

Instructions for DD2870: Authorization for Disclosure of Medical or Dental Information

- **Fields 1-13:** Required for Correspondence to process request.
- **Field 5:** Type of treatment you are requesting; inpatient, outpatient or both.
- **Field 6:** Name of facility you are requesting records from.
 - **6 a:** Name of the facility or individual you grant permission to receive the medical information.
 - **6 b:** Address of individual or facility for medical information to mailed, if requested.
 - Medical information cannot be disclosed to anyone other than who is on this form.
 - If you would like the records released to you, put your information in fields 6 a & b.
- **Field 8:** Information to be released. Specify what you are requesting (i.e. operation report; narrative summary, discharge summary, all records in specified range from field 4, etc).
- **Fields 9 and 10:** **Start date:** Day you fill out the form. **Expiration date:** Typically 1 year from start date. This request will only be valid until the specified expiration date.
- **Field 12:** only required if you are filling out a request for someone other than yourself that you have legal rights over.
- **Fields 11 and 13:** Request cannot be initiated without the requestor's signature and signing date.