Form DD2870 Instructions
Authorization for Disclosure of Medical Information

- **Fields 1 – 13**
  Required by Correspondence to process request

- **Field 5** Type of treatment you are requesting (Outpatient, Inpatient, Both)

- **Field 6** Name of facility you are requesting records from

  6a Name of facility or individual you grant permission to receive the medical information

  6b Address of facility or individual for medical information to be mailed

  Medical information cannot be disclosed to anyone other than who is on this form

  If the information is to be released to you, enter your information in fields **6a** and **6b**

- **Field 8** Specific information to be released. (Operative report, narrative summary, discharge summary, all records within range listed in field **4**)

- **Fields 9 and 10**
  Start date: Date the DD2870 is being completed

  Expiration date: One year from start date

  This request will remain valid until the specified expiration date

- **Field 12** Required only if you are completing a request on behalf someone else (Must provide proof of legal rights)

- **Fields 11 and 13**
  Request cannot be initiated without the requestor's signature and date