AUTHORIZATION FOR DISCLOSURE OF ALCOHOL AND DRUG ABUSE PREVENTION/TREATMENT (ADAPT)
355 MDG DAVIS-MONTHAN AFB AZ 85707

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.
AUTHORITY: 42 CFR Part 2; 42 U.S.C 290dd-2; E.O. 9397 (SSAN); DoD 1010.4; Public Law 104-191; DoD 6025.18-R.
PRINCIPLE PURPOSE(S): This form is to provide the Military Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information with respect to **ADAPT Records**.
ROUTINE USES: To any third party or the individual upon authorization for the disclosure from the individual for: legal; continued medical care; security clearance check; personal use; or for other reason.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2; 42 U.S.C 290dd-2) prohibit you from making further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for the release of **ADAPT Records**.

Section 1 – Patient Data

1. NAME (Last, First, Middle Initial)	2. Sponsor's SSN	3. Date of Birth *(YYYYMMDD)*:

4. Patient's Address (Street, City, State, ZIP Code)	5. Patient's Telephone Number

Section 2 – Disclosure

6. I AUTHORIZE **355 MDG ADAPT PROGRAM, DAVIS-MONTHAN AFB, AZ** TO RELEASE MY PATIENT INFORMATION TO:

a. NAME OR TITLE OF PERSON OR ORGANIZATION	b. ADDRESS (Street, City, State, ZIP Code)
355 SVS/SVYY (Kathy Sands DMAFB Youth Sports Director)	5915 E. Quijota Blvd. Bldg 6000 Davis-Monthan AFB, AZ 85707
c. TELEPHONE (Include Area Code) 520/228-8390	d. FAX (Include Area Code)

7. Purpose or Need for the Information

	Legal		Continued Medical Care		Security Clearance Check		Personal Use (COPY OF MY RECORD)	X	Other (Specify): (Youth Programs)

8. Information to be Released (or Copied for Personal Use):
Review record as required for the "installation record review" (IRC) IAW AFI 34-804 & AFI 34-249.

9. Start Date *(YYYYMMDD)*:	10: Expiration Date (if not recorded; valid for 1 year): Or Action Completed ☐

Section 3 – Release Authorization (I understand that):

a. I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on this authorization. My revocation must be in writing and provided to the facility where my ADAPT records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF/DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used my protected health information on the basis of this authorization.
b. 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.
c. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment, payment, enrollment or eligibility on the failure to obtain this authorization. **I request and authorize 355 MDG ADAPT Program, Davis-Monthan AFB, AZ to release my patient information described above to the named individual/organization indicated.**

11. Signature of Patient or Legal Representative:	Relationship to Patient:	Date *(YYYYMMDD)*:
12. Signature of Witness:		Date *(YYYYMMDD)*:

Section 4 – FOR STAFF USE ONLY (To be completed only upon receipt of written revocation)

13. Authorization Revoked	14. Revocation completed by	15. Signature	Date *(YYYYMMDD)*: