DEPARTMENT OF THE ARMY
US ARMY INSTALLATION MANAGEMENT COMMAND
HEADQUARTERS, UNITED STATES ARMY GARRISON, FORT POLK
6661 WARRIOR TRAIL, BUILDING 350
FORT POLK, LOUISIANA 71459-5339

Greetings Sir/Ma'am,

The Exceptional Family Member Program (EFMP) conducts virtual Family Member Travel Screenings (FMTS) to determine if a Family Member may require specialty care at the gaining installation. For example if you have a Family Member that see's any kind of specialist outside of their primary care provider then an enrollment may/may not be necessary. That will be determined by the EFMP Provider during the Family Member Travel Screening appointment.

Please complete all forms attached and return them to the EFMP Coordinator as soon as possible. Do not submit these attached documents to the ROI office. These are not medical records, they are only screening tools for the EFMP Coordinator. Due immediately after completion.

- Contact Sheet (Required)
- DA Form 5888 (Required)
- DA Form 7246 (Required)
- DA Form 5888-1 (Required in your Family is not located at Fort Polk)
- CHCS Reg. Form (Complete if Family Members are not registered at BJACH. One per Family Member)
- MEDCOM Form 756 (Required for authorizing unencrypted emails which contain PII/HIPAA. One per Family Member.)
- DD Form 2870 (You may use this to request medical records for off post providers.)
- Memorandum for RHC Europe (For those PCSing to Europe only.)
- Korea CMD SPON Fam Mem Statement (For those PCSing to South Korea only.)

All Family Members need to have completed a wellness exam with their Primary Care Provider with-in 12 months from the report date. If an off post provider completed the exam you must submit a copy of the clinical/encounter notes to the ROI office. You will also need to provide medical records from the past 12 months to the ROI office. Please call the ROI office (337-531-3935) to get instructions on how they would like to receive the medical records. Give the ROI office a few days to post the medical records to Genesis. Call them back to verify they have been uploaded.

After the exams have been completed. Please call the Bayne Jones Army Community Hospital (BJACH) appointment line at 337-531-3011 to schedule the "Overseas Travel Screening" using the words in quotation.

Inform your Family Member/Spouse/Guardian they will be receiving a text message in a day or two before the scheduled Overseas Travel screening with instructions.

Remember every Family Member listed on the 5888 are required to be visible to the EFMP provider conducting the screening.

The EFMP provider and/or EFMP Coordinator reserves all rights to terminate the appointment if:
-All Family Member listed on the 5888 are not present and available to be seen including infants.
-All Family Members have not had a wellness exam completed within 12 months of the report date.
-All Family Member's medical records have not been turned in to the ROI office and uploaded into the system.
-All forms requested to be completed have not been received by the EFMP Coordinator. (These are due immediately after completion: See forms attached as listed above.)

Each screening appointment is 10 minutes per Family Member. This appointment is virtual so please be prepared and expect either delays or running ahead of schedule. Typically you will be contacted between, one hour before to one hour after the scheduled appointment.

School: If your child is in school/summer school and an excuse is needed, please let us know before or during the virtual appointment.

For additional questions or concerns, please contact Tammy Summers at the medical EFMP office at (337) 531-3002.

EFMP Assist or FMTS Request Contact Sheet

Submit to EFMP Fort Polk: tammy.k.summers.civ@mail.mil; usarmy.polk.medcom-bjach.list.efmp@mail.mil

PLEASE FILL OUT FORM COMPLETELY and PLEASE PRINT CLEARLY or DIGITALLY COMPLETE

Sponsor's name:______________________________ Rank: ______ Branch: __________

Sponsor's SS#:__________________ DOD ID#:________________________

Sponsor's phone number(s):________________ Sponsor's Duty Phone: ________________

Sponsor's Official E-mail:____

Sponsor's Personal E-mail:____

Sponsor's Previous Duty Station:____

Sponsor's Current Location: ____________________________Date Arrived:___________

Overseas Assignment Location:__________________________ Country:______________

Assignment Notification Date: ________ Original Report Date: ________ Early Report Date:________

Family member name(s) and Dates of Birth that will be screened for overseas assignment:

NAME	DOB	Administrative Use Only		
		EFMP Validation Date	Developmental Review Date	Exams Completed Date

☐ Dual Military Family ______________________________ Rank: _____ Branch: _________

Dual SM Official E-mail:____

Spouse/dependent, or Family Member's Email address: ______________________________

Phone number(s) where your **spouse/dependent** or **family** can be contacted immediately:

Home/Cell:___________________ ☐ iPhone or ☐Other:__________, Work:_______________

Number to call for Virtual Screening:: ______________________ ☐ iPhone or ☐Other:_________

Spouse/dependent, or Family Member's Mailing Address where they can be reached:

____

________________________________ Indicate County/Parish of mailing address:_____________

DOUBLE CHECK THE ABOVE INFORMATION FOR ACCURACY.

Please be certain to tell your family someone from EFMP will be contacting them shortly!

Administrative Use Only		
☐ Local FMTS	☐ Long Distance FMTS	☐ Referral FMTS

Date Sent:___________________________ Date Returned:____________________________

Location: ____

Recipient Names: ____

____

☐ New Enrollment ☐ Update ☐ Disenrollment | ☐ Routine ☐ Compassionate ☐ FMTS

FAMILY MEMBER DEPLOYMENT SCREENING SHEET

For use of this form, see AR 608-75; the proponent agency is OACSIM

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, USC Section 3013.

PRINCIPAL PURPOSE: Personnel support.

ROUTINE USES: To validate family member deployment screening, and to provi degaining command with data to assist in making an assignment decision.

DISCLOSURE: The provision of requested information is mandatory. Failure to respond may preclude successful processing of an application for family member travel/command sponsorship and may lead to appropriate administrative or disciplinary action against the soldier.

PART A - SOLDIER/FAMILY MEMBER DATA

1. NAME OF SOLDIER *(Last, first, MI)*	2. SOCIAL SECURITY NUMBER	3a. RANK	3b. MOS/BRANCH

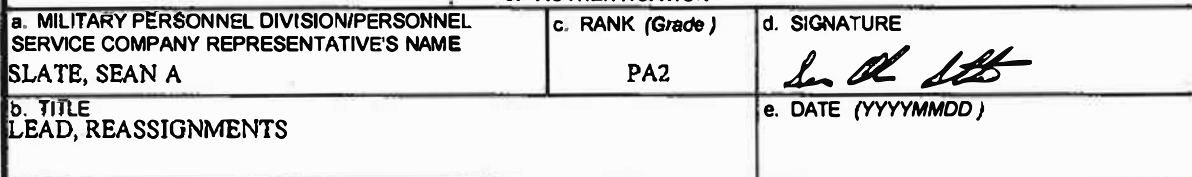
4a. HOME ADDRESS	5a. DUTY ADDRESS	6. DATE OF EDAS CYCLE OR RFO *(OFF)* DATE

4b. HOME PHONE NO. *(Include Area Code)*	5b. DUTY PHONE NO. a. DSN b. COMMERCIAL *(Include area code)*

7. FAMILY MEMBERS

a. NAME	b. RELATIONSHIP	c. DOB *(YYYYMMDD)*	d. HOME ADDRESS

8. AUTHENTICATION



a. MILITARY PERSONNEL DIVISION/PERSONNEL SERVICE COMPANY REPRESENTATIVE'S NAME	c. RANK *(Grade)*	d. SIGNATURE
SLATE, SEAN A	PA2	

b. TITLE	e. DATE *(YYYYMMDD)*
LEAD, REASSIGNMENTS	

PART B - FAMILY MEMBER SCREENING RESULTS

9. NAME	EXCEPTIONAL FAMILY MEMBER PROGRAM *(EFMP)* ENROLLMENT *(Check one)*				
	a. NOT WARRANTED	b. CONSIDERATION WARRANTED *(Date sent for Coding)*	c. SUBSTANTIAL CHANGE SINCE ENROLLMENT		
			NO	YES	DATE SENT FOR CODING
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

10. ARMY MEDICAL TREATMENT FACILITY *(MTF)* EFMP MEDICAL PRACTITIONER COMPLETING THIS FORM

a. PRINTED NAME OF MEDICAL PRACTITIONER	b. SIGNATURE	c. DATE *(YYYYMMDD)*

d. ADDRESS	e. PHONE NUMBER *(Include Commercial and DSN)*
BJACH EFMP, 1585 Third Street, Fort Polk, LA	337-531-3002

11. ARMY MTF EFMP PHYSICIAN'S AUTHENTICATION *(To be signed when a medical practitioner other than a physician completes this form.)*

a. TYPED OR PRINTED NAME OF PHYSICIAN	b. TITLE	c. RANK

d. SIGNATURE	e. DATE *(YYYYMMDD)*

EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) SCREENING QUESTIONNAIRE

For use of this form, see AR 608-75; the proponent agency is OACSIM

NAME OF MEDICAL TREATMENT FACILITY

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: PL 94-142 *(Education for all Handicapped Children Act of 1975)*, PL 95-561 *(Defense Dependents' Education Act of 1978)*; DODI 1342.12 *(Education of Handicapped Children in DODDS)*, 17 December 1981; DODI 1010.13 *(Provision of Medically Related Services to Children Receiving or Eligible to Receive Special Education in DOD Dependents Schools Outside the United States)*, 28 August 1986, 10 USC 3013; 20 USC 921-932 and 1401 et seq.

PRINCIPAL PURPOSE: To obtain information needed to evaluate and document the special education and medical needs of family members. This will permit consideration of special education and medical needs of family members in the personnel assignment process.

ROUTINE USES: Information will be used by personnel of the Military Departments to evaluate and document special education and medical needs of family members for consideration in personnel assignments.

DISCLOSURE: The provision of requested information is mandatory. Failure to respond will preclude U.S. Total Personnel Command from enrolling soldiers in the EFMP. Soldiers who knowingly refuse to enroll exceptional family members will receive, at a minimum, a general officer letter of reprimand. Refusal to provide information may preclude successful processing of an application for family travel/command sponsorship.

SERVICE MEMBER'S NAME/RANK		DATE *(YYYYMMDD)*
BRANCH	UNIT	DUTY PHONE
PROJECTED PCS ASSIGNMENT	DSN	HOME PHONE
PROJECTED PCS DATE	HOME ADDRESS	DUTY ADDRESS

LIST ALL FAMILY MEMBERS	FAMILY MEMBER PREFIX	SEX	DATE OF BIRTH *(YYYYMMDD)*	CHECK IF ENROLLED IN EFMP
				☐
				☐
				☐
				☐
				☐

PLEASE ANSWER ALL QUESTIONS - FOR FAMILY MEMBERS ONLY

MEDICAL

1. Do any family members, excluding service member, have any medical records *(civilian or military)* other than the records you have provided us to screen? If yes, please list conditions/services received and address of provider. YES ☐ NO ☐

FAMILY MEMBER	CONDITIONS/SERVICES	NAME/ADDRESS OF PROVIDER

2. In the past five *(5)* years, have any members of your family, excluding service member, been hospitalized, excluding hospitalization for normal uncomplicated childbirth? If yes, please explain. YES ☐ NO ☐

NAME	REASON

3. Are any members of your family, excluding service member, currently receiving medical *(includes mental health)* or educational services from any providers other than a general practitioner or family practice physician? YES ☐ NO ☐

4. Are any family members, excluding service member, taking any prescribed medication other than birth control pills on a regular basis?	YES ☐	NO ☐

NAME	PRESCRIBED MEDICATION

5. In the past five *(5)* years, have any members of your family, excluding service member, been treated for, or had any problems related to any of the following? *(You will have an opportunity to discuss all "YES" answers with a screener.)*

		YES	NO			YES	NO
a.	Problems with sight *(other than corrected by glasses)*			g.	Asthma, allergies or other respiratory problems		
b.	Problems with hearing			h.	Cerebral Palsy		
c.	Heart condition			i.	Delayed Speech		
d.	Seizure disorder			j.	Sickle Cell Trait/Disease		
e.	Loss of mobility *(requiring use of a wheelchair/ walker or aid in mobility)*	☐	☐	k.	Cancer		
				l.	High blood pressure		
f.	Diabetes			m.	Other, if yes, explain		

MENTAL HEALTH:

6. In the past five *(5)* years, have any members of your family, excluding service member, been treated for, or had any problems related to any of the following? *(You will have an opportunity to discuss all "YES" answers with a screener.)*

		YES	NO			YES	NO
a.	Referral to, diagnosed by, or therapy with a Psychiatrist, Psychologist, or Social Worker in reference to a mental health problem	☐	☐	d.	Alcohol and drug use or abuse		
				e.	Emotional problems		
b.	Depression			f.	Behavioral problems/acting out behavior		
c.	Suicidal thoughts/ideas, gestures, attempts	☐	☐	g.	Received therapy *(marital, family, individual or group counseling)*	☐	☐

7. Have any members of your family, excluding service member, been in any of the following? Inpatient Psychiatric Facility, Residential Treatment Center, Group Homes, Day Treatment Centers, Drug and Alcohol Treatment Rehabilitation Center. If Yes, please explain:	YES ☐	NO ☐

EDUCATION

8. Do any of your children now have, or have they ever had, any of the following?

		YES	NO			YES	NO
a.	Slow development *(infants and preschoolers)*			d.	Counseling services for school-related problems	☐	☐
b.	Learning problems *(school)*						
c.	Special services *(i.e., OT, PT, Speech, etc.)* for special education	☐	☐	e.	Intellectual disability	☐	☐

9. Are any of your children receiving Special Education help in school *(not in regular class placement and on an Individual Education Plan (IEP))*? If yes, who?	YES ☐	NO ☐

According to AR 608-75, Exceptional Family Member Program, soldiers will provide accurate information as required when requested to do so by Army officials. Knowingly providing false information in this regard may be the basis for disciplinary or administrative action. For soldiers, refusal to provide information may preclude successful processing of an application for family travel or command sponsorship.

Commanders will take appropriate action against soldiers who knowingly provide false information, or who knowingly fail or refuse to enroll family members that meet the criteria for enrollment. *(A false official statement is a violation of Article 107, Uniform Code of Military Justice (UCMJ).)* These actions will include, at a minimum, a general officer letter of reprimand.

All the above information is true and correct to the best of my knowledge. I understand that it is my responsibility to provide any information about changes in medical or educational status for all members of my family, after the date indicated below, and prior to PCS move.

PRINTED NAME OF MILITARY SPONSOR OR SPOUSE COMPLETING THIS FORM	SIGNATURE OF MILITARY SPONSOR OR SPOUSE COMPLETING THIS FORM	DATE *(YYYYMMDD)*
PRINTED NAME OF PHYSICIAN OR MEDICAL PRACTITIONER IF UNDER THE SUPERVISION OF A PHYSICIAN	SIGNATURE OF PHYSICIAN OR MEDICAL PRACTITIONER IF UNDER THE SUPERVISION OF A PHYSICIAN	DATE *(YYYYMMDD)*

SCREENING OF FAMILY MEMBERS IN REMOTE OCONUS AREAS

For use of this form, see AR 608-75; the proponent agency is OACISM.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, USC Section 3013.

PRINCIPAL PURPOSE: Personnel Support.

ROUTINE USES: To determine the need to complete DD Form 2792 (Exceptional Family Member Medical Summary) and DD Form 2792-1 (Exceptional Family Member Special Education/Early Intervention Summary).

DISCLOSURE: The requested information is mandatory. Failure to respond may preclude successful processing of an application for family member travel/command sponsorship and may lead to appropriate administrative or disciplinary action against the Soldier.

If **Yes** is checked for any of the boxes below, the authorized local screener/medical provider must complete the applicable DD Form 2792 (medical) or DD Form 2792-1 (educational). Attach this page to DA Form 5888 (Family Member Deployment Screening Sheet).

Part A - Medical Condition - Use DD Form 2792, if applicable.

Yes	No	
☐	☐	1. Potentially life-threatening conditions and/or chronic medical/physical conditions (such as high risk newborns, patients with a diagnosis of cancer within the last 5 years, sickle cell disease, insulin-dependent diabetes) requiring follow-up support more than once a year, or specialty care.
☐	☐	2. Current and chronic (duration of 6 months or longer) mental health condition (such as bi-polar, conduct, major affective, or thought/personality disorders); inpatient or intensive outpatient mental health service within the last 5 years; intensive (greater than one visit monthly for more than six months) mental health services required at the present time. This includes medical care from any provider, including a primary health care provider.
☐	☐	3. A diagnosis of asthma or other respiratory-related diagnosis with chronic recurring wheezing which meets one of the following criteria: - Scheduled use of inhaled anti-inflammatory agents and/or bronchodilators. - History of emergency room use or clinic visits for acute asthma exacerbations within the last year. - History of one or more hospitalizations for asthma within the past 5 years. - History of intensive care unit admissions for asthma within the past 5 years.
☐	☐	4. A diagnosis of attention deficit disorder/attention deficit hyperactivity disorder that meets one of the following criteria: - A co-morbid psychological diagnosis. - Requires multiple medications, psycho-pharmaceuticals (other than stimulants), or does not respond to normal doses of medication. - Requires management and treatment by mental health provider (e.g., Psychiatrist, Psychologist, or Social Worker). - Requires specialty consultant, other than a family practice physician or general medical officer, more than twice a year on a chronic basis. - Requires modifications of the educational curriculum or the use of behavioral management staff.
☐	☐	5. Requires adaptive equipment (such as an apnea home monitor, home nebulizer, wheelchair, splints, braces, orthotics, hearing aids, home oxygen therapy, home ventilator, etc.).
☐	☐	6. Requires assistive technology devices (such as communication devices) or services.
☐	☐	7. Requires environmental/architectural considerations (such as limited numbers of steps, wheelchair accessibility/housing modifications and air conditioning).

It is DoD policy that family members of active duty service members and civilian employees appointed to an overseas position who are eligible for early intervention or special education or meet one or more of the following criteria shall be identified as a family member with special educational needs.

Part B - Educational Condition - Use DD Form 2792-1, if applicable.

Yes	No	
☐	☐	1. Has or requires an Individualized Education Program (IEP) - for preschool and school-aged children.
☐	☐	2. Has or requires an Individualized Family Service Plan (IFSP) - for children birth to 36 months.

☐ I did not ☐ I did identify a family member with a medical or educational condition that meets the above criteria (identify family member's status in Part B of DA Form 5888).

Print Sponsor's Name	Signature of Local Screener/Medical Provider	Date (YYYYMMDD)

BJACH CHCS REGISTRATION FORM

LAST NAME: ______________________ FIRST NAME: ______________________

MIDDLE INITIAL:________ FMP: _____ SEX: ____ DOB (YYYY/MMM/DD): ______________

SSN #:______________________________ DOD ID #: ______________________

MARITAL STATUS: ____________________ RELIGION: ______________________

BRANCH OF SERVICE: ________________ ACTIVE, ACTIVE RC, RC, NG OR RETIRED

RACE: (CIRCLE BELOW)

BLACK WHITE OTHER

ASIAN/PACIFIC ISLANDER AMERICAN INDIAN

ETHNIC ORIGIN: (CIRCLE BELOW)

FILIPINO HISPANIC OTHER

OTHER ASIAN/PACIFIC ISLANDER SE ASIAN

ADDRESS: ______________________________ CITY:______________ STATE:________

ZIP: ___________ HOME PHONE: ( )_____-__________ CELL PHONE: ( )_____-__________

RANK: ________ MOS: _________ YEARS OF SERVICE: __________ FLYING DUTY: ________

UNIT: ______________________________ UNIT ADDRESS: ______________________

CITY: ______________________________ STATE:________ ZIP:____________

EMERGENCY CONTACT: ____

RELATIONSHIP: ______________________ PHONE:( ) _____ - ____________

ADDRESS:___________________ CITY:_______________STATE:______ ZIP:____________

DO YOU SPEAK A LANGUAGE OTHER THAN ENGLISH? YES NO

IF YES, PLEASE LIST ALL THAT APPLY:

DO YOU HAVE ANY OTHER COMMUNICATION NEEDS? YES NO

(IF YES PLEASE CIRCLE) DEAF, MUTE, BLIND, DEVELOPMENTAL DELAY, OTHER

WOULD YOU LIKE TO BE AN ORGAN DONOR? YES NO UNDECIDED

*******SIGNATURE OF PRIVACY ACT IS MANDATORY*******

When Completed FAX to (337) 531-3089 or SCAN and E-MAIL to usarmy.polk.medcom-bjach.list.admissions@mail.mil For Questions contact Out Patient Records at (337) 531-3622/3624/3625 during hours (0800-1600) Contact Admissions at (337) 531-3160/3161 after 1600

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN). Title V, Public Law 92-129; section 501, 42 UCS section 290dd.

2. MANDATORY VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION.
   a. Disclosure is mandatory for Active Army soldiers. Failure to obey order from competent authority to provide required information may be subject to appropriate disciplinary action under the UCMJ.
   b. Disclosure is voluntary for civilian employees and other personnel. The failure to disclose the information will result in reduced capability of the program to provide treatment and services.

3. Your signature below merely acknowledges that you have been advised of the foregoing.

______________________________ ______________

4. Signature of Patient Sponsor 5. Date

USAMEDDAC Form 477, (REV) Mar 2020 All previous editions are obsolete.

Fort Polk, LA 71459-5110

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		

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)*
20210602-20220602

5. TYPE OF TREATMENT *(X one)*
[ ] OUTPATIENT [ ] INPATIENT [X] 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
Bayne-Jones Army Community Hospital

b. ADDRESS *(Street, City, State and ZIP Code)*
ATTN: ROI
1585 Third Street, Bldg. 285, Fort Polk, LA 71459

c. TELEPHONE *(Include Area Code)* (337) 531-3935

d. FAX *(Include Area Code)* (337) 531-3177

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*
[ ] PERSONAL USE [ ] CONTINUED MEDICAL CARE [X] SCHOOL [X] OTHER *(Specify)* Overseas Travel Screening with EFMP.
[ ] INSURANCE [ ] RETIREMENT/SEPARATION [ ] LEGAL

8. INFORMATION TO BE RELEASED
All medical and behavioral heath encounter notes, or documentation of exams.

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:

DEPARTMENT OF THE ARMY
UNITED STATES ARMY REGIONAL HEALTH COMMAND EUROPE
UNIT 29421
APO AE 09136-9421

MCEU-CLE 29 November 2017

MEMORANDUM FOR Regional Health Command Europe, Exceptional Family Member Program (EFMP), APO AE 09042

SUBJECT: Acknowledgement of Documents submitted for Family travel by Service Member (SM)

1. The EFMP Office completing the documents is the originating OCONUS Screening (OSS) office, RHCE EFMP is the gaining EFMP office. All information in both the OSS and Family Member medical records will be used in the family travel review process to make recommendations on the availability of care in assignment locations. SM and Family is responsible for reviewing the completeness and accuracy of the information and recommendations in the Family members file._____(SM Initials).

2. If there are any changes to medical or educational information it is the SM responsibility to inform originating OSS office._____(SM Initials).

3. If Family travel is approved, medical care may be provided by host nation providers. Local provider(s) may revise the beneficiary's treatment plan, so the current treatment may not be continued in the overseas environment. Additionally, there may be some cultural and language barriers associated with receiving care on the local economy that could impact the sponsor/patient's expectation of care._____(SM Initials).

4. The EFMP Office that completes the OSS holds the responsibility of reviewing all the forms with the Family/SM, for providing guidance in reference to a reconsideration, and/or updating medical information._____ (SM Initials)

5. If a SM receives a Family travel denial message they should contact their personnel office and branch manager for assignment options. Medical information questions will be referred to, the point of contact in the office that completed the OSS._____(SM Initials)

6. I have read and understand these instructions and the instructions for DD Form 2792. In accordance with AR 608-75, Soldiers who knowingly and willfully disregard or provide false information might be subject to Uniform Code of Military Justice (UCMJ, Art. 92 and Art 107).

________________________	________________________	______________
Service Member Printed Name	Signature	Date

7. Point of contact for this memorandum is the EFMP Office that completed the OSS.

Regional Health Command Europe
EFMP Family Travel Office

DEPARTMENT OF THE ARMY
HEADQUARTERS, JOINT READINESS TRAINING CENTER AND FORT POLK
6661 WARRIOR TRAIL, BLDG 350
FORT POLK, LOUISIANA 71459

IMPO-HRM Date: ________

MEMORANDUM FOR Military Personnel Division USAG Humphreys, Command Sponsorship Program, APO, AP 96271-5228

SUBJECT: Command Sponsorship Family Member Statement.

1. In accordance with (IAW) AR 608-75, Family members will be screened when the Soldier is on assignment instructions to an OCONUS area for which command sponsorship/Family member travel is authorized and the Soldier elects to serve the accompanied tour. This applies to CONUS-to-OCONUS and OCONUS-to-OCONUS reassignments. ______ (SM Initials)

2. I understand that Command Sponsorship will not be requested until the DA Form 5888 has been completed for all Family Member physically residing with me ______ (SM Initials)

3. I understand that in order to request Dependent Student Travel IAW AR 55-46 and the Joint Travel Regulation that my student dependent must be Command Sponsored. ______ (SM Initials)

4. IAW AR 608-75, Soldiers who knowingly and willfully disregard or provide false information may be subject to Uniform Code of Military Justice (UCMJ, Art 92 and Art 107). ______ (SM Initials)

5. I have read and understand these statements ______ (SM Initials)

6. Point of contact for this memorandum is the MPD that completed the Family Travel request

______________________ ______________________ ______________
Soldier's Printed Name Signature Date

Sean A. Slate
Lead, Reassignments