REQUEST FOR PRIVATE MEDICAL INFORMATION

For use of this form, see AR 40-66; the proponent agency is the OTSG

1. Date.

2. Patient's Name and SSN.

3. Medical Treatment Facility *(Name and Location)*

4. Reason for Request.

5. Private Medical Information Sought (*Specify dates of hospitalization or clinic visits and diagnosis, if known)*

6. Requestor's Name, Title, Organization and SSN.

FOR USE OF MEDICAL TREATMENT FACILITY ONLY

7. Check applicable box.

☐ Approved ☐ Disapproved *(State reason for disapproval)*

8. Summary of Private Medical Information Released.

9. Signature of Approving Official.

10. Date.