ARMY RESERVE MEDICAL MANAGEMENT CENTER

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.

1. NAME (Last, First, MI): _____ DOD ID: _____

2. Unit POC _____ POC Phone: _____ Unit Name and UIC: _____

CDR Name and Rank: _____ CDR EMAIL & Phone Number: ***Required***

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

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

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

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@mail.mil**

a. SUBJECT LINE: "Profile Request", Last name, First name and Last 4 of SSN

example- **PROFILE REQUEST: Snuffy, Joe 1234**

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

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)*
ALL periods	☐ OUTPATIENT ☐ INPATIENT ☐ BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ 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)*	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
☐ INSURANCE	☐ RETIREMENT/SEPARATION	☐ LEGAL	

8. INFORMATION TO BE RELEASED
All records

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

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

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

PRIVACY ACT STATEMENT: This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique identifier to distinguish between employees with the same names and birth dates and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed.

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

SUMMARY OF CARE BY NON-MILITARY MEDICAL PROVIDER

NOTE TO MEDICAL PROVIDER: YOUR PATIENT IS A SOLDIER. THIS FORM WILL BECOME PART OF THEIR OFFICIAL MILITARY HEALTH RECORD. ANY CONDITION(S) FOUND THAT IMPACT YOUR PATIENT'S ABILITY TO PERFORM HIS/HER FUNCTIONAL ACTIVITIES (LISTED BELOW IN SECTION IV) MAY IMPACT THE SOLDIER'S MILITARY MEDICAL READINESS. THIS IS NOT A WORKER'S COMPENSATION CLAIM.

1. Is this a request for a new profile or a request to continue a permanent profile written prior to 01JUN17? Check one: New ☐ Continue ☐

I. EXAM (TO BE COMPLETED BY MEDICAL PROVIDER. PLEASE PRINT LEGIBLY):

2. What medical conditions were evaluated today? For acute injuries, please describe mechanism of injury and when it happened.

3. Please attach lab and x-ray results and provide brief summary of physical, radiological, and lab exam findings:

4. Does the patient have any allergies with severity that requires epi-pen (medications, food, insects (bees, wasps, fire ants), grass, plants, etc.)? If YES, Please List:

5. What medication(s) does the patient take (prescription, over the counter, vitamins/minerals, supplements)? Please List:

II. DOES THE PATIENT HAVE ANY OF THE FOLLOWING CONDITIONS (TO BE COMPLETED BY MEDICAL PROVIDER):

6.	YES		YES		YES		YES
a. ADD/ADHD	☐	b. Anxiety	☐	c. Arthritis/Joint Pain	☐	d. Asthma/Shortness of Breath	☐
e. Concussion/TBI/Head Trauma	☐	f. Depression	☐	g. Diabetes/High blood sugar	☐	h. Dizziness	☐
i. Fainting	☐	j. Headaches/Migraines	☐	k. High blood pressure	☐	l. High cholesterol	☐
m. Insomnia	☐	n. PTSD	☐	o. Seizures	☐	p. Sleep apnea	☐

q. Other (e.g. additional pertinent medical history, past surgical procedures)

III. IS PATIENT ABLE TO PERFORM THE FOLLOWING ACTIVITIES (MEDICAL PROVIDER SEE NOTE AT TOP OF PAGE) :	YES	NO
7. Physically and or mentally able to carry and fire an individual assigned weapon (~8 lbs) that requires crouching, kneeling on one or both knees, lying prone or standing all while wearing a helmet (~3 lbs), body armor (~30 lbs), and load bearing equipment (~10 lbs)?	☐	☐
8. Ride in a military vehicle wearing helmet (~3 lbs), body armor (~30 lbs), and load bearing equipment (~10 lbs) without worsening condition?	☐	☐
9. Wear helmet (~3 lbs), body armor (~30 lbs), and load bearing equipment (~10 lbs) without worsening condition?	☐	☐
10. Able to wear a protective mask & full protection outfit (HAZMAT) against chemical or biologic agents for at least 2 continuous hours per day?	☐	☐
11. Move greater than 40 lbs (backpack/duffle bag) while wearing a helmet (~3 lbs), body armor (~30 lbs), and load bearing equipment (~10 lbs) up to 100 yards?	☐	☐
12. Live and function, without restrictions, in ANY geographical or climatic area (Desert, Jungle, or Urban) without worsening condition?	☐	☐
13. Lifting/Carrying Restriction: Maximum weight restriction in lbs:	☐	☐
14. Standing Limitation in minutes:	☐	☐
15. Walking in all terrains with Standard Field Gear (40 lbs) for _____ minutes or ____ miles	☐	☐

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	DOD ID NUMBER (EDIPN)	RELATIONSHIP TO SPONSOR	
		N/A	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)*

REGISTER NUMBER	WARD NUMBER
N/A	N/A

SOLDIER NAME

RANK

DOB

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 11/2010)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

PRIVACY ACT STATEMENT: This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique identifier to distinguish between employees with the same names and birth dates and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed.

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

Questions 16-18 are the events in the Army Physical Fitness Test (APFT)	**YES**	**NO**
16. Able to perform two minute timed **sit-ups**? • If unable to perform sit-ups, which medical condition(s) contribute to this limitation?_____	☐	☐
17. Able to perform two minute timed **push-ups**? • If unable to perform push-ups, which medical condition(s) contribute to this limitation?_____	☐	☐
18. Able to perform timed **2-mile run**? • If unable to perform timed run, which medical condition(s) contribute to this limitation?_____ • If unable to perform the timed **2-mile run**, can your patient participate in a timed alternate aerobic event? (check all that apply) 2.5 Mile Timed Walk ☐ 6.2 Mile Timed Stationary Bike ☐ 800 Yard Timed Swim ☐	☐	☐

IV. DIAGNOSIS (TO BE COMPLETED BY MEDICAL PROVIDER. PLEASE PRINT LEGIBLY):

THE FOLLOWING SECTION MUST BE COMPLETED AND SIGNED BY THE EXAMINING MEDICAL PROVIDER.

Your evaluation of this patient's Limitations in section IV is important. Please complete all items below.

19. Diagnosis:

_____

20. Treatment Plan (example: X Rays, Physical Therapy, Medication):

_____

_____

21. Follow Up:

_____

22. Physical Limitations are: ☐ Permanent or ☐ Temporary: the expected duration of the limitation(s) is for _____Days (Max 90)

Can the patient take record Army Physical Fitness Test **now** (Refer to 16-18 above)? Yes ☐ No ☐ If No, when can they? (enter date)_____

Medical Provider's Full Name (Print or Type):_____

Medical Provider's Medical Degree (MD, DO, NP, PA): _____

Medical Provider's Specialty:_____ Medical Provider's Full Signature:_____

Date of Evaluation:_____ Email Address: _____

Office Telephone Area Code & Number:_____ Fax Area Code Number:_____

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 3031, Secretary of the Army; AR 40-501 Standards of Medical Fitness, AFI 48-123 Medical Examinations and Standards.

PRINCIPAL PURPOSE(S): This form is used to assess a Soldier's physical and functional capacity and limitations on both a temporary and permanent basis. Following this assessment, this form will be provided to the Soldier's military physician and support staff for the development of a temporary or permanent profile.

ROUTINE USE(S): Law Enforcement Routine Use: If a system of records maintained by a Component to carry out its functions indicates a violation or potential violation of law, whether civil, criminal, or regulatory in nature, and whether arising by general statute or by regulation, rule, or order issued pursuant thereto, the relevant records in the system of records may be referred, as a routine use, to the agency concerned, whether Federal, State, local, or foreign, charged with the responsibility of investigating or prosecuting such violation or charged with enforcing or implementing the statute, rule, regulation or order pursuant thereto. Congressional Inquiries Disclosure Routine Use: Disclosure from a system of records maintained by a Component may be made to a congressional office from the record of an individual in response to an inquiry from the congressional office made at the request of that individual. Disclosure to the Department of Justice for Litigation Routine Use: A record from a system of records maintained by a Component may be disclosed as a routine use to any component of the Department of Justice for the purpose of representing the Department of Defense or any officer, employee or member of this entity in pending or potential litigation to which the record is pertinent. Disclosure of Information to the National Archives and Records Administration Routine Use: A record from a system of records maintained by a Component may be disclosed as a routine use to the National Archives and Records Administration for the purpose of records management inspections conducted under authority of 44 U.S.C. 2904 and 2906. Data Breach Remediation Purposes Routine Use: A record from a system of records maintained by a Component may be disclosed to appropriate agencies, entities, or persons when (1) the Component suspects or has confirmed that the security or confidentiality of the information in the system of records has been compromised; (2) the Component has determined that as a result of the suspected or confirmed compromise there is a risk of harm to economic or property interests, identity theft or fraud, or harm to the security or integrity of this system or other systems or programs (whether maintained by the Component or another agency or entity) that rely upon the compromised information; and (3) the disclosure made to such agencies, entities, and persons is reasonably necessary to assist in connection with the Components efforts to respond to the suspected or confirmed compromise and prevent, minimize, or remedy such harm.

DISCLOSURE: Voluntary. Failure to provide information or sign may delay development of the patient's military certification of physical limitations (profile).

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SOCIAL SECURITY/ID NUMBER	RELATIONSHIP TO SPONSOR N/A	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)*	REGISTER NUMBER	WARD NUMBER
SOLDIER NAME RANK DOB	N/A	N/A

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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