# REQUEST FOR INFORMATION NEEDED TO LOCATE MEDICAL RECORDS

## SECTION I - ABOUT THE PATIENT

(Please print or type, but first read the instructions on the front side.)

**Name of patient at time of treatment** _____ (last) (first) (middle initial)

**A. STATUS OF PATIENT *AT TIME OF TREATMENT*:** (Please check appropriate box and fill in the information requested on the blank lines.)

☐ **MILITARY SERVICE MEMBER** Branch of service _____ Service number _____ SSN _____

☐ **RETIRED MILITARY SERVICE MEMBER** Branch of service _____ Service number _____ Date retired _____
SSN _____

☐ **DEPENDENT OF MILITARY SERVICE MEMBER** Dependent's date of birth _____

*Sponsor's* Name _____ Branch of military service _____
last first middle initial

Social security number _____ Service number (if different from social security number) _____

☐ **FEDERAL EMPLOYEE** Birth date _____ Social security # _____ Fed. employment separation _____

☐ **DEPENDENT OF FEDERAL EMPLOYEE** Employee's name (last, first, m.i.) _____ Social Security # _____

☐ **OTHER** (specify) _____

**B. INFORMATION AND/OR DOCUMENTS REQUESTED** _____

**C. INFORMATION NEEDED TO LOCATE RECORDS.** If you are requesting **inpatient records**, show date and place of each hospitalization desired *and any additional hospitalization in later years related to the same illness/injury.* If you are requesting **outpatient records**, show each military medical facility at which this patient received outpatient care for any reason, and the year(s) of such care. *The year and place of last outpatient treatment are the most important.*

**CHECK ONE:**

| NATURE OF ILLNESS, INJURY, OR TREATMENT | TREATMENT DATES From (mo/yr) To (mo/yr) | ADMITTED (overnight stay) | TREATED (but not admitted) | NAME, NUMERICAL DESIGNATION, AND LOCATION OF HOSPITAL, DISPENSARY, OR MEDICAL FACILITY |
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## SECTION II - RETURN ADDRESS AND SIGNATURE

**1. REQUESTER IS**

☐ Patient identified in Section IA, above.

☐ Parent of minor dependent or legal guardian of patient (If guardian, please submit copy of court appointment.)

☐ Next of kin of deceased patient (show relation) _____ (Furnish proof of death and evidence of kinship.)

☐ Other (specify) _____

**2. AUTHORIZATION SIGNATURE REQUIRED** (of patient or legal guardian) I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section II is true and correct.

_____
Signature of patient, next of kin, or legal guardian (Please do *not* print.)

_____
E-mail address

_____
Date of this request

**3. SEND INFORMATION/DOCUMENTS TO**
(Please print or type. See eligibility instructions below.)

_____
Name

_____
Street

_____
City State ZIP Code

_____
Daytime phone number (including area code)

### ELIGIBILITY TO RECEIVE INFORMATION FROM MEDICAL RECORDS

**a. Restrictions on release of information.** Release of information is subject to restrictions imposed by the military services and civilian agencies consistent with Department of Defense and civilian agency regulations and the provisions of the Freedom of Information Act (FOIA) and the Privacy Act of 1974. The former patient or the patient's legal guardian has access to almost any information contained in the patient's own record. Others requesting information must have the release authorization in Section II, above, signed by the patient or legal guardian. If the patient is deceased, surviving next of kin may, under certain circumstances, be entitled to these records as well. The next of kin may be any of the following: unremarried surviving spouse, father, mother, son, daughter, sister, or brother. The next of kin should provide proof of death and evidence of kinship; the legal guardian should provide a copy of the court appointment or court order proving guardianship or mental incompetence, as appropriate.

**b. Where the reply may be sent.** The reply may be sent to the patient or any other address designated by the patient or other authorized requester.