MRF

MEDICAL RECORD RELEASE FORM

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C 136, Under Secretary of Personnel and Readiness; 24 U.S.C. 401, Armed Forces Retirement Home; DoD Directive 5124.09 Assistant Secretary of Defense for Personnel and Readiness Force Management; DoD Instruction 1000.28, Armed Forces Retirement Home (AFRH); and E.O. 9397 (SSN), as amended.

PURPOSE: To determine and verify eligibility for admission to the AFRH.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, the records contained herein may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: To the Federal Reserve for processing the debt on the resident account; To authorized contractors or vendors for the purpose of providing medical services to the residents of the Armed Forces Retirement Home; To any Federal agency which provides medical services to residents of the Armed Forces Retirement home; To the Inspector General of the Department of Defense or his/her designee, for conducting inspections of AFRH records; To a Federal agency, or an organization or person contracting with the AFRH for information needed in the performance of official duties related to reconciling or reconstructing data files, compiling descriptive statistics, and/or making analytical or financial studies to support the function for which the records were collected and maintained; Law Enforcement Routine Use; Congressional Inquiries Disclosure Routine Use; Disclosure of Information to the National Archives and Records Administration Routine Use; Disclosure to the Merit Systems Protection Board Routine Use; and Data Breach Remediation Purposes Routine Use.

The applicable system of records notice is DPR 38 DoD, Armed Forces Retirement Home electronic Resident Information System (eRIS) and is available at: (ADD LINK WHEN PUBLISHED).

DISCLOSURE: Voluntary; however, failure to provide the required information may result in the delay or denial of admission.

ARMED FORCES RETIREMENT HOME

Authorization to Release Medical Records

Form Completed by the Applicant

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MEDICAL INFORMATION DISCLOSURE FORM: *SIGNATURE OF RELEASE IS **REQUIRED** FOR PROCESSING OF ANY MEDICAL FORMS*

Patient's Name:				Birthdate:	
Street:		Apt.:			
City:		State:		Zip:	
Phone:		Cell:			
Email:					(if available)

Healthcare providers: Applicants must include the examiner's **Name, Phone,** and **FAX** numbers for the healthcare professionals who completed the medical exam form and the functional assessment form.

Primary Care Provider* – Completed the Medical Exam Form (must be a licensed MD, DO, PA, or NP)

Examiner's Name :				Credentials*	
Street:		Clinic:			
City:		State:		Zip:	
Phone*:		Fax*:			
Email:		(If provided, email is only to be used for contact not submission of patient information)			

Occupational/Physical Therapist* – Completed the Functional Assessment Form (must be a licensed PT or OT)

Examiner's Name :				Credentials*	
Street:		Clinic:			
City:		State:		Zip:	
Phone*:		Fax*:			
Email:		(If provided, email is only to be used for contact not submission of patient information)			

I grant my permission to disclose information to:

☐ Armed Forces Retirement Home
3700 North Capitol Street, NW
Washington, DC 20011

Attn: Admissions Board
Public Affairs Office #584
Tel: 202-541-7922 Fax: 202-541-7519

Specific information to be disclosed:

☐ Medical Records covering the last 12 months
☐ Insurance records
☐ Drug, Alcohol or Substance Abuse records
☐ HIV/AIDS-Related Information and test results
☐ Patient history and office notes
☐ Billing records
☐ Mental Health records
☐ COVID-19 Related Information and test results

I understand that release of this information is provided on a voluntary basis in accordance with the Privacy Act Statement Authority: 10 U.S.C 136; 24 U.S.C. 401 (full version is provided on the cover page of the application) to determine and verify eligibility for admission to the Armed Forces Retirement Home. I understand that I may revoke this authorization at any time by giving written notice to AFRH at the aforementioned address. I also understand the revocation of this authorization will not affect any action taken by AFRH in reliance on this authorization prior to receipt of a written revocation. I fully acknowledge that failure to provide any required information may result in the delay or denial of admission to the Armed Forces Retirement Home.

Patient's Signature*	***Date****