REQUEST FOR USAJFKSWCS MEDICAL WAIVER AND AUTHORIZATION FOR DISCLOSURE OF MEDICAL DATA

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.
AUTHORITY: Public law 104-191; E.O. 9397 (SSAN); DoD 6025.18R.
PRINCIPLE PURPOSE(S): This form is to provide the Military Treatment Facility/1st SWTG(A) with a means to collect, request and use and/or disclose an individual's protected health information to process the individual's request for a waiver of medical standards, continued medical care, school, legal, retirement/separation, or other reasons.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the form will result in the inability to process the individual's request for a waiver of medical standards.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - SERVICE MEMBER DATA

1. NAME: *(Last, First, MI)*

2. DATE OF BIRTH: *(YYYYMMDD)*

3. DOD ID#:

4. E-MAIL ADDRESS: *(someone@mail.mil)*

5. GRADE:

6. PHONE NUMBER: *[(123) 456-7890]*

SECTION II - PROSPECTIVE COURSE(S)

7. COURSE(S): *(Select up to three from the lists. Please refer to Army Regulation 40-501 for standards.)*

SECTION III - SUMMARY OF MEDICAL CONDITION(S)

8. MEDICAL CONDITION(S): *(List all medical conditions requiring a waiver.)*

9. LOCATION OF RECORDS: *(Name of MTF, Address, Phone, and Fax # of MTF)*

10. HISTORY OF CONDITION(S): *(Describe the details of your medically disqualifying condition. Make sure to describe how your condition came about, when it started, and what impact or limitations the condition had on you (i.e., ABN status, APFT, schools attended since condition). Please list all treatment(s) and profiles you have had regarding your condition and any other details you think might influence the waiver decision.)*

I **AUTHORIZE** my MTF in Block #9 to release my Inpatient and Outpatient data to USAJFKSWCS, Fort Bragg, North Carolina 28310, (910)432-3566 or swcswaivers@socom.mil. This authorization will begin on the date signed by me, and will end two years from that date.
I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
I request and authorize the named provider/treatment facility to release the information described above to the named individual/organization indicated.

11. CURRENT PROFILE:

13. WAIVER DISPOSITION:

12. SERVICE MEMBER'S SIGNATURE:

14. AUTHORITY'S SIGNATURE: