Womack Army Medical Center
Bariatric Surgery Clinic
2817 Reilly Road
Fort Bragg, NC 28310-7301
Phone: (910) 907-0787
Fax: (910) 907-6667

Please fill out this form as completely as possible. If a question does not apply to you, please indicate N/A.

Date: _____

Name: _____

Date of Birth: _____ Age:_____ Gender: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □ Widowed

Race: □ Caucasian □ Hispanic □ African American □ Asian □ Native American □ Other

Religion: _____

Mailing Address: _____

City:_____ State:_____Zip Code: _____

Home Phone:_____ □ OK to leave detailed message

Cell Phone:_____ □ OK to leave detailed message

Work Phone: _____

Primary Spoken Language: □English □ Spanish □ Other

Email Address: _____

Employment Status:

□ Full Time	□ Homemaker	□ Disabled
□ Part Time	□ Student	□ Other
□ Self-Employed	□ Retired	

Occupation: _____

Insurance Information (other than Tricare/VA Benefits)
Name as appears on card: _____
Type: □ HMO □ PPO □ Medicaid □ Medicare
Insurance CO. _____
Phone Number: _____
Group #:_____ Member ID #: _____

Family Medical History: Mark all that apply.

	Obesity	Cancer	Diabetes	Heart Disease	Blood Clots	High Cholesterol	Stroke	High Blood Pressure	Other
None									
Mother									
Father									
Grandmother									
Grandfather									
Brother									
Sister									
Aunt									
Uncle									

Past/Current Medical History

Cardiac □N/A	□Chest Pain/Coronary Artery□Disease/Angina □Congestive Heart Failure □Irregular/RapidHeartBeat(arrhythmias) □Peripheral Vascular Disease □Leg Swelling (edema) □Hypertension/High Blood □Pressure □Stroke □Blood Clots/Deep Vein Thrombosis □ Other:	Gastrointestinal □N/A	□ Gastro Esophageal Reflux (GERD) □ Heartburn □ Ulcers □ Crohn'sDisease/Ulcerative □Colitis □ FrequentDiarrhea □ FrequentConstipation □ Gallbladder Disease □ Fatty Liver □ Hemorrhoids □ Polyps □ Hepatitis (Type): □ Cirrhosis □ Other:
Pulmonary □N/A	□ Sleep Apnea □ Shortness of Breath □ Asthma □ COPD (emphysema, chronic bronchitis) □ Pulmonary Embolism (blood clot in the lungs) □ Pulmonary Hypertension □ Other:	Psychological □N/A	□ Depression □ Bi-Polar Disorder □ EatingDisorder □ Anorexia □ Bulimia □ Anxiety □ Other:
Hematologic □N/A	□ Vitamin D Deficiency □ Anemia □ Iron Deficiency □ Other:	Musculoskeletal □N/A	□ Back Pain □ Gout □ Arthritis □ Fibromyalgia □ Other:
Endocrine □N/A	□ Diabetes □ High Cholesterol, High Triglycerides □ Infertility □ MenstrualIrregularities □ Polycystic Ovarian Syndrome □ Thyroid □ Hypothyroidism(Underactive) □ Hyperthyroidism(Overactive) □ Excessive Hot or Cold Feeling □ VisualChanges □ Changesin your Voice □ Recent Increase in thirst or urination □ Abnormal Hair Growth □ Numbness or Tingling in your Hands/Feet □ Other:	Other □N/A	□ Urinary Stress Incontinence □ Pseudotumor Cerebri □ AbdominalSkin/PannusIrritation/Infection □ Abdominal Wall Hernia □ KidneyDisease □ KidneyStones □ Other:

Hospitalizations/Non-Bariatric Surgeries

Please list all inpatient hospitalizations, including psychiatric and substance abuse treatment. If you need additional room, please continue on the back of this page.

Date	Problem	Hospital/Facility

Previous Non-Bariatric Surgeries: Check all that apply.

□ None
□ Knee replacement
□ Laminectomy
□ Hip Replacement
□ Other
□ Anti-reflux procedure
□ C-section
□ Breast cancer, radiation
□ Vasectomy
□ Breast Cancer, biopsy
□ Bowel Resection
□ Hysterectomy
□ Tubal Ligation
□ Removal of gallbladder
□ Peripheral Vascular Procedure
□ Breast cancer, mastectomy
□ Nissen Fundoplication

Have you ever had an adverse reaction to anesthesia/sedation? Y N
(If you answered yes, please comment)

Has any of your relative had an adverse reaction to anesthesia/sedation? Y N
(If you answered yes, please comment)

Allergy Information

Food Allergy: □ Yes □ No (if yes please list below)

Food	Reaction	Severity (Mild or Severe)

IV Dye Allergy (i.e. for CT scans or other x-ray tests): □ Yes □ No (if yes please list below)

Reaction	Severity (Mild or Severe)

Medication Allergy: □ Yes □ No (if yes please list below)

Medication	Reaction	Severity (Mild or Severe)

Medication Information: Please list ALL prescription medications and over the counter supplements.

Medication Name	Dose	Frequency	Purpose

Health Care Provider Information:

Please list all health care providers and specialists. If you need more space, list additional providers' names, specialties, addresses, telephone and fax numbers on the back of this page.

Provider Name/Specialty	Address	Phone/Fax
Primary Care Provider		
Mental Health Provider		
Behavioral Health Provider		

Alcohol, Tobacco, Non-Prescription Drug Use

Do you have a history of drug or alcohol abuse in the past? □ Yes □ No If so, when? _____

Do you currently use illegal or illicit drugs to include medical marijuana? □ Yes □ No

If yes, please elaborate on the type and amount.

Alcohol Use

	None	< 2 drinks/week	2-5 drinks/week	6 or more drinks/week
Beer				
Wine				
Liquor				

Do you plan on quitting? □ Yes □ No If so, when? _____

Nicotine Use

	None	< 1 pack/roll/box per day	> 1 pack/roll/box per day
Cigarettes			
Cigar			
Chewable tobacco			

Do you plan on quitting? □ Yes □ No If so, when?

Weight History

How long have you had issues with your weight?_____
Current weight or best estimate:_____lbs.
Are you at your highest weight ever? □ Yes □ No
If so, how much have you gained in the past year? _____
If no, what was your highest weight and when?_____lbs. Year _____
What is your personal goal weight?_____lbs.
Have you participated in a highly structured, supervised weight loss program?

Please check all previous weight loss methods that you have tried. List any additional methods not shown.

Commercial Diet Programs

- ❑ None
- ❑ Weight Watchers
- ❑ Diet Workshop
- ❑ Jenny Craig
- ❑ OA
- ❑ TOPS
- ❑ Nutri-System
- ❑ Other: _____
- ❑ Other: _____

Prescription Diet Medications

- ❑ None
- ❑ Redu (dexfenfluraramine)
- ❑ Pondimin (fenfluramine)
- ❑ Phen-Fen
- ❑ Phentermine (Fastin, Adipex)
- ❑ Amphetamines
- ❑ Meridia (sibutramine)
- ❑ Other:
- ❑ Other:

Liquid Diets

- ❑ None
- ❑ Optifast
- ❑ HMR
- ❑ Slimfast
- ❑ Other: ___

Herbal and Non-Prescription Remedies

- ❑ None
- ❑ Epedra, ma huang
- ❑ Other Herbals:
- ❑ Over the counter diet aids
- ❑ Other: _____

Therapy and Other Programs

- ❑ None
- ❑ Behavior Therapy
- ❑ Psychotherapy
- ❑ Exercise Programs
- ❑ Feeding Ourselves
- ❑ Self-Initiated or fad diets:

Medical and Health Care Treatments

- ❑ None
- ❑ Previous Gastric Surgery/Stapling
- ❑ Jaw Wiring
- ❑ Other Surgery:_____
- ❑ Acupuncture
- ❑ Hypnosis

Were you successful with any of these methods? If so, how much weight loss_____ for how long_____?

Please use the space below to provide any additional information you want us to know about your weight history.

Obstructive Sleep Apnea Screening Questionnaire (STOP-BANG)

Have you ever been diagnosed with Sleep Apnea? □ Yes □ No When/Where: _____
Are you currently on a CPAP Machine? □ Yes □ No Settings: _____
Are you using your CPAP machine every night? □ Yes □ No

Do you snore loud enough to be heard through closed doors? □ Yes □ No
Do you often feel tired, fatigued, or sleepy upon waking? □ Yes □ No
Has anyone observed you stop breathing during your sleep? □ Yes □ No
Do you have high blood pressure? □ Yes □ No
Are you being treated for it? □ Yes □ No
Is your Body Mass Index more than 35? □ Yes □ No
Are you over 50 years old? □ Yes □ No
Is your neck circumference greater than 40 cm? □ Yes □ No
Are you a male? □ Yes □ No

GERD-Health Related Quality of Life Questionaire (GERD-HQRL)

Are you currently taking PPIs (Prilosec, Protonix, Nexium, etc)? □ Yes □ No Since_____
Have you needed to take PPIs in the past? □ Yes □ No

Please check the box to the right of each question which best describes your experience over the past 2 weeks
0 = No symptoms; 1 = Symptoms noticeable but not bothersome; 2 = Symptoms noticeable and bothersome but not every day; 3 = Symptoms bothersome every day; 4 = Symptoms affect daily activity; 5 = Symptoms are incapacitating.

1.	How bad is the heartburn?	□0	□1	□2	□ 3	□4	□5
2.	Heartburn when lying down?	□0	□1	□2	□ 3	□4	□5
3.	Heartburn when standing up?	□0	□1	□2	□ 3	□4	□5
4.	Heartburn after meals?	□0	□1	□2	□ 3	□4	□5
5.	Does heartburn change your diet?	□0	□1	□2	□ 3	□4	□5
6.	Does heartburn wake you from sleep?	□0	□1	□2	□ 3	□4	□5
7.	Do you have difficulty swallowing?	□0	□1	□2	□ 3	□4	□5
8.	Do you have pain with swallowing?	□0	□1	□2	□ 3	□4	□5
9.	If you take medication, does this affect your daily life?	□0	□1	□2	□ 3	□4	□5
10.	How bad is the regurgitation?	□0	□1	□2	□ 3	□4	□5
11.	Regurgitation when lying down?	□0	□1	□2	□ 3	□4	□5
12.	Regurgitation when standing up?	□0	□1	□2	□ 3	□4	□5
13.	Regurgitation after meals?	□0	□1	□2	□ 3	□4	□5
14.	Does regurgitation change your diet?	□0	□1	□2	□ 3	□4	□5
15.	Does regurgitation wake you from sleep?	□0	□1	□2	□ 3	□4	□5

Cardiac Questionnaire

Have you had heart surgery within the last 3 years? □ Yes □ No
Have you been seen recently by a heart doctor? □ Yes □ No
Do you have a heart condition? If yes describe. □ Yes □ No
Do you get chest pain with exercise? □ Yes □ No
Have you ever had a heart attack? □ Yes □ No
Have you been treated for heart failure? □ Yes □ No
Do you have diabetes mellitus? □ Yes □ No
Can you carry groceries in from the car? □ Yes □ No
Can you vacuum the house? □ Yes □ No
Can you mow the lawn using a push mower? □ Yes □ No
Have you ever had a stroke? □ Yes □ No

Previous Bariatric Surgeries: (Please check all that apply)

□ Gastric Bypass, (Roux-en-Y) laparoscopic
□ Gastric Bypass, (Roux-en-Y) open
□ Sleeve Gastrectomy
□ Gastric banding, adjustable
□ Duodenal Switch (BPD with DS)
□ SIPS/SADS/SADI-S
□ Biliopancreatic diversion (BPD)
□ Gastric band, non-adjustable
□ Gastric Bypass, banded
□ Gastric Bypass, mini loop
□ Intestinal Bypass
□ Vertical Banded Gastroplasty
□ Other

Date of Surgery: _____
Surgeon:_____Hospital: _____

Date of Surgery: _____
Surgeon:_____Hospital: _____

Highest Weight:
Weight at Surgery:
Lowest Weight:
Maintenance Weight:
Goal Weight:
How long after surgery did you achieve your lowest weight? _____

Complications:

□ None
□ Marginal Ulcer
□ Stricture
□ Other
□ Reflux
□ Nausea/Vomiting
□ Internal Hernia
□ Nutritional Deficiencies
□ Skin Issues
□ Weight Regain (Please see below)

Please provide additional details as needed:

_____
_____
_____
_____
_____
_____

For patients with weight regain:
How long were you maintaining a comfortable weight after surgery?
When did weight regain become an issue for you?
How much have you gained?_____lbs in_____months/years
What factors have affected your weight gain? Check all that apply.

□ Overeating
□ Illnes/Injury
□ Other_____
□ Food Choices
□ Medications
□ Decreased Exercise
□ Psychological Factors

What methods of weight loss have you tried since this has become an issue?

Psychological History

In accordance with ASMBS guidelines, all candidates for bariatric surgery will undergo a psychosocial-behavioral evaluation, which assesses environmental, familial, and behavioral factors.

In order to prevent a delay in your psychological evaluation, please answer the following questions and assist us with obtaining supporting documentation from providers outside of the military healthcare system.

Do you currently have or *have you ever had*:

□ Yes □ No Depression/Anxiety/Panic/Bipolar disorder
□ Yes □ No Eating disorder
□ Yes □ No Substance abuse
□ Yes □ No PTSD
□ Yes □ No Uncontrollable anger
□ Yes □ No Suicidal thoughts, gestures, or attempts
□ Yes □ No Personality Disorder
□ Yes □ No Self-mutilation (cutting, burning, skin picking)
□ Yes □ No Psychosis
□ Yes □ No Other mental health or behavioral health issues

Have you ever been prescribed antidepressants, anti-anxiety, or other psychiatric medications, by any medical provider (including your Primary Care doctor) and including for any off-label or non-psychiatric use? □ Yes □ No

Have you had any therapy or counselling, either in an individual, marital, or group setting? □ Yes □ No

Have you ever been hospitalized for psychiatric care? □ Yes □ No

If you have answered YES to any of the above, please list the names of the providers who provided treatment (or the name and location of the practice), the years in which the treatment occurred, and whether the treatment was with a mental health/behavioral health provider or your Primary Care/Family Medicine doctor.

PLEASE NOTE: The responsibility of obtaining the necessary records will rest with the patient. Please inform the Bariatric Clinic if you are having difficulty in obtaining records as it may cause delay your psychological screening.

Womack Army Medical Center
Bariatric Surgery Clinic

Contract for Bariatric Surgery

I,_____, agree to abide by this contract for Bariatric Surgery. I understand that it is in my best interest to follow these instructions and it is expected by the Bariatric Surgery Service that each will be adhered to explicitly.

(Initial each line)

I confirm that I attended a Bariatric Orientation and I fully understand the nutritional consequences of bariatric surgery. _____

I will attend **TWO** pre-operative support group meetings. I will attend support group meetings for at least one year after surgery. Studies show that patients who participate in a support group have a higher success rate in the long term. _____

I will adhere strictly to the preoperative diet. This may start prior to my preoperative interview with the surgeon. I understand that this diet allows for shrinking of a fatty liver and therefore facilitates a smoother operation. _____

I am aware that I must not gain weight from the date of my orientation or I will not be cleared for surgery. I understand that there is no limit to the weight I am allowed to lose before surgery, and that significant weight loss will not necessarily disqualify me from surgery. _____

I will incorporate **daily physical activity and exercise** prior to my operation and will resume post operatively. I agree to attend an educational session with the Army Wellness Center for exercise instruction OR (for VA patients only) will provide documentation of completion of the MOVE Program within the past year. Exercise is essential to Preventing weight regain. _____

I understand and consent to random drug, alcohol, and nicotine testing. _____

I understand that the Bariatric Surgery service will manage my acute postoperative pain for up to 30 days after surgery. After this, pain management issues must be seen by a specialist. If I have an existing pain contract, I will provide a letter from my providers stating that they are aware that I will be receiving pain medications after surgery. _____

I will notify the bariatric clinic if, during the preoperative process, I find out that I am PCS'ing, ETS'ing, or will lose Tricare coverage. _____

I am aware that I must stay in the area for 12 months following surgery in order to receive the best postoperative care. I will inform the clinic if I find out that I am PCS'ing or ETS'ing after surgery in order to facilitate continuity of care with the receiving medical providers. _____

I will keep all follow-up appointments with the Bariatric Clinic as scheduled and obtain fasting laboratory studies as directed. I agree to long-term follow-up care with Bariatric Program, which is recommended for a minimum of five (5) years. _____

I agree to have established and maintained care through a primary care physician (PCP), and any other essential health care providers, even in the case that I am not eligible for services through WAMC primary care or family medicine services. I understand that the Bariatric Clinic will not assume responsibility for my primary care needs. _____

I understand that having **TWO no shows** (not including patient or facility cancellations) to any appointments during the preoperative phase will result in referral closure and possible dismissal from the program. _____

I understand that I have a maximum of **NINE** months to complete the Bariatric pathway. _____

I will adhere strictly to the postoperative diet. I understand the importance of following nutritional guidelines after surgery. _____

I will keep a dietary journal, consistent with the requirements of the Registered Dietician providing care during my evaluation for surgery. I will bring this journal with me to all required nutrition education sessions and individual nutrition/bariatric clinic visits. I understand that if my dietary journal is deemed necessary at a visit and it is not presented, I may be required to reschedule that appointment. I understand that it is my **responsibility** to follow the recommendations by the Registered Dietician. _____

I understand the importance of monitoring fluid intake and staying hydrated. I understand that all carbonated beverages should be avoided permanently after surgery. I will abstain from alcohol for at least one year after surgery. _____

I agree to take nutritional supplements and medications regularly, as directed. Do not discontinue medications without MD approval. _____

I will see the nutrition department relative to (**within one month of**) my bariatric postoperative appointments. I understand that maintaining a food journal postoperatively will help to ensure optimal weight loss. _____

I will not use nicotine products including Nicorette Gum, lozenges, E-Cigarettes, patches, chew, or cigarettes. The effects of nicotine following bariatric surgery could be catastrophic, resulting in life threatening stomach bleeding, ulcers, perforation, gastrointestinal problems requiring emergency surgery, and potential death. _____

I will not use illicit drugs or weight loss medicines pre-operative or post-operative. _____

I am aware that it is my responsibility to call and schedule all postoperative appointments with the bariatric clinic as well as the nutrition clinic. **I understand that I need to take responsibility for my weight management.** If you are having difficulties with weight loss or nutritional issues, you should contact us, nutrition, or behavioral medicine as appropriate for guidance and/or assistance. _____

I will not become pregnant for 18-24 months after surgery. I will adhere to this time frame so I am medically optimized for my health and the health of my child. I understand that birth control pills may NOT be effective after surgery and that two alternative methods of birth control are recommended. I will consult with an obstetrician for a pre-pregnancy evaluation if I desire to become pregnant after bariatric surgery. _____

I agree to avoid plastic surgery for excess skin removal for 18-24 months following surgery to allow stabilization of your weight loss. I understand that panniculectomy may not be medically necessary and requires consultation with a provider on an individual basis. In most cases this procedure is associated with some out of pocket expense for the patient.

_____

I understand that I may be approached to participate in research before or after bariatric surgery. I will give these requests consideration prior to accepting or denying participation. _____

I understand that in order to remain in active status I have a responsibility to pursue the requirements of the program in a timely manner; that from the date of Orientation, I have thirty (30) days to complete my lab work and call the bariatric clinic for scheduling my initial visit; and that after forty-five (45) days of inactivity, in the absence of extenuating circumstance, the clinic reserves the right to close my file. _____

In order to remain in active status, provider ordered pre-operative testing must be completed before the order expires. Staff will re-order a pre-op test one time. Failure to complete testing during the preoperative phase will result in referral closure and possible **dismissal** from the program. _____

I understand if I leave the program for a period of time, I may have to repeat certain requirements of the program, even if they have already been completed. I understand Bariatric staff may require me to repeat pre-operative requirements if an extended period of has passed. _____

I understand it is my responsibility to follow the recommendations and requirements of the Bariatric program in order to be cleared for a safe surgery. The Bariatric team consists of multiple healthcare personnel who collaborate together in order to prepare me for surgery. I understand the team may change my pathway throughout the program depending on various pre-operative assessment/results. I understand I may be found to be a poor candidate for Bariatric surgery based on pre-operative testing o but I may also be dismissed from the program for failure to comply with my specific plan of care, failure to comply with program requirements, misconduct to staff such as disrespect, failure to tell the truth, and failure to follow instructions. _____

PATIENT RESPONSIBILITIES adapted from the DoD Patient Bill of Rights and Responsibilities in the Military Health System (MHS) September, 26, 2011 NUMBER 6000.14

a. Providing Information. Patients are responsible for providing accurate and complete information about complaints, past illnesses, hospitalizations, medications, and other matters relating to their health to the best of their knowledge. Patients are responsible for letting their healthcare provider know whether they understand the diagnosis, treatment plan, and expectations.

b. Respect and Consideration. Patients are responsible for being considerate of the rights of other patient and MTF/DTF healthcare personnel. Patients are responsible for being respectful of the property of other persons and of the MTF/DTF.

c. Adherence with Medical Care. Patients are responsible for adhering to the medical and nursing treatment plan, including follow-up care, recommended by healthcare providers. This includes keeping appointments on time and notifying MTF/DTF when appointments cannot be kept.

d. Medical Records. Patients are responsible for returning medical records promptly to the MTF/DTF f for appropriate filing and maintenance if records are transported by the patients for the purpose of medical appointments, consultations, or changes of duty location. All medical records documenting care provided by any MTF/DTF are the property of the U.S. Government.

e. MTF/DTF Rules and Regulations. Patients are responsible for following MTF/DTF rules and regulations affecting patient care and conduct.

f. Refusal of Treatment. Patients are responsible for their actions if they refuse treatment or do not follow the practitioner's instructions.

g. Healthcare Charges. Patients are responsible for meeting financial obligations incurred for their healthcare as promptly as possible.

Signature_____Date_____

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)*	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
	☐ 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 BARIATRIC CLINIC	2817 REILLY ROAD FORT BRAGG, NC 28310
c. TELEPHONE *(Include Area Code)* 910-907-0787	d. FAX *(Include Area Code)* 910-907-6667

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

☐ PERSONAL USE	☐ CONTINUED MEDICAL CARE	☐ SCHOOL	☒ OTHER *(Specify)* PHI
☐ INSURANCE	☐ RETIREMENT/SEPARATION	☐ LEGAL	

8. INFORMATION TO BE RELEASED
Authorization to discuss personal health information (PHI) in an open forum setting for all classes included in the Bariatric program.

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 **s** 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:**

DD FORM 2870, DEC 2003

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