ARMY RESERVE MEDICAL MANAGEMENT CENTER

AR-MMC MAIN PHONE LINE (910)771-5175

PROFILE REQUEST
LETTER OF INSTRUCTION (LOI)

This form is subject to Privacy Act of 1974. The proponent is USARC SURGEONS OFFICE

Complete the following information. All fields are mandatory.

*****ALL FIELDS IN THIS SECTION REQUIRED*****

NAME (Last, First, MI): DOD ID NUMBER

1. MIL EMAIL ADDRESS CIV EMAIL ADDRESS PHONE NUMBER

2. Unit POC Unit POC Email Unit POC Number

CDR Name and Rank: CDR EMAIL & Phone Number: Unit Name and UIC:

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3. Profile Request Type: (must select one) ○ Permanent ○ Temporary

Profile Request Status: (must select one) ○ New ○ Continue

Profile for Condition(s): **list all**

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4. **Required Document Checklist (check all items submitted with this packet)**

☐ Summary of Care by Civilian Provider Form (see pages 3 and 4)

OR

☐ Personal Provider Letter on Office Letterhead and signed by provider

(Prescription Pad is UNACCEPTABLE) Dated in last 60 days and include items listed below:

- ☐ Diagnosis
- ☐ Specific Limitations
- ☐ APFT limitations (if any)
- ☐ Time length of limitations
- ☐ Diagnostic Imaging Reports
- ☐ Labs
- ☐ Treatments
- ☐ Prognosis for improvement

NOTE: Letters from Chiropractors will be accepted for TEMP musculoskeletal conditions only.

5. **Approved LOD**

☐ **Yes** - include Approval Memo **DODI 1241.01, IAW AR 600-8-4, USARC LOD Policy**

☐ **No** - but Service Member believes injury occurred while in a Qualified Duty Status (QDS). **THE SOLDIER MUST CONTACT THEIR UNIT FOR LOD ASSISTANCE AND PROCESSING.** QDS includes: active duty for a period of 30 days or less; inactive duty training (IDT); performance of funeral honors duty; or while remaining overnight immediately before the commencement of IDT; or while remaining overnight, between successive periods of IDT, at or in the vicinity of the site of the IDT;**(ARMMC does not initiate, track or approve LOD actions).**

☐ **No** - Case will be processed as Non Duty PEB.

6. **CERTIFICATION**

I certify that this Medical Profile Request packet is accurate and complete. I understand that incomplete or inaccurate information will result in return without action.

Signature: Date:

Relationship to the Soldier (select one): Soldier☐ Profiling Officer☐ Commander☐ Other

Email completed documentation to **usarmy.usarc.usarc-hq.mbx.armmc@army.mil**

a. SUBJECT LINE: "Profile Request", Last name

example- **PROFILE REQUEST: Snuffy**

**While not mandatory, use of Military e-mail with encryption is Strongly encouraged

DD FORM 2870

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

The Form below to be filled out for

Military Medical Facility

or

VA Medical Facility only

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
		XXX-XX-

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

SECTION II - DISCLOSURE

6. I AUTHORIZE All Military Treatment Facilities and Veterans Administration Facilitie 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)*
AR-MMC - (Army Reserve Medical Management Center)	2801 Grand Avenue Pinellas Park, FL 33782
c. TELEPHONE *(Include Area Code)* 910-771-5088	d. FAX *(Include Area Code)* 910-771-5354

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

[ ] PERSONAL USE [ ] CONTINUED MEDICAL CARE [ ] SCHOOL [✘] OTHER *(Specify)* Military Case Management
[ ] INSURANCE [ ] RETIREMENT/SEPARATION [ ] LEGAL

8. INFORMATION TO BE RELEASED
ALL Armed Forces Health Longitudinal Technical Application(AHLTA)(MTF)medical records and Veterans Administration medical records from all periods necessary for but limited to proper medical case management and possible military medical board processing.

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)*

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:**

Reset

DD FORM 2870

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

The Form below to be filled out for Civilian Medical Facility only

#6 Civilian Medical Facility

#8 ALL medical records from Civilian Medical Facility from all periods necessary for but limited to proper medical case management and possible military medical board processing.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

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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

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		XXX-XX-

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

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6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO:
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a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
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c. TELEPHONE *(Include Area Code)* 910-771-5088	d. FAX *(Include Area Code)* 910-771-5354

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

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

8. INFORMATION TO BE RELEASED

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

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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.
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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:**

Reset

MEDICAL RECORD - CONSENT FORM
Authorization To Send And Receive Medical Information By Electronic Mail

For use of this form see, MEDCOM Supplement 1 to AR 40-66; the proponent agency is MCHO

SECTION I - PATIENT DATA

1. NAME (Last, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. SOCIAL SECURITY NUMBER (Last four only)
4. E-MAIL ADDRESS		5. TELEPHONE NUMBER

SECTION II - CONDITIONS FOR USE OF E-MAIL

Health care providers cannot guarantee but will use reasonable means to maintain security and confidentially of electronic mail (E-mail) information sent and received. You must acknowledge and consent to the following conditions:

1. E-mail is not appropriate for urgent or emergency situations. Healthcare providers will respond within _____.
   Contact the clinic telephonically if you have not received a response after _____.
2. E-mail must be concise. You should schedule an appointment if the issue is complex or sensitive precluding discussion by E-mail.
3. E-mail should not be used for communications regarding sensitive medical conditions such as sexually transmitted diseases. HIV/AIDS, spouse or child abuse, chemical dependency, etc.
4. Medical or dental treatment facility staff may receive and read your messages.
5. E-mails related to health consultation will be copied, pasted, and filed.

SECTION III - RISKS OF USING E-MAIL

Transmitting information by E-mail has risks that you should consider these include, but are not limited to the following risks:

1. E-mails can be intercepted, altered, forwarded. or used without authorization or detection.
2. E-mails can be circulated, forwarded and stored in paper and electronic files.
3. E-mail senders can easily type in the wrong E-mail address.
4. E-mail may be lost due to technical failure during composition, transmission, and/or storage.

SECTION IV - PATIENT GUIDELINES

To communicate by E-mail, the patient shall:

1. Place the category (topic) of the communication in the subject line of the E-mail (for example, appointment, prescription, medical advice, etc.)
2. Include the patient's name, telephone number, family member prefix, and the last 4 numbers of the sponsor's social security number (for example: 30/0858) in the body of the E-mail.
3. Acknowledge receipt of the E-mail when requested to do so by a health care provider.
4. Inform the medical or dental treatment facility of changes in E-mail address by completing a new consent form.
5. Notify the health care provider of any types of information considered by the patient to be inappropriate for E-mail.
6. Take precautions to preserve the confidentiality of E-mail.

SECTION V - PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have read and fully understand the information in this authorization form. I consent to the E-mail conditions and agree to abide by the guidelines listed above. I futher understand that this E-mail relationship may be terminated if I repeatedly fail to adhere to these guidelines.

I understand and accept the risks associated with the use of unsecure E-mail communications. I further understand that, as with all means of electronic communication, there may be instances beyond the control of the family and the health care provider where information may be lost or inadvertently exposed, such as during technical failures, acts of God, acts of war, and so forth.

I understand that I have he right to revoke this authorization, in writing, at any time.

By signing this form I acknowledge the privacy risks associated with using E-mail and authorize health care providers to communicate with me or any minor dependent/ward for purpose of medical advice, education, and treatment.

(Date)	SIGNATURE of Patient or Parent/Guardian	RELATIONSHIP (if other than patient)

PATIENT IDENTIFICATION *(For typed or written entries note: Name-last, first, middle initial; hospital or medical facility)*	Patient's Name		Sex
	Year of Birth	Relationship to Sponsor	Component/Status
	Depart/Service	Sponsor's Name	
	Rank/Grade	FMP-SSAN (Last four only)	
	Organization		

MEDCOM FORM 756, DEC 2004 MC PE v1.02

U.S. ARMY RESERVE MEDICAL MANGEMENT CENTER
BEHAVIORAL HEALTH EVALUATION

1. **Name: (last, first MI):_____Rank:_____**
2. **Current symptoms/stressors/relevant history:_____**

_____

_____

3. **Psychiatric or behavioral health disorder history, including treatment and medications:_**

_____

_____

4. **Family history of psychiatric/behavioral health: no☐ yes☐ specify:_____**

_____

5. **Hospitalizations for psychiatric conditions: no☐ yes☐ dates_____**

_____

6. **Suicide attempts/homicide attempts/domestic violence: no☐ yes☐ dates_____**

_____

7. **Current drug/alcohol use/abuse: no☐ yes☐ specify:_____**
8. **Legal issues: no☐ yes☐ describe with date(s)_____**

_____

9. **DWI/DUI in past year: no☐ yes☐ date(s)_____**
10. **Soldier currently in school: no☐ yes☐**
11. **Soldier currently employed: no☐ yes☐**
12. **Soldier's current marital status: _____**

Mental Status Evaluation (check/circle all that apply):

APPEARANCE:	**well groomed ☐**	**over/under weight ☐**	**disheveled ☐**
ATTITUDE:	**cooperative ☐**	**uncooperative ☐**	**belligerent ☐**
BEHAVIOR:	**calm ☐**	**tearful/withdrawn ☐**	**agitated/hyperactive ☐**
MOOD:	**euthymic ☐**	**anxious/manic ☐**	**depressed ☐**
AFFECT:	**appropriate ☐**	**labile ☐**	**inappropriate ☐**
SUICIDAL IDEATION:	**absent ☐**	**passive thoughts ☐**	**current plan ☐**
HOMICIDAL IDEATION:	**absent ☐**	**passive thoughts ☐**	**current plan ☐**
CONCENTRATION:	**intact ☐**	**impaired by history ☐**	**impaired on exam ☐**
PERCEPTION:	**normal ☐**	**hallucinations ☐**	**illusions ☐**
THOUGHT PROCESS:	**intact ☐**	**abnormal/circumstantial ☐**	**grossly abn/bizarre ☐**
THOUGHT CONTENT:	**normal ☐**	**compulsions/obsessions ☐**	**paranoia/delusions ☐**
INSIGHT:	**good ☐**	**partial recognition ☐**	**denial/poor ☐**
JUDGMENT:	**intact ☐**	**impaired ☐**	**severely impaired ☐**
IMPULSE CONTROL:	**good ☐**	**fair ☐**	**poor ☐**
MEMORY:	**intact ☐**	**impaired by history ☐**	**impaired on exam ☐**
COGNITIVE:	**A & O X4 ☐**	**not alert ☐**	**O X 1 2 3 ☐**

DIAGNOSIS (DSM - 5):

Please List Diagnoses

TREATMENT PLAN:

Individual therapy: **no** ☐ **Yes** ☐ **frequency**
Group therapy: Other **no**☐ **yes**☐ **frequency**_____
therapy: **no**☐ **yes**☐ **specify**_____**frequency**_____
Psychotropic medications prescribed: no☐ **yes**☐ **refused**☐

NAME	DOSAGE/FREQUENCY	DATE PRESCIBED

How long have you been providing treatment for the Soldier? Give dates:_____

Is Soldier being counseled by a mental health provider? no☐ **yes**☐
Specify type:
psychiatrist☐ **psychologist**☐ **social worker**☐ **chaplain**☐ **other**_____

Date of initial counseling:_____ **frequency**_____

If on medication, is Soldier asymptomatic on medication(s)? no☐ **yes**☐

If on medication, is the condition stable and controlled on medication(s)? no☐ **yes**☐

In your judgment, does current condition result in any of the following:

no☐ **yes**☐ persistence or recurrence of symptoms which necessitates limitations of duty or duty in protected environment.

no☐ **yes**☐ persistence or recurrence of symptoms which results in interference with effective military performance (ability to manage people, make complex decisions or direct actions where others may be at risk).

no☐ **yes**☐ unsafe for Soldier to carry or have access to weapons.

Recommended limitations, if any, are: permanent☐ **temporary**☐ **# days**_____

NOTE: ***this form must be accompanied by a copy of the Soldier's current progress notes and/or a supporting statement.***

Provider's Printed Name:_____
Provider's Signature: _____
Provider's Medical Specialty:_____
Provider's Office Address:
_____
_____
Provider's Telephone #: (area code and number): _____
Provider's Fax #: (area code and number): _____+_____
Date: _____