

Instructions for Completing Authorization Forms to Request Copies of Records

1. The attached DD Form 2870, Authorization for Disclosure of Medical or Dental Information, serves as the mechanism for beneficiaries to request copies of their medical record. All blocks must be completed in their entirety.
2. To complete the DD Form 2870, please follow these instructions:

Block 1: Put patient name in this block.

Block 2: Put patient date of birth in this block.

Block 3: Put sponsor's SSN in this block.

Block 4: Indicate the dates of treatment that the patient wants copied (or put "all time periods")

Block 5: If patient is requesting only regular outpatient information, mark the block for "Outpatient". If patient is requesting regular outpatient **and** behavioral health/psychiatric type information, mark the block for "Outpatient", then write the letters "BHD" next to this block. "BHD" stands for "Behavioral Health Division".

Block 6: Information already entered.

Block 6a: Put name of the individual authorized to pick up medical record (can be the patient, or another person named by the patient)

Block 6b: Put address of patient listed in Block 6a.

Block 6c: Put phone number of patient listed in Block 6a.

Block 7: Mark as appropriate, or leave blank (patient's choice)

Block 8: Mark whichever applies. If a whole copy of just the regular outpatient medical record documentation is required, mark "Copy entire medical record". If psychiatric type documentation is required, mark "Copy of Behavioral Health/Psychiatric Record". If anything else is required, mark "other" and indicate what specifically is required. Please note that psychiatric type documentation **will not** be provided unless this block is checked.

Block 9 and 10: Skip these blocks

Block 11: Patient signs in this block

Block 12: Either put the word "self" if you are the patient, or whatever your relationship is to the patient if the patient is under the age of 14 (such as "parent").

Block 13: Date the form the day it is brought to Fox, or sent/mailed to Fox.

Block 17: Please provide the information requested for Sponsor Name, Rank, Sponsor's SSN, Branch of Service and Phone Number.

3. After completing the form, please turn it in at the Medical Records Window at Fox Army Health Center **in person**. If anyone other than the patient is bringing the form to Fox, the patient must provide a photocopy of their military ID card and their state issued driver's license (if applicable) to the individual who is turning in the form. That individual will present this identification to Medical Records personnel at Fox when requesting the copies.

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4. Please keep in mind that it generally takes approximately **60 days** for a copy to be provided. Copies of medical records are only provided on a CD, in PDF format. A copy on CD will automatically be mailed to your address marked in Block 6b unless you specifically indicate in Block 6b that you will come by and pick up the disk in person.
5. If you have any questions, please call the undersigned at (256) 955-8888, Extension 1600, or Medical Records Personnel at Extensions 1605 or 1607.

JANET L. FURSDON
Chief, Medical Records Department/
HIPAA Privacy Compliance Officer