USMC Wounded Warrior Regiment

1998 Hill Road
Quantico, VA 22134-5103

AUTHORIZATION FOR DISCLOSURE OF MEDICAL, PSYCHOTHERAPY AND SUBSTANCE ABUSE INFORMATION

Privacy Act Statement

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 carefully.

Principal Purpose(s): This form is to provide the Wounded Warrior Regiment with a means to request the use and/or disclosure of an individual's protected health information.

PATIENT'S FULL NAME:_____
(Printed)

Sponsor's SSN:_____ Patient's SSN:_____

Family Member Prefix:_____ Date of Birth:_____

Initial:_____ I hereby authorize any hospital staff, physicians, or other medical professional who has treated or examined me, or who may hereafter treat or examine me, to disclose any and all medical information (records, x-rays, photographs, reports) relative to this injury or illness to the USMC Wounded Warrior Regiment for the purpose of my healthcare coordination.

Initial:_____ I further authorize that this information may be shared in writing, electronically, or by telephone by the USMC Wounded Warrior Regiment and other medical professionals, agencies, or insurance companies who may be involved in the provision of care or payment of services that may be necessary.

Initial:_____ I further authorize the USMC Wounded Warrior Regiment to contact my next of kin who may be involved in the provision of my care.

Initial:_____ I fully understand that the intent of this authorization is to secure information for the purpose of providing assistance for medical care or claims.

Initial:_____ This authorization will remain in effect for one year from the date noted below while I am receiving case management services. Expires on:_____20_____. Consent can be withdrawn via written letter addressed to Wounded Warrior Regiment, Attn: Medical, 1998 Hill Road, MCB Quantico, VA 22134.

Initial:_____ I understand I may withdraw this consent at any time except to the extent that action has already been taken.

Initial:_____ I agree that a photocopy of this authorization shall be as valid and acceptable as the original, if necessary.

_____ _____
(Signature of Service Member or Legally Authorized representative) (Date)