leave blank.

Block 13: Please date the form the same date as when you sign the form.

Block 17: Please provide all information requested for the patient's sponsor's name, rank, sponsor's SSN, branch of service and phone number.

3. Once you, the patient, complete the form, please turn it in – in person - at the Medical Records Customer Service Window at FAHC.

4. If you, the patient who is authorizing this release, are unable to present the form in person, you may mail the completed hard copy **signed original** of the DD Form 2870 to the address listed below. In addition to the completed form, you **must** provide a photocopy of your military ID card and state issued driver's license, copied both front and back. This will allow us to verify your signature and ensure your confidentiality is protected at all times.

5. If you, the patient who is authorizing this release, request another person to bring this form to FAHC for you, that person must also bring in a copy of your military ID card and state issued driver's license (copied both front and back).

6. Address to mail DD Form 2870:

Fox Army Health Center
ATTN: MCXW-PAD (ROI)
4100 Goss Road
Redstone Arsenal, Alabama 35809-7000

7. For any questions, please call 256-955-8888, and choose Extensions 1605, 1607, or 1616.

JANET L. FURSDON
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Privacy Officer