DEPARTMENT OF THE ARMY
WARFIGHTER REFRACTIVE EYE SURGERY
PROGRAM WOMACK ARMY MEDICAL CENTER
FORT BRAGG, NORTH CAROLINA 28310

MEMORANDUM FOR RECORD

SUBJECT: Refractive Eye Surgery Application

I, _____, _____ , _____ , have reviewed the information
Name DOD ID MOS

available at www.wamc.amedd.army.mil/SitePages/WRESP.aspx for the Warfighter Refractive Eye Surgery Program at Womack Army Medical Center and request to be evaluated for refractive surgery to reduce my dependency on glasses.

I understand that I am only eligible for refractive surgery if I have at least six months of active duty service obligation (ADSO) remaining from the actual date of my surgery. Furthermore, I acknowledge that I will become ineligible for refractive surgery during the final six months of ADSO regardless of the presence of a signed command endorsement letter and/or a completed preoperative evaluation.

I understand that wearing contact lenses interferes with the preparation and performance of refractive eye surgery. I am aware that *soft* contact lenses must be removed for **2 WEEKS** prior to any preoperative or surgery appointments. Rigid Gas Permeable (*hard*) contact lenses must be removed for **1 MONTH** prior to any preoperative or surgery appointment. I have been informed that I must remove my contact lenses, if applicable, prior to requesting a preoperative appointment for me, therefore, as of_____, I have removed my contact lenses and agree not to wear them again.
Date taken out

Hormonal changes associated with pregnancy and breastfeeding may effect results obtained during the preoperative evaluation which could negatively impact the success of refractive surgery. To my knowledge, I am not pregnant and have not been breastfeeding within the last 6 months.

I understand that I am required to have a driver on the date of my surgery and all postoperative/ follow up appointments until the doctor has cleared me to drive. If I choose to call my driver after my surgery is completed, I understand I will not be permitted to leave the clinic until my driver arrives. In the event of a schedule conflict, or if I cannot attend my appointment, it is my responsibility to notify the Refractive Eye Clinic prior to the appointment time.

I understand that it is my responsibility to keep all follow-up appointments scheduled with the Refractive Eye Clinic. I am aware that the typical follow-up period after LASIK is one month and three months for PRK and ICL. Follow-up period may be longer based an individual's healing.

My signature acknowledges that I will comply with all rules set forth by the Refractive Eye Clinic. Failure to comply may result in my being deemed ineligible for refractive eye surgery and possible punishment under the Uniformed Code of Justice (UCMJ).

Patient Signature:

Phone number:

Email Address:

DEPARTMENT OF THE ARMY
Unit Letterhead

REPLY TO
ATTENTION OF:

Office Symbol Date

MEMORANDUM FOR Commander Womack Army Medical Center
ATTN: Warfighter Refractive Eye Surgery Clinic, Fort Bragg, NC 28310

SUBJECT: Commander's Endorsement of Refractive Eye Surgery

1. I endorse Name, Rank, DOD ID, MOS, to be evaluated and considered for enrollment in the Refractive Eye Surgery Program. The service member listed above, as of date of this endorsement, has at least six months retainability in service.

a) Scheduled ETS/retirement date is _____
b) Date of Deployment is _____

2. I acknowledge that, following surgery, the service member listed above must keep all follow-up appointments.

3. I acknowledge that the service member listed above will have profile for 30 days, with the following limitations:
a) No Airborne operations
b) No swimming
c) No night operations

4. I acknowledge that the service member listed above cannot be deployed after surgery for 30 days for LASIK and 90 days for PRK and ICL.

5. This endorsement expires 180 days from date of memorandum.

6. The point of contact for this action is the undersigned at phone number or email address .

COMMANDER'S SIGNATURE BLOCK
Must be digital or original signature

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

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 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
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 authorization form will result in the non-release of the protected health information.
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 - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
	[X] OUTPATIENT [ ] INPATIENT [ ] BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE Not Applicable TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
WOMACK ARMY MEDICAL CENTER OPHTHALMOLOGY CLINIC	2817 REILLY ROAD FORT BRAGG, NC 28310
c. TELEPHONE *(Include Area Code)* 910-907-6423	d. FAX *(Include Area Code)* 910-907-8647

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

[ ] PERSONAL USE [ ] CONTINUED MEDICAL CARE [ ] SCHOOL [X] OTHER *(Specify)* PHI
[ ] INSURANCE [ ] RETIREMENT/SEPARATION [ ] LEGAL

8. INFORMATION TO BE RELEASED

Authorization to discuss personal health information (PHI) in an open forum setting during the process of Refractive Eye Surgery.

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION
	[ ] DATE *(YYYYMMDD)* [ ] ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

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 or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. 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.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*
	SELF	

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
[ ] AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	
	SPONSOR NAME: **SPONSOR RANK:** **FMP/SPONSOR SSN:** **BRANCH OF SERVICE:** **PHONE NUMBER:**

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