

YOUR INFORMATION

LAST NAME:	FIRST NAME AND MIDDLE INITIAL:	PHONE NUMBER:
ADDRESS	CITY/STATE:	ZIP CODE:

Person/Organization Providing the Information <i>[DoD 6025.18R C5.3.1.2]</i>	Person/Organization to Receive the Information <i>[DoD 6025.18R C5.3.1.3]</i>

Description of the Information to be Released
(Provide a detailed description of the specific information to be released)
[DoD 6025.18-R, C5.3.1.1]

Interview and/or photography which may include release of Private Health Information self-disclosure and interview with medical provider

Description of Each Purpose for the Use or Release of the Information
(Provide a detailed description of the activity for which the information will be used)
[DoD 6025.18-R, C5.3.1.4]

INTERVIEW OF PATIENT & MEDICAL STAFF WHO PROVIDED MEDICAL CARE AT (facility)_____

This authorization for release of the above information to the above named persons/organizations will expire on: N/A (date). *[DoD 6025.18R, C5.3.1.5]*

I understand:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I have the right to revoke this authorization. *[DoD 6025.18-R C5.3.2.1]*
- I understand the Notice of Privacy Practices provides instructions should I choose to revoke my authorization.
- **I understand that I cannot revoke information once it has been given to the media.** *(Covered entities must select one of the following: 1) this authorization because the covered entity has taken action in reliance on the authorization, or 2) the authorization because it was obtained as a condition of obtaining insurance coverage) [DoD 6025.18-R C5.2.5]*
- I understand that I am signing this authorization voluntarily and that treatment, payment or eligibility for my benefits will not be affected if I do not sign this authorization. *[DoD 6025.18-R C5.3.2.2.1]*
- I understand if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. *[DoD 6025.18-R C5.3.2.3]*
- I understand I have the right to receive a copy of this authorization. *[DoD 6025.18-R C5.3.4]*
- I understand DoD covered entities may use and disclose protected health information (PHI) of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission. *[DoD 6025.18-R C7.11.1.1]*

Signature:	Signature of Parent (if patient is under legal age of consent):	Date:

[DoD 6025.18-R, C5.3.1.6].

When using or disclosing protected health information (PHI) in any form or when requesting PHI from another covered entity, a covered entity shall make reasonable efforts to limit the use, disclosure, or request of PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. [DoD 6025.18-R C8.2.1]