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Army Regulation 40–66

Medical Services

Medical Record Administration and Health Care Documentation

Headquarters
Department of the Army
Washington, DC
22 May 2006

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SUMMARY of CHANGE

AR 40-66
Medical Record Administration and Health Care Documentation

This rapid action revision dated 22 May 2006-

- Substitutes DD Form 2870 (Authorization for Disclosure of Medical or Dental Information) for DA Form 5006 (Authorization for Disclosure of Information) (throughout).
- Outlines a cultural change whereby outpatient medical records are not transported by patients (para 1-4*d*, 1-5*a*, 1-5*b*, 5-28*c*(1), 6-4*a*(1), and 6-8).
- Requires that original outpatient documentation stay at the medical treatment facility where it was created (para 1-4*e*(3)).
- References DODI 6040.43 (para 1-5).
- Adds provision for clinical use of electronic mail (para 2-8).
- Requires that all medical records entries be timed (as well as dated) (para 3-4*d*).
- Adds a provision for reporting detainee documentation (para 3-13*d*).
- Provides new guidance on the procedures for inpatient and outpatient treatment record retirement (para 4-4*a*(5).
- Provides guidance on the Medical Registry System for accessioning, retiring, and retrieving inpatient and outpatient records (para 4-4*c*(4)).
- Adds a requirement to print out laboratory and radiology reports before the record is retired (para 4-4*c*(5) and 9-25*b*).
- Updates figures 5-1, pages 1 and 3; 5-2, pages 1 and 6; 6-1, pages 1 and 3; 6-2, pages 1 and 5; 7-1, pages 1 and 3; 9-1, pages 1 and 5; and 10-1, page 5.
- Includes a requirement to send a copy or electronic version of the health record to the patient's ward (para 5-2*c*).
- Adds a requirement to mail or courier the health record after a patient is released (para 5-2*c*(3)).
- Requires the use of DD Form 2882 (Pediatric and Adolescent Preventive and Chronic Care Flow Sheet) instead of the DA Form 5571 (Master Problem List) for pediatric patients (para 5-10).

- Includes instructions for filing the most recent Flying Duty Medical Examination (para 5-13*b*(1)).

- Allows SF 600 entries to be typed, electronically entered, written in ink, or printed (para 5-18).

- Requires an unremarried former spouse to use his/her own social security number for medical record identification (para 6-1).

- Provides new guidance for initiating and keeping outpatient treatment records (para 6-3).

- Updates guidance for family health center outpatient treatment records (para 6-4*e*).

- Requires loose documents to be retired through Composite Health Care System or Composite Health Care System II medical records tracking (para 6-6*a*).

- States that x--rays stored on electronic media are not eligible for retirement to National Personnel Records Center in outpatient treatment record folders (para 6-6*c*).

- Adds new guidance on behavioral health records (para 6-7*h*).

- Addresses retention requirements for civilian employee health records (para 7-2*d*).

- Adds additional countries to the North Atlantic Treaty Organization listing (table 9-1).

- Refers to appendix D of the Medical Record Tracking, Retirement, Retrieval User Guide for guidance on retirement of fetal monitors (para 9-3).

- Provides new guidance on disposition of extended ambulatory records (para 10-6).

- Adds the health record, outpatient treatment record, and civilian employee medical record to the list of those medical record delinquencies that are reported on a quarterly basis (para 12-3*c*).

- Deletes SF 536 (Medical Record -- Pediatric Nursing Notes).

This revision, dated 20 July 2004--

- Implements DOD 6025.18-R, Department of Defense Health Information Privacy Regulation.

- Updates the responsibilities of military and dental treatment facility commanders to ensure compliance with the Privacy Rule of the Health Insurance Portability and Accountability Act (Public Law 104-191) and DOD 6025.18-R (para 1-4a(6)).

- Adds a requirement to conduct an annual risk assessment to ensure compliance with the protected health information provisions outlined in DOD 6025.18-R (para 1-4e(4)).

- Modifies the procedures for disclosure of protected health information, including psychotherapy notes (paras 2-3, 2-4, and 2-5).

- Outlines the process by which individuals may file complaints when they believe that protected health information relating to them has been used or disclosed improperly (para 2-5).

- Updates information concerning requested amendments to protected health information (para 3-4).

- Adds a requirement to attach the Notice of Privacy Practices acknowledgement label to treatment folders (paras 4-4 and 7-4a).

- Updates instructions regarding the disposal of health records for veterans who are filing medical claims (para 5-29a).

- Updates instructions for filing inpatient treatment records for previous admissions and extended ambulatory records (paras 9-2b(1), 10-6a, and 10-7a(2)).

- Adds permission for qualified podiatrists to perform admission histories and physical examinations (para 9-12a(3)).

- Updates the management control evaluation checklist (app C).

This revision, dated 10 March 2003--

- Reiterates the use of DA Form 4 (Department of the Army Certification for Authentication of Records) in certifying copies of medical records (para 2-5g).

- Authorizes the filing of photographs in medical and dental records (para 3-1b).

- Adds a requirement for countersignatures in cases of therapeutic abortions (para 3-16c).

- Adds guidelines for recording videotaped documentation of episodes of medical care (para 3-18).

- Revises the requirement to prepare carded-for-record-only cases to include only the deaths of active duty military personnel (para 3-19).

- Prescribes the use of two new forms: DD Form 2766 (Adult Preventive and Chronic Care Flowsheet) and DD Form 2766C (Adult Preventive and Chronic Care Flowsheet--Continuation) (paras 5-13, 5-19, 5-32a, and 5-36a).

- Updates the instructions for the use of a revised form, SF 602 (Medical Record--Serology Record) (paras 5-18g, 5-21b(10), and 5-26b(2)(1)).

- Adds the filing of DA Form 4466 (Patient Progress Report) to the health record (para 5-21b(4)).

- Adds the requirement to transfer the health record of a retiring member to the Veterans Affairs Records Management Center rather than to the National Personnel Records Center (para 5-29).

- Authorizes the filing of DD Form 2341 (Report of Animal Bite--Potential Rabies Exposure) in various records (figs 5-1, 5-2, 6-1, 6-2, 7-1, 9-1, and 10-1).

- Authorizes the filing of the Occupational Safety and Health Administration Respirator Medical Evaluation Questionnaire in several records (para 7-4b(8) and figs 5-1, 5-2, and 7-1).

- Allows the option of filing DA Form 3666 (Department of the Army Nonappropriated Funds Statement of Physical Ability for Light Duty Work) in the Civilian Employee Medical Record (para 7-4b(11)(b)).

- Prescribes the use of the Extended Ambulatory Record (chap 10).

- Adds the definitions of an attending physician, a preceptor physician, and a senior resident to the glossary.

- Rescinds the use of DA Form 5128 (Clinical Record--Visual Field Examination), DA Form 5694 (Denver Developmental Screening Test), DA Form 8007-R (Individual Medical History), and SF 556 (Immunohematology).

Headquarters
Department of the Army
Washington, DC
22 May 2006

*Army Regulation 40–66

Effective 22 June 2006

Medical Services

Medical Record Administration and Health Care Documentation

By Order of the Secretary of the Army:

PETER J. SCHOOMAKER
General, United States Army
Chief of Staff

Official

JOYCE E. MORROW
Administrative Assistant to the
Secretary of the Army

History. This publication is a rapid action revision. The portions affected by this rapid action revision are listed in the summary of change.

Summary. This regulation prescribes policies for preparing and using medical reports and records in accordance with North Atlantic Treaty Organization Standardization Agreements 2348 ED.3(1), 2132 ED.2, and American–British–Canadian–Australian Quadripartite Standardization Agreement 470 ED.1.

Applicability. This regulation applies to the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve unless otherwise stated. Also it applies to other members of the uniformed services of Allied nations who receive medical treatment or evaluation in an Army military treatment facility. This publication is applicable during mobilization.

Proponent and exception authority. The proponent of this regulation is The Surgeon General. The proponent has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific guidance.

Army management control process. This regulation contains management control provisions and identifies key management controls that must be evaluated.

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from the Office of the Surgeon General, ATTN: DASG–HS–AP, 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to the Office of the Surgeon General, ATTN: DASG–HS–AP, 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Distribution. This publication is available in electronic media only and is intended for command levels A, B, C, D, and E for the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve.

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*This regulation supersedes AR 40–66, dated 20 July 2004.

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Glossary

Chapter 1
Introduction

1–1. Purpose

a. This regulation sets policies and procedures for the preparation, disposition, and use of Army electronic and paper medical records and other health care documentation discussed in the following chapters.

b. The purpose of a medical record is to provide a complete medical and dental history for patient care, medicolegal support (for example, reimbursement and tort claims), research, and education. A medical record also provides a means of communication, where necessary, to fulfill other Army functions (for example, identification of remains).

c. The following types of health–care records will be used to document medical and dental care. All care provided to beneficiaries as hospital inpatients will be recorded in an inpatient treatment record (ITR). Outpatient care on a military member will be recorded in either the member's treatment record or dental record. Combined, the treatment record and dental record are considered a health record (HREC). Care provided to nonmilitary beneficiaries will be documented in an outpatient treatment record (OTR) that includes a separate dental record. Both military and nonmilitary personnel enrolled in the Army Substance Abuse Program (ASAP) will have an ASAP outpatient medical record (ASAP–OMR). Occupational and nonoccupational outpatient care provided to a civilian employee will be recorded in a civilian employee medical record (CEMR).

d. The ability to retrieve the documentation of care provided to patients is paramount. The original documentation of outpatient care will be maintained at the medical treatment facility (MTF) where it was created. These documents will be maintained separately from health records (HREC), outpatient treatment records (OTR), and civilian employee medical records (CEMR). The MTFs which currently have access to electronic records documentation generating and storage systems may continue their use until the Composite Health Care System II (CHCS II) is implemented at that MTF. The MTFs that do not have access to electronic information systems must implement a paper medical document storage and retrieval system (see DODI 6040.43).

1–2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms

a. Abbreviations and special terms used in this regulation are explained in the glossary.

b. Abbreviations and symbols authorized for use in medical records are explained in appendix B. Dental terminology, abbreviations, and symbols are provided in TB MED 250. The use of locally approved abbreviations and symbols is authorized if the conditions in paragraph 3–8 of this regulation are met. When electronic systems are utilized, users must resolve any inconsistencies concerning local abbreviations and capitalization.

1–4. Responsibilities

a. Military treatment facility (MTF) and dental treatment facility (DTF) commanders. The MTF or DTF commanders will—

(1) Be the official custodians of the medical or dental records at their facilities.

(2) Ensure that policies and procedures of this regulation are followed.

(3) Issue local rules to enforce the policies and procedures stated in this regulation.

(4) Ensure that an adequate and timely ITR is prepared for each patient who must have one.

(5) Ensure that a blood sample for deoxyribonucleic acid (DNA) identification is on file with the Armed Forces Repository of Specimen Samples for the Identification of Remains for all military members and deploying civilians.

(6) Ensure compliance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) (Public Law (PL) 104–191), DOD 6025.18–R, and with the process of investigations of privacy violations.

b. Unit commanders. If a commander acquires HRECs or documents belonging in HRECs, the commander will ensure that the documents are properly secured and sent to the proper HREC custodian without delay. As an exception to *e*(1), below, if no Army medical department (AMEDD) or MTF personnel are available to act as the custodian of unit HRECs, a unit commander may act as the custodian of his or her unit's HRECs, or, as an alternative, appoint a competent person of the unit as the custodian. Unit commanders will also ensure that information in HRECs is kept private and confidential in accordance with law and regulation. Examples of situations in which unit HRECs may be maintained centrally at a unit in the custody of the unit commander or competent designee include those units located away from an MTF, to include recruiting stations, Reserve Officers' Training Corps detachments, professors of military science, and Reserve Component (RC) units receiving medical or dental care from civilian facilities. HRECs maintained at such units must be managed in accordance with this regulation. Such units must place special emphasis on compliance with chapter 2 of this regulation. Questions about centralized HREC maintenance in isolated units will be referred to the Army Regional Medical Command with administrative responsibility for that geographic area. OTRs for family members accompanying those active duty military members assigned to isolated units will not be maintained at the unit. In accordance with paragraph 6–4 of this regulation, a copy of an OTR may be furnished to a pertinent family

member. However, the original record will be returned, along with an explanatory letter, to the MTF that last provided medical care to that family member.

c. RC specific commanders.

(1) State adjutants general will initiate, maintain, and dispose of Army National Guard of the United States (ARNGUS) HRECs.

(2) The Commander, HRC–Stl will initiate, maintain, and dispose of HRECs for Individual Ready Reserve (IRR) members.

(3) The Commanding General, Army Reserve Personnel Command (AR–PERSCOM), will initiate and dispose of HRECs for Individual Ready Reserve (IRR) members.

(4) The commander or assigned agency head will maintain and dispose of HRECs for Individual Mobilized Augmentees (IMAs).

d. Military personnel officers. Military personnel officers will—

(1) Initiate HRECs and send them to the proper HREC custodian.

(2) Ensure that the records of personnel who are changing stations are sent to the next duty station.

(3) Tell the HREC custodian of impending unit or personnel movements 1 month prior to movement or as soon as possible.

(4) Provide, on a quarterly basis, rosters that identify personnel for whom MTF and DTF commanders are medical record custodians.

(5) Keep secure any defense information in HRECs (para 2–7). When military personnel officers acquire HRECs or documents belonging in HRECs, they will ensure that the records are maintained confidentially (chap 2) and sent to the proper HREC custodian without delay.

e. AMEDD officers. AMEDD officers will—

(1) Serve as custodians of HRECs, except in those instances where exception is granted as outlined in *b* and *c*, above, and in paragraph 5–26*b*(1). AMEDD officers are in charge of the HRECs for members of the units to which they supply primary medical and dental care. They are also in charge of the HRECs of other individuals they are currently treating.

(2) Use HRECs for diagnoses and treatment. HRECs are important for the conservation and improvement of patient health. Therefore, AMEDD officers will ensure that all pertinent information is promptly entered in the HRECs in their custody. If any such pertinent information has been omitted, AMEDD officers will take immediate action to obtain such information from the proper authority and include it in the HREC.

(3) Send the appropriate records to the military member's HREC custodian when an AMEDD officer examines or treats a person whose HREC is not in his or her custody. Original outpatient documentation stays at the MTF where it was created. These records will be sent sealed in an envelope that is stamped or plainly marked "Health (or Dental) Records." In addition to the address, the envelope will also be plainly marked "Health (or Dental) Record of (person's name, grade, and Social Security number (SSN))." The person's unit of assignment will also be shown. If the HREC custodian is not known, the document will be sent to the medical department activity (MEDDAC), U.S. Medical Center (MEDCEN), or dental activity (DENTAC) commander of the person's assigned installation.

(4) At least annually, conduct risk assessments. Consistently, throughout the year, monitor internal policies to ensure compliance with the HIPAA Privacy Rule provisions outlined in DOD 6025.18–R.

f. Chief, Patient Administration Division. The Chief, Patient Administration Division of an MTF, will act for the commander in matters pertaining to medical records management and information. The office of patient administration will keep the professional staff informed of the requirements for medical records and related health care documentation.

g. Medical and dental officers. Medical and dental officers will ensure that—

(1) Information is promptly and accurately recorded on medical and dental forms.

(2) Records prepared and received from other MTFs and DTFs are promptly reviewed and filed in the medical record.

h. Health–care providers. Health–care providers will promptly and correctly record all patient observations, treatment, and care.

i. Chaplains. Hospital chaplains are allowed access to medical records subject to standards contained in the American Hospital Association Guidelines for Recording Chaplains' Notes in Medical Records. Visiting clergy will not have access to ITRs. Chaplains enrolled as students in clinical pastoral education courses will be afforded the same privileges as hospital chaplains. Chaplains assigned to a residential treatment facility (RTF) will be allowed, but not required, to document information in medical records. The RTF chaplain will document the factual and observational information called for in the American Hospital Association Guidelines. As a team member in an RTF, the chaplain is encouraged to include additional information that would be helpful for the total care and treatment of the patient. Such information is considered observational.

j. Persons within Department of the Army (DA) agencies. Persons within DA agencies who use protected health

information (PHI) for official purposes must protect the privacy and confidentiality of that information in accordance with law and regulation.

k. Research personnel. Research personnel will ensure that data collected from medical records are within guidelines of human use committees and maintain the confidentiality of patients. See AR 40–38 and paragraph 2–8 of this regulation.

1–5. Record ownership

a. Army medical records are the property of the Government. Thus, the same controls that apply to other Government documents apply to Army medical records. (See DODI 6040.43, AR 25–55, AR 25–400–2, and AR 340–21 for policies and procedures governing the maintenance and release of Government documents.)

b. Army medical records, other than those of RCs, will remain in the custody of the MTFs at all times. RC records will remain in the custody of the appointed HREC custodian. The medical records of special operations forces will also remain in the custody of the MTFs at all times. This medical record is the Government's record of the medical care that it has rendered and must be protected. The patient will not transport the HREC, OTR, or CEMR. Upon request, the patient may be provided with a copy of his or her record, but not the original record. Only one free copy may be provided to the patient. Procedures should ensure conscientious Government control over medical records for good medical care, performance improvement, and risk management. Limit access to all open record storage areas and to electronic records to authorized personnel only.

1–6. International standardization agreements

Some provisions of this regulation are covered by North Atlantic Treaty Organization (NATO) Standardization Agreements (STANAGs) 2348 ED.3(1) and 2132 ED.2 and American–British–Canadian–Australian (ABCA) Quadripartite Standardization Agreement (QSTAG) 470 ED.1. These parts are annotated to show the related agreement. Any proposed changes or cancellations of these provisions must be approved through international standardization channels.

Chapter 2
Confidentiality of PHI

2–1. General

This chapter explains DA policies and procedures governing the release of PHI pertaining to individual patients. The policies expressed in this chapter will be used in coordination with those expressed in AR 25–55, AR 340–21, and DOD 6025.18–R. Note that no information pertaining to the identity, treatment, prognosis, diagnosis, or participation in the ASAP will be released, except in accordance with AR 600–85, chapter 6, and chapter 8 of this regulation. Refer to AR 40–68, paragraph 2–5, for information pertaining to the confidentiality of medical quality assurance records.

2–2. Policies governing PHI

DA policy mandates that the confidentiality of PHI of both living and deceased individuals will be ensured to the fullest extent possible. PHI will be disclosed only if authorized by law and regulation.

a. Within DA, PHI may be used for treatment, payment, health care operations, and preventive care of patients. PHI may also be used within DA to monitor the delivery of health–care services, to conduct medical research, to provide medical education, to facilitate hospital accreditation, and to satisfy other official purposes.

b. Each Army MTF/DTF will give patients a copy of the Notice of Privacy Practices (NOPP). The NOPP explains to beneficiaries how their PHI may be used as well as their patient rights concerning PHI. Beneficiaries will sign the NOPP acknowledgment (para 4–4) showing that they received this notice. Note: A military prison inmate does not complete the NOPP acknowledgment.

c. Unless authorized by law or regulation, no person or organization will be granted access to PHI.

d. Any person who, without proper authorization, discloses PHI may be subject to adverse administrative action or disciplinary proceedings. Under HIPAA, penalties for misuse or misappropriation of PHI include both civil monetary penalties and criminal penalties. Civil penalties range from $100 for each violation to a maximum of $25,000 per year for the same violations. Criminal penalties vary from $50,000 and/or 1–year imprisonment to $250,000 and/or 10–years imprisonment (Sections 1320d–5 and 1320d–6, Title 42, United States Code). Report all possible violations of this regulation to the Privacy Officer and/or the commander, who will consult with the servicing legal office to determine a proper disposition for the reported violation.

e. PHI is often viewed by clerical and administrative personnel, such as secretaries, transcriptionists, and medical specialists. This access is authorized and necessary in order for an MTF to properly process and maintain information and records. However, the MTF commander will ensure that all persons with access to PHI are trained in their obligation to maintain the confidentiality and privacy of PHI. Required training includes web–based program modules covering health information privacy laws and procedures for using or disclosing PHI.

f. When PHI is officially requested for a use other than patient care, only enough information will be provided to satisfy the request.

g. All business associate arrangements in the form of contracts or other more informal memoranda involving PHI will establish satisfactory assurances to—

(1) Ensure that the information is used only for intended purposes.

(2) Safeguard the information from misuse.

h. The policy and the procedures contained herein do not apply specifically when members of the workforce exercise their right to—

(1) File a complaint with the Department of Health and Human Services (HHS).

(2) Testify, assist, or participate in an investigation, compliance review, proceeding, or hearing under the Social Security Act.

(3) Oppose any act made unlawful by the privacy laws, provided the individual or person has a good faith belief that the act opposed is unlawful, and the manner of the opposition is reasonable and does not involve a disclosure of PHI in violation of the privacy laws.

(4) Disclose PHI as a whistleblower and the disclosure is to a health oversight agency, public health authority, or an attorney retained by the individual for purposes of determining the individual's legal options with regard to the whistleblower activity.

(5) Disclose PHI to a law enforcement official if the employee is a victim of a crime and provided that the PHI is about a suspected perpetrator of the criminal act and is only limited to identification information. In response to law enforcement requests for limited information for identification and location purposes, the MTF may disclose only items listed in (a) through (h) below. (Note: PHI for the purpose of identification or location does not include DNA or DNA analysis, dental records or typing, samples or analysis of body fluids or tissue (see DOD 6025.18–R, para C.7.6.2.2).)

(a) Name and address.

(b) Date and place of birth.

(c) Social Security number.

(d) ABO blood type and Rh factor.

(e) Type of injury.

(f) Date and time of treatment.

(g) Date and time of death, if applicable.

(h) A description of distinguishing physical characteristics, including height, weight, gender, race, and eye color; presence or absence of facial hair (beard or mustache); scars; and tattoos.

(i) All sanctioning of employees, business associates, and limited data set recipients will be documented and retained for at least six years from the date of its creation.

(j) Individuals may file a complaint when they believe that PHI relating to them has been used or disclosed improperly; that an employee has improperly handled the information; that they have wrongfully been denied access to or opportunity to amend the information; or that the entity's notice does not accurately reflect its information practices. All such complaints must be in writing.

(k) The Freedom of Information Act/Privacy Official is the primary point of contact for individuals to file complaints pursuant to this policy.

(l) As stated in the NOPP, individuals may also complain to the HHS if they believe their privacy rights have been violated. If an individual chooses to file a complaint with HHS, the complaint must—

1. Be filed in writing, either on paper or electronically;

2. Name the entity that is the subject of the complaint and describe the actions that have allegedly been violations of the privacy standards; and

3. Be filed within 180 days of when the complainant knew or should have known that the violation occurred.

(m) All workforce members are prohibited from retaliating against individuals filing a complaint or requiring individuals to waive their rights to file a complaint with the HHS as a condition of the provision of treatment, payment, enrollment, or eligibility for benefits.

2–3. Release of information when the patient consents to disclosure

a. Requests from patients. If a patient requests information from his or her medical record or copies of documents in the record, the information or record will be provided to the patient.

(1) Any request from a patient for disclosure of information or documents from his or her own medical record must be in writing. The patient may complete DD Form 2870 (Authorization for Disclosure of Medical or Dental Information); if the form is not available to the patient, he or she may submit a letter detailing the request for information or documents. This form is available at the Department of Defense Forms Management Program Web site (www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm). If the patient is requesting information from his or her own record or a document from that record, the patient is not required to disclose the use of medical information. Accordingly, that

part of DD Form 2870 need not be completed by a patient who is requesting information or documents from his or her own record.

(2) If a physician or dentist determines that a patient's access to his or her own medical record could adversely affect the patient's physical, mental, or emotional health, the patient will be asked to designate a physician or dentist to receive the record. Such a determination, together with the rationale for such, should be documented by the determining physician or dentist in a memorandum for record to be forwarded with the record to a physician or dentist chosen by the patient. However, the failure or refusal of a patient to designate a physician to receive information from his or her health record does not relieve the Army of the obligation to eventually provide the requested information to the patient. In this circumstance, competent medical authority will institute and adhere to appropriate procedures to ensure that the actual or perceived harm to the patient by disclosure of the health record is minimized. All such medical records will be identified with a conspicuous strip of tape. (See para 4–4*a*(10).) Direct access of an identified patient to his or her original record will be allowed only in the presence of the patient administrator or his or her designee.

(3) PHI obtained from nonmilitary sources will be filed with the patient's medical record. Such information is available for further diagnosis and treatment of the patient and for other official DA uses. The MTF will release a copy of the information to the individual if requested to do so but will caution the patient that the copy is not certified as a correct and true copy. The patient or other requester will be told that the original PHI is the property of the nonmilitary facility and may be requested from the originating facility. This does not apply to PHI on patients treated under supplemental care. Such information may be released as a part of the patient's medical record.

b. Requests from third parties when patient consents to disclosure.

(1) PHI pertaining to a particular patient may be disclosed to a third party provided that the third party has obtained the prior written consent of the patient concerned. Whenever possible, DD Form 2870 will be completed by a patient to document the patient's consent to disclose PHI; if the form is not available to the patient, a letter may be used. The original DD Form 2870 or patient letter must be submitted by the third party with that party's request for a patient's PHI. In all cases, the DD Form 2870 or letter must—

(a) Be submitted in writing.

(b) Contain the patient's original signature and must be dated by the patient.

1. If the patient is a minor child, a parent or legal guardian must sign the consent form on behalf of the child. A minor child is any person who has not attained the age of 18 years and who is not emancipated as determined by the law of the State in which the MTF is located. (See the definition of a "patient with decision making capacity" in AR 40–3, glossary.)

2. If the patient has been determined to be mentally incompetent by a court of competent jurisdiction, the person who has been appointed as the legal guardian of that patient may sign the consent form on behalf of the incompetent patient. A copy of the court order appointing the legal guardian must accompany the signed consent form.

(c) Be submitted to the MTF for processing within one year from the date on which the form was signed by the patient. Consent forms older than one year are not valid.

(d) State the specific PHI for which the patient has consented to release. Only the specific information or medical record for which the patient has consented to release will be released.

(e) Name the individual or organization to whom the patient has authorized release of PHI. PHI will be released only to those persons or organizations named.

(f) State the purpose(s) for which the patient has consented for his or her PHI to be used upon disclosure to a third party.

(2) Consult with the local judge advocate to determine the validity of the information provided on a DD Form 2870.

(3) DA Form 4876 (Request and Release of Medical Information to Communications Media) will be used for release of PHI to communications media. This form is available on the AEL CD–ROM and at the USAPD Web site (www.apd.army.mil). (See AR 25–55, paragraph 3–200.)

2–4. Disclosure without consent of the patient

a. Requests from personnel within the Department of Defense (DOD).

(1) PHI may be disclosed to officers and employees of the DOD who have an official need for access in the performance of their duties; patient consent is not required.

(2) The MTF/DTF may, subject to specific terms and conditions addressed in DOD 6025.18–R, chapter 7, use or disclose PHI in the following situations without the individual's authorization or opportunity to object:

(a) When required by law or Government regulation.

(b) For public health purposes.

(c) About victims of abuse or neglect.

(d) For health oversight activities authorized by law.

(e) For judicial or administrative proceedings.

(f) For law enforcement purposes.

(g) Concerning decedents in limited circumstances.

(h) For cadaveric organ, eye, or tissue donation purposes.

(i) For research involving minimal risk.

(j) To avert a serious threat to health or safety.

(k) For specialized Government functions, including certain activities relating to Armed Forces personnel. Part 164, Title 45, Code of Federal Regulations (45 CFR 164) and DOD 6025.18–R allow a covered entity (including a covered entity not part of or affiliated with the DOD) to use and disclose the PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission. The purposes for which any and all of the PHI of an individual who is a member of the Armed Forces may be used or disclosed are the following:

1. To determine the member's fitness for duty, including but not limited to the member's compliance with standards and all other activities carried out under the authority of AR 40–501, AR 50–5, AR 635–40, and similar requirements.

2. To determine the member's fitness to perform any particular mission, assignment, order, or duty, including compliance with any actions required as a precondition to performance of such mission, assignment, order, or duty.

3. To carry out activities under the authority of DOD Directive (DODD) 6490.2.

4. To report on casualties in any military operation or activity according to applicable military regulations or procedures.

5. To carry out any other activity necessary to the proper execution of the mission of the Armed Forces.

(l) For workers' compensation programs. PHI may be disclosed to comply with workers' compensation or other similar programs established by law that provide benefits for work–related injuries or illness without regard to fault.

(3) DOD personnel will submit requests for PHI on DA From 4254 (Request for Private Medical Information) (available on the AEL CD–ROM and at the Army Publishing Directorate Wed site (www.apd.army.mil)). Ordinarily, direct access to medical records will not be permitted. Only the minimum necessary PHI will be provided to satisfy the intended purpose. When requesting disclosure of a patient's PHI, DA personnel will present their official credentials and document their official need to know the requested information.

(4) The receiving MTF will file all DA Forms 4254 received according to AR 25–400–2.

b. Requests from the Defense Security Service (DSS). DSS agents are required to provide the following appropriate release form(s) before they are provided the requested information.

(1) A completed DSS Form 40 (Alcohol and Drug Abuse Information Release and Consent to Redisclosure) is required for release of ASAP records to DSS agents.

(2) A completed "Authorization for Release of Medical Information" included in Standard Form (SF) 86 (Questionnaire for National Security Positions) is required for release of information from HRECs.

(3) A completed DSS Form 16 (Doctor/Patient Release Statement) is required before releasing general records maintained by doctors, hospitals, and other institutions pertaining to medical or psychiatric examinations or treatment. This form should also be used if the DSS agent desires to interview a physician for evaluation or opinion of the individual's case.

c. Other requests. All other requests for disclosure of PHI will be analyzed and processed according to AR 25–55 and AR 340–21.

2–5. Processing requests for PHI, restrictions, and revocations

a. The MTF commander is responsible for the management and oversight of this program. The patient administrator, as the representative of the MTF commander, is responsible for the processing of requests for patient PHI. In the absence of the patient administrator, the acting patient administrator will assume this responsibility.

b. All requests for patient PHI must be submitted in writing using DD Form 2870; if the form is unavailable to the patient, a letter may be submitted instead. Requests will be acted on within 30 days. In urgent situations, facsimile requests for disclosure may be accepted. In some situations (for example, cases of emergency, rape, assault, child abuse, or death), the need for information may be extremely urgent. In such cases, a verbal request for disclosure of medical information or medical records may be submitted and acted on. The requester will be informed that the verbal request must be supplemented by the submission of a written request according to law and regulation, at the first available opportunity.

c. Authorization for the release of PHI will normally be documented in writing. However, in certain emergency situations, the MTF commander or patient administrator may verbally authorize the release of PHI, provided that such release is otherwise authorized by law and regulation. Immediately after granting verbal authorization for disclosure, the authorizing official will prepare a memorandum for record, documenting the release and the reasons for the use of emergency procedures.

d. Usually, copies of PHI authorized for release must be picked up, in person, by the requester or other person to whom disclosure has been authorized. In emergency situations, facsimile transmission of released PHI is authorized, provided that appropriate measures are taken to ensure that the information is delivered to the correct party. A cover letter, including a confidentiality notice, will accompany each such facsimile transmission. The confidentiality notice will include instructions on redisclosure and destruction of the disclosed information. A sample is shown in figure 2–1.

e. MTF commanders or patient administrators will determine the legitimacy of the request for patient PHI. MTF commanders or patient administrators are encouraged to seek the advice and assistance of their servicing judge advocate in determining the legitimacy of a request for disclosure and in authorizing release of PHI.

"CONFIDENTIALITY NOTICE"

The documents accompanying this facsimile transmission contain confidential information, belonging to the sender, that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled.

If you are not the intended recipient you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for return of these documents.

Figure 2–1. Sample confidentiality notice accompanying facsimile transmissions

f. Only that specific PHI required to satisfy the terms of a request will be authorized for disclosure. If the request is for psychotherapy notes, the patient administrator or his/her representative will obtain an authorization for use or disclosure except—

(1) To carry out the following treatment, payment, or health care operations:

(a) Use by the originator of the psychotherapy notes for treatment.

(b) Use or disclosure by the covered entity for its own training programs that students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.

(c) Use or disclosure by the covered entity to defend itself (or to defend the United States in a claim or action brought under the Federal Tort Claims Act or Military Claims Act, in a legal action, or other proceeding brought by the individual).

(2) A use or disclosure that is—

(a) Required by the Secretary of HHS in relation to compliance activities of the Secretary of HHS.

(b) Required by law.

(c) Pertaining to uses and disclosures for health oversight activities, with respect to the oversight of the originator of the psychotherapy notes.

(d) Pertaining to uses and disclosures about decedents to coroners and medical examiners.

(e) Pertaining to uses and disclosures to avert a serious and imminent threat to health or safety of a person or the public, which may include a serious and imminent threat to military personnel or members of the public or a serious or imminent threat to a specific military mission or national security under circumstances which in turn create a serious and imminent threat to a person or the public.

g. If a request for certified disclosure of all or part of the request for patient PHI is approved, certified copies of that information or record will be released. (See AR 27–40 and paragraph 12–4*b*(3) of this regulation for the use of DA Form 4 (Department of the Army Certification for Authentication of Records) to certify records.) If the requester seeks disclosure of the original records, the requester must justify, in writing, why certified copies are not adequate to fulfill the purpose for which the records are being sought. Advice of the local judge advocate should be sought in determining the legitimacy of a request for disclosure of an original record.

h. A copy of the request for disclosure of PHI, a copy of any consent form, together with copies of the disclosure authorization and a notation of which records have been disclosed, will be filed in the patient's medical record. If these copies cannot be made, the request will be annotated to reflect the specific information disclosed. When requests are made for information from both inpatient and outpatient records at the same time, the request and an annotation of which copies were disclosed will be filed in the inpatient record. The outpatient record will be properly cross–referenced.

i. A patient has the right to request restrictions on the uses and disclosures of their medical record.

(1) The MTF/DTF is not required to agree to the restriction. The restriction should be denied if the MTF/DTF

cannot reasonably accommodate the restriction, if it conflicts with this regulation or any other applicable DOD or DA directive, or for any other appropriate reason. A response to a request for restriction should be provided to the individual requesting it as soon as practicable and should include the rationale for denying it, if the request is denied in whole or part.

(2) The MTF/DTF commander or designee must act on requests to restrict information in a timely manner and do so in writing. No restriction will be effective above the management authority level that agreed to the restriction. No restriction will be effective unless the person agreeing to the restriction is actually authorized to agree to it and establishes a written record of the restriction.

(3) The needs of the patient should be weighed against the burden that would be put on the facility to comply with the request. If the restriction is granted, the patient should be informed that the restriction is not permanent, that it only applies to the individual or MTF that granted the restriction, and that it does not transfer to another individual or MTF.

j. An individual may revoke an authorization provided under this section at any time, if the revocation is in writing, except if the MTF/DTF has already taken action on the authorization. The MTF/DTF will document and retain any signed authorization and/or revocation.

k. An individual has a right to receive an accounting of PHI disclosures made by a covered entity in the six years prior to the date that the accounting is requested, except for disclosures—

(1) To carry out treatment, payment, and health care operations as provided in DOD 6025.18–R, chapter 4.

(2) To individuals of PHI about themselves.

(3) Pursuant to an authorization under DOD 6025.18–R, chapter 5.

(4) For the facility's directory or to persons involved in the individual's care or other notification purposes as provided in DOD 6025.18–R, chapter 6.

(5) For national security or intelligence purposes as provided in DOD 6025.18–R, paragraph C7.11.4

(6) To correctional institutions or law enforcement officials as provided in DOD 6025.18–R, paragraph C7.11.6.

(7) As part of a limited data set according to DOD 6025.18–R, section C8.3.

(8) Incident to a use or disclosure otherwise permitted or required by DOD 6025.18–R, section C8.4.

(9) That occurred prior to 14 April 2003.

l. Information for each disclosure will include—

(1) The date of the disclosure.

(2) The name of the entity or person who received the PHI and, if known, the address of such entity or person.

(3) A brief description of the PHI disclosed.

(4) A brief statement that reasonably informs the individual of the basis for the disclosure; or, in lieu of such statement, a copy of a written request for disclosure under DOD 6025.18–R, section C2.5, or chapter 8, if any.

m. The covered entity will provide the first accounting to an individual in any 12–month period without charge. The covered entity may impose a reasonable, cost–based fee according to AR 25–55 for each subsequent request for an accounting by the same individual within the 12–month period, if the covered entity informs the individual in advance of the fee and provides the individual with an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.

n. Fees and charges for copying, certifying, and searching records will be calculated and imposed according to AR 25–55, chapter 6.

o. Continued coordination with a judge advocate is encouraged on all matters pertaining to the request for and disclosure of patient PHI.

2–6. Medical records of teenage family members

a. Disclosure of information.

(1) Minors have rights to access under the Privacy Act, Section 552a, Title 5, United States Code (5 USC 552a). Parents or guardians have a right to access the medical records of their minor children under the Privacy Act, 5 USC 552*a*(h). The law of the State in which the minor is located determines whether, for the purposes of the Privacy Act, the child is a minor. If not a minor, the teenager can act on his or her own behalf and the parent or guardian does not have a right to access. If, however, the teenager is a minor under the State law where he or she resides, then the law of the State in which the medical record is maintained governs the disclosure of information from that record. Patient administrators must be especially sensitive to restrictions contained in statutory or regulatory programs for—

(a) Drug and alcohol abuse.

(b) Venereal disease control.

(c) Birth control.

(d) Abortion.

(2) For overseas installations, the opinion from the DOD Privacy Board Legal Committee (23 September 1998) will be used. (See fig 2–2.)

The Privacy Act applies to any "individual" which is defined as "a citizen of the United States or an alien lawfully admitted for permanent residence" (5 USC section 552a(a)(2)). With respect to any rights granted the individual, no restriction is imposed on the basis of age. Therefore, minors have the same rights and protections under the Privacy Act as do adults.

The Privacy Act provides that "the parent of any minor . . . may act on behalf of the individual" (5 USC section 552a(h)). This subsection ensures that minors have a means of exercising their rights under the Privacy Act (Office of Management and Budget Privacy Act Guidelines (OMB Guidelines), 40 Federal Register 28949, 28970 (July 9, 1975)). It does not preclude minors from exercising rights on their own behalf, independent of any parental exercise. Parental exercise of the minor's Privacy Act rights is discretionary. A Department of Defense (DOD) component may permit parental exercise of a minor's Privacy Act rights at its discretion, but the parent has no absolute right to exercise the minor's rights absent a court order or the minor's consent. See OMB Guidelines, 40 Federal Register 56741, 56742 (December 4,1975). Further, the parent exercising a minor's rights under the Privacy Act must be doing so on behalf of the minor and not merely for the parent's benefit (DePlanche v. Califano, 549 F. Supp. 685 (W.D. Mich. 1982)).

The age at which an individual is no longer a minor becomes crucial when an agency must determine whether a parent may exercise the individual's Privacy Act rights. With respect to records maintained by DOD components, the age of majority is 18 years unless a court order states otherwise or the individual, at an earlier age, marries, enlists in the military, or takes some other action that legally signifies attainment of majority status. Once an individual attains the age of majority, Privacy Act rights based solely on parenthood cease.

Figure 2–2. Defense Privacy Board Advisory Opinion—the Privacy Act and Minors, 23 September 1998

b. Medical confidentiality. So that medical confidentiality will not be compromised, medical records of minors that contain information mentioned in *a*(1)*(a)* through *a*(1)*(d)*, above, will be maintained as "Mental Health Records (Minors)." Because PHI in these records may be an important part of continued and follow–up care, SF 600 (Medical Record—Chronological Record of Medical Care) will note "Patient seen, refer to file number 40–216k2" and will be filed in the patient's OTR. Disposition of these records will be in accordance with AR 25–400–2, file number 40–216k2, (mental health records (minors). (See table 3–1 and para 6–7*h* of this regulation.)

2–7. Disclosure of medical records containing classified defense information

a. Medical records will not usually contain classified defense information. The entry of such information should be avoided unless doing so jeopardizes the interests of the patient or of the Government. If entered, the documents containing classified defense information will be safeguarded and transferred according to AR 380–5. The custodian of the record will state on SF 600 that the record has a classified portion. Such documents will be screened often to see whether declassification is possible. When declassified, a note will be made on SF 600, and the documents will be returned to the custodian of the record.

b. Before records are sent to the Department of Veterans Affairs (VA), any separate file of documents bearing defense information will be reviewed for possible declassification. Documents that cannot be declassified will not be sent to the VA. Those documents in records of officers and warrant officers will be sent to the Commander, USA HRC–Alexandria, ATTN: AHRC–MSO, Alexandria, VA 22332–0002. Those documents in records of enlisted personnel will be sent to the Commander, AHRC–RP, 8899 56th Street, Indianapolis, IN 46249.

2–8. Research using military medical records

Qualified people may have access to Army medical records—electronic or paper—and biostatistical information for research and study. Access may be granted to records in MTFs and DTFs, Army record centers, and facilities of the General Services Administration. Medical records used for research will not be removed from the MTF or DTF or the center; space and facilities will be furnished by the custodian. Further, commanders of MTFs and DTFs will not borrow retired records for researchers. The Surgeon General will approve any exception.

a. Approval of requests.

(1) The Surgeon General will approve all requests for research. An exception to this is given in (2), below.

(2) The MTF/DTF commanders will approve requests from personnel under their command whose research projects

involve medical records at that facility. Researchers will abide by applicable portions of AR 40–38 and 32 CFR 219 and obtain approval from the Institutional Review Board.

b. Submission of requests. With the exception of those requests falling under *a*(2), above, all requests from outside and within DA will be made through channels to U.S. Patient Administration Systems and Biostatistics Activity, ATTN: MCHS–IN, 1216 Stanley Rd., Ste. 25, Fort Sam Houston, TX 78234–6000. Such requests will—

(1) Provide the names and addresses of the researcher and of any assistants.

(2) List the professional qualifications of the researcher and of any assistants.

(3) Describe the researcher's project or field of study.

(4) Provide the reason for requesting the use of Army records.

(5) Name the particular records needed (for example, the historical range for which records are desired) and their location.

(6) Give inclusive dates when access is wanted.

(7) Attach evidence of institutional approval (training director) for residency training projects.

(8) Have each person named in the request sign an agreement that lists the following conditions:

(a) Information taken from Army medical records will be treated according to the ethics of the medical and dental profession.

(b) The identities of people mentioned in the records will not be divulged without their permission, and photographs of a person or of any exterior portion of his or her body will not be released without his or her consent.

(c) The researcher understands that permission to study the records does not imply approval of the project or field of study by The Surgeon General.

(d) All identifying entries about a person will be deleted from abstracts or reproduced copies of the records. Health information that does not identify an individual and there is no reasonable basis to believe that the information can be used to identify an individual is not considered individually identifiable health information.

(e) Any published material or lectures on the particular project or study will contain the following statement: "The use of Army medical records in the preparation of this material is acknowledged, but it is not to be construed as implying official Department of the Army approval of the conclusions presented."

c. Access authorization proof. Any approval letter from The Surgeon General allowing access to records will be shown to the proper authority (Chief, Patient Administration Division; health information administrator) when requesting access to records at the MTF level.

d. Clinical use of electronic mail. Clinical use of electronic mail in provider–to–patient communications will be in accordance with MEDCOM guidance.

Chapter 3
Preparation of Medical Records

Section I
Forms and Documents

3–1. Authorized forms and documents

a. The forms authorized for use in medical and dental records are listed in the figures in chapters 5, 6, 7, 8, 9, and 10. Unless authorized by this regulation, only documents prepared by authorized AMEDD personnel will be filed in Army medical records. (This restriction does not prohibit the use of other documents created by attending physicians and dentists outside the AMEDD (Navy, Air Force, civilian, and so forth), or the filing of other documents as summaries or brief extracts. If such documents are filed, their source, and the physician or dentist under whom they were prepared, must be identified.)

b. Photographs may be mounted on authorized forms and filed in medical and dental records. They may be mounted on various forms, depending on the size of the photo and the interpretation location. Examples of forms that may be used for this purpose are DA Form 4700 (Medical Record—Supplemental Medical Data), Department of Defense (DD) Form 2161 (Referral for Civilian Medical Care), SF 513 (Medical Record—Consultation Sheet), and SF 600.

c. Recordkeeping requirements (file numbers) required by this regulation are listed in table 3–1.

3–2. Filing electronic/computerized forms

a. Electronic/computerized medical reports may be filed in Army medical records. Examples of such reports are electrocardiograms, coronary care unit or intensive care unit vital–sign–monitoring records, scans, anesthesia monitoring records, commercially available emergency room charting systems, and laboratory test results. Such reports will be filed with the SFs, DD forms, or DA forms to which they most closely relate (for example, electrocardiogram and cardiac monitoring with Optional Form (OF) 520 (Clinical Record—Electrocardiographic Record) (formerly SF 520),

anesthesia monitoring with DA Form 7389 (Medical Record—Anesthesia) (formerly SF 517 and OF 517), commercially available emergency room charting systems with SF 558 (Medical Record — Emergency Care and Treatment), and laboratory test results with SF 545 (Laboratory Report Display). Undersized reports, such as monitoring strips, will be mounted on DA Form 4700 overprints identified as display sheets, except for cardiac rhythm strips, which may be mounted on the corresponding SF 510 (Medical Record—Nursing Notes). When DA Form 4700 is used, it should be referenced on SF 600. (Also see paras 3–3, 9–2, and 12–4 for information on DA Form 4700.)

b. When a computerized or electronic summary of all previous laboratory (lab) tests is provided, only the cumulative final report will be filed. All other results will be discarded. For this reason, it is vital that health–care providers not document PHI or opinions on the daily lab reports because they will not be retained.

c. Computerized or electronic versions of recognized forms will include reference to "electronic version of (form number)" in the lower–left corner and must be mirror images of DOD or DA forms.

d. The Interagency Committee on Medical Records, with approval of the General Services Administration, has eliminated the requirement that every electronic version of a medical standard or optional form be reviewed and granted an exception. The elements required for electronic versions of these forms have been published in the Federal Register. These elements must be included in any electronic versions of these forms.

e. MTFs may discontinue the daily filing of laboratory and radiology results in the medical record and maintain these results electronically within the Composite Health Care System (CHCS), CHCS II, or clinical information systerm (CIS). MTFs planning to implement this practice will develop a migration plan before converting to the electronic storage of test results. These plans will include the following, at a minimum:

(1) Procedures for ensuring laboratory and radiology reports will be properly authenticated in CHCS, CHCS II, or CIS by authorized MTF staff members according to CHCS, CHCS II, or CIS functionality and business rules.

(2) Procedures for providing information during CHCS, CHCS II, or CIS unavailability and for entering any results obtained if or when the system is unavailable.

(3) Mechanism for retrieval of archived information.

(4) Procedures for ensuring cumulative laboratory and radiology results are filed in medical records upon permanent change of station (PCS), referral for treatment to other facilities, record retirement, and valid request.

(5) Procedures for ensuring test results for active duty members assigned to deployable units are included in DD Form 2766 (Adult Preventive and Chronic Care Flowsheet), or other applicable documents created during a deployment, and ultimately placed in the active duty member's OTR/HREC.

3–3. Guidelines for local forms and overprints

The approval of overprinted medical forms and proposed forms using the DA Form 4700 overprint not listed in figures in chapters 5, 6, 7, 8, 9, and 10 is delegated to MEDCEN and MEDDAC or DENTAC commanders, using the guidelines described in *a* through *r*, below.

a. Local forms and proposed overprints will be well thought out in content and design; be well identified with a title, heading, and or subject; and present data in a neat and organized format. The MTF or DENTAC overprint number will appear under the form number and edition date on each form or overprint. On SF overprints, the entry "approved by U.S. Army Publishing Directorate" must be printed under the overprint number.

b. All overprinting of SFs, OFs, DD forms, and DA forms must be processed and approved before implementation. Overprinting of these forms is limited to items that specifically pertain to the form on which they are printed (for example, admission note overprint on SF 509 (Medical Record—Progress Notes) and nursing history and assessment overprint on DA Form 3888–2 (Medical Record—Nursing Care Plan)). Other overprints should be printed on DA Form 4700.

c. The MTF or DENTAC group that reviews medical records is directly responsible for review and approval of local forms and overprints.

d. Local forms and overprints submitted to the MTF or DENTAC for review and approval as in *c*, above, will be accompanied by written justification.

e. Creation of a form for which a higher echelon form exists (for example, creation of a local form as a substitute for an SF) is prohibited.

f. Titles of overprints should be printed inside the border of the form because titles printed at the top of the page between hole perforations are obscured when the forms are fastened in the records. OF 275 (Medical Record Report) may be used in ITRs, HRECs, and OTRs. OF 275 may be used for the transcription of dictated reports, or it may replace approved overprints on DA Form 4700. When OF 275 is used, the title and number of the form that it replaces are noted in the bottom part of the form. All standard information needed on the report form replaced by OF 275 will be entered on OF 275, including subtitles and name and address of MTF. OF 275 will be filed in the ITR, HREC, or OTR, according to the number of the form that it replaces. (Also see para 9–12 for information to be included on OF 275.)

g. Overprints on SFs, OFs, DD forms, and DA forms (other than DA Form 4700) must facilitate completion of subject forms, not provide "substitute" information.

h. Overprints that contain fill–in lines and or lined charts or graphs must be printed on DA Form 4700, rather than

on lined SFs, OFs, DD forms, or DA forms. Lined overprints superimposed on lined SFs, OFs, DD forms, and DA forms create serious printing and user problems.

i. Overprinting on nonstandard–size DA Forms 4700 (for example, 8–inch by 13–inch overprints) will not be approved.

j. Multi–page forms and overprints should be printed on both sides of the paper (head to foot) and indicate "page 1 of 3," "page 2 of 3," and so on if they consist of more than two pages.

k. Overprints on SF 509 and SF 600 should not extend over into the "Date" column, except for data pertaining specifically to the date and or time entry.

l. Ward policies and procedures should not be included in forms and overprints because they do not belong in the patient's medical record.

m. Worksheets should not be overprinted on SFs, DD forms, and DA forms (including DA Form 4700) because these documents will not be permanently filed in medical records.

n. When preprinted instructions are given to the patient and family, the patient's record will so indicate, and a sample of the instruction sheet will be retained in the ITR, HREC, or OTR on a DA Form 4700 overprint. Local policy will dictate how classes, videos, and other types of learning activities are documented. (Also see para 3–18.)

o. Preprinted instructions to the health–care provider do not belong in the patient's record and therefore should not be included in local forms and overprints.

p. Approval for entering doctors' orders on DA Form 4256 (Doctor's Orders) and DA Form 4700 is not required, including orders that are handwritten, taken over the phone by authorized personnel, or preprinted as standing orders. (See para 9–26.)

q. OF 522 (Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures) (formerly SF 522) or a State–mandated consent form will be used to meet the requirements of counseling and authorization required for consent to inpatient or outpatient medical or dental care. Local consent forms will not be used in place of these forms.

r. Use of abbreviations on forms and overprints should be in strict compliance with those included in appendix B or locally approved in accordance with paragraph 3–3*c*. Otherwise the abbreviations must be spelled out.

Section II
Medical Record Entries

3–4. General

a. Content. Entries will be made in a record by the health–care provider who observes, treats, or cares for the patient and in accordance with the locally defined patient assessment policy. No health–care practitioner is permitted to complete the documentation for a medical record on a patient unfamiliar to him or her. In unusual extenuating circumstances (for example, death of a provider), local policy will ensure that all means have been exhausted to complete the record. If this action is impossible, the medical staff may vote to file the incomplete record as is. Documentation summarizing the reason for the action will be filed with the record.

b. Legibility. All entries must be legible. Entries should be typed, but they may be handwritten. (However, radiology, pathology, and operative reports, as well as narrative summaries, will be typewritten.) Handwritten entries will be made in permanent black or blue–black ink, except when pencil entries are either directed or necessary under field conditions. Erasable ink and felt tip pens will not be used. Rubber stamps may be used only for standardized entries, such as routine orders.

c. Signatures. All entries must be signed or electronically authenticated.

(1) Electronic signatures on a medical record are usually admissible and will not normally jeopardize the admissibility of the record in court. However, courts address this issue on a case–by–case basis. (See the definition of "electronic signature" in the glossary, sec II.)

(2) The first entry made by a person will be signed (first and last name); later entries on the same page by that person will be signed or initialed. (A military member must add grade and corps; a civilian must add his or her title or certification.) To verify initials that are on ITR documents, a DA Form 4700 with the typed name of each staff member, their payroll signature, and their initials must be placed in each ITR. Initials must be legible and correspond to the individual's name.

(3) Rubber–stamped signatures will not be used in place of written signatures, initialing, or electronic authentication. However, the use of (rubber) block stamps or handprinted or typed names under written signatures is recommended because it establishes a method to identify the authors of entries. Block stamps for military members will contain printed name, grade, and corps (officers), or military occupational specialty (enlisted); block stamps for civilians will contain printed name and title or certification or professional licensure (such as registered nurse (RN) or licensed practical nurse (LPN)).

d. Dating and timing entries. All entries must be dated and timed. Dates will be written in the day–month–year sequence; months will be stated by name, not by number. For example, a correct entry is 17 Jun 2005 @ 1400 hours.

e. Corrections to entries. To correct an entry, a single line is drawn through the incorrect information, and it is

noted as "error," then dated and initialed. This information must remain readable. Deletion, obliteration, or destruction of medical record information is not authorized. The new information is then added, with the reason for the change (for example, "wrong patient's chart"), the date, and signature (with title) of the person making the change. Electronic corrections to entries must show a complete audit trail.

f. Amendment to medical records.

(1) Under HIPAA, individuals have the right to request an amendment or correction to their PHI. MTFs/DTFs will have procedures in place to address this issue.

(2) MTFs/DTFs may deny any individual's request for amendment, if they determine that the PHI that is subject to the request—

(a) Was not created by the covered entity, unless the individual provides a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment.

(b) Would not be available for inspection under DOD 6025.18–R, chapter 11; or

(c) Is accurate and complete.

(3) If the MTF/DTF denies the requested amendment, in whole or in part, they will provide the individual with a timely, written denial, written in plain language, that will contain—

(a) The basis for the denial.

(b) A statement of the individual's right to submit a written statement disagreeing with the denial.

(c) A description of how the individual may file such a statement.

(d) A description of how the individual may complain to the MTF/DTF, to include the name, title, and telephone number of the contact person or office designated to receive such complaints.

(e) A description of how the individual may file a complaint with the HHS.

(f) A statement that, if the individual does not submit a statement of disagreement, he or she may request that the MTF/DTF provide his or her request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment.

(4) Medical records will be amended according to AR 340–21, paragraph 2–10.

g. Use of rubber stamps. Rubber stamp entries constitute overprints only when they are used to collect clinical data, not when used to document administrative data, such as the name of a specialty clinic, time and date of clinic visit, or signature block.

3–5. Patient identification

The patient identification section will be completed when each record document is begun. The patient's recording card will be used for the HREC and OTR; the inpatient identification plate will be used for the ITR. When mechanical imprinting is not available, patient identification will be typed, computer–generated, or handwritten in black or blue–black ink. Patient identification must include at least the patient's name; his or her rank, grade, or status; his or her family member prefix (FMP) and sponsor's SSN (para 4–1); the patient's SSN; date of birth; code for MTF that maintains records; and his or her register number (if any).

a. Patient's recording card. This card is used to enter identifying data on forms filed in the OTR and HREC; it is used with the ward or clinic identification plate. (See *b*, below.) The card also may be used as an appointment card. An adhesive–backed paper appointment notice may be attached to the back. The clinic receptionist or appointment clerk fills in the date, time, and clinic name on the blank lines of the notice. (The notice also has space for the name, location, and telephone number of the MTF.) This information is then available to the patient and to clinical personnel during the patient's next visit.

(1) The patient's recording card should be prepared when the patient is first examined or treated in a troop medical clinic, health clinic, or MTF. The patient's DD Form 1173 (Uniformed Services Identification and Privilege Card) or DD Form 2(ACT) (Armed Forces of the United States Identification Card (Active)), DD Form 2(RES) (Armed Forces of the United States Identification Card (Reserve)), or DD Form 2(RET) (United States Uniformed Services Identification Card (Retired)) will be used to prepare the card; these forms contain all the information needed to prepare the patient's recording card.

(2) The information that may be embossed on the patient's recording card is given below. Format may vary at MTFs using the CHCS, CHCS II, or CIS. The optical card reader font will be used for the FMP and SSN to make the filing of records easier. The suggested format for this card is described in *(a)* through *(e)*, below.

(a) Line 1. Spaces 1 through 14—FMP and SSN (para 4–1). Spaces 15 through 22—Blank.

(b) Line 2. All spaces—Blank.

(c) Line 3. Spaces 1 through 22—Patient's name (last, first, and middle initial).

(d) Line 4. Spaces 1 through 4—Year of birth. Space 5—Blank. Space 6—Sex (M–male, F–female). Spaces 13 through 16—Status of patient and of sponsor if patient is a family member (for example, AD equals active duty). Space 17—Blank. Spaces 18 through 22—Department of patient or of sponsor (Army, Navy, Air Force, and so forth.).

(e) Line 5. Spaces 1 through 3—Three–character abbreviation of grade or rank of patient or of sponsor if patient is a

family member; otherwise, blank. Space 4—Blank. Spaces 5 through 22—Sponsor's name, if patient is a family member; otherwise, blank.

(3) Because patients may be treated at several MTFs, information identifying the MTF that is the custodian of the patient's record, as well as any other locally required information, may be imprinted on the card.

(4) The patient's recording card is designed only to make the printing of identification data on records easy. It is not used to determine eligibility of care. Such determinations are made in accordance with AR 40–400.

b. Ward or clinic identification plate. This plate is used to identify the MTF and the nursing unit or clinic. It will also be used to identify the Uniformed Chart of Accounts code. This plate is used with the inpatient identification plate and the patient's recording card. Suggested format for this plate is as follows:

(1) *Lines 1 and 2.* Name and location of MTF and Uniformed Chart of Accounts code.

(2) *Line 3.* Name of the nursing unit or clinic.

c. Inpatient identification plate. This plate is used to imprint patient identification information on all forms in the ITR; it is used with the ward or clinic identification plate.

(1) Format may vary at CHCS, CHCS II, or CIS facilities. The suggested format for this plate is as follows:

(a) Lines 1 and 2. All spaces—Blank.

(b) Line 3. Spaces 8 through 23—Patient's name (last, first, and middle initial). Space 24—Blank. Spaces 25 through 29—Rank, grade, or status.

(c) Line 4. Spaces 8 through 15—Register number. Space 16—Blank. Spaces 17 through 29—FMP and sponsor's SSN (para 4–1).

(d) Line 5. Space 8–Sex (M–male, F–female). Space 9—Blank. Spaces 10 through 12—Age. Spaces 13 through 29—Blank.

(2) The patient's identification plate will accompany the medical record. When the patient is ready for final disposition, local procedure will cover the use of the plate.

d. Patient bed card. This card will be prepared on a plain 3– by 5–inch card. The format for the information on the card is—

(1) Patient's first name, middle initial, and last name.

(2) Rank, grade, or status.

(3) Service affiliation (Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service, or National Oceanic and Atmospheric Administration).

(4) Date of admission.

3–6. Facility identification

The MTF or DTF providing care will be clearly named in all medical records and reports. (Such entries on SF 600 will be made by rubber stamp when possible.) Because patients are often treated at several MTFs, the MTF that is custodian of the patient's records will also be named. For OTRs and HRECs, this identification may be accomplished using the patient recording card.

3–7. Destruction of unidentifiable medical documents

An unidentifiable document is one that contains either no identifying data or such a small amount that it is impossible to identify the person to whom it belongs. Destruction of unidentifiable documents will follow instructions outlined in the MTF Information Management Plan.

Section III
Recording Diagnoses and Procedures

3–8. Nomenclature used in recording diagnoses

a. Acceptable diagnostic nomenclature will be used. Vague and general expressions will be avoided.

b. The affected body part will always be stated when relevant to the condition and when not given in the name of the condition. In addition, the body part will be described in as much detail as is needed (for example, "skin of," "tissue of," or "region of"). Terms such as "right," "left," "bilateral," "posterior," and "anterior" will also be added when applicable.

c. Few abbreviations should be used in medical records. Those abbreviations and symbols listed in appendix B, as well as locally approved abbreviations and symbols, are authorized if the following conditions are met:

(1) Local abbreviations and symbols will not delete or alter the meaning of those listed in appendix B.

(2) A copy of locally approved abbreviations and symbols will be readily available to those authorized to make entries in the medical record and to those who must interpret them.

(3) This exception to policy applies to all MTFs. However, each treatment facility will be responsible for altering its approved lists as new additions or deletions are made to appendix B. It is recommended that abbreviations not listed in

appendix B or not locally approved be used in long narratives only if they are defined in the text. For example: "Nerve conduction time (NCT) is changed by many factors. NCT varies with electrolytes. NCT varies with temperature."

d. Instructions for recording dental diagnoses and procedures, to include abbreviations and symbols, are provided in TB MED 250.

3–9. Special instructions for certain diseases

(See Tri–Service Disease and Procedure ICD–9–CM Coding Guidelines (app A) for details on coding specific diseases.)

3–10. Special instructions for certain diagnoses

Information on, and results of, Human Immunodeficiency Virus (HIV) testing will be entered in individual medical records, as follows, (in accordance with AR 600–110, para 2–10):

a. For force surveillance testing, an entry will be made on SF 600 that will include the date and location of testing. Recording of test results in the medical record of Active Duty soldiers is required when the soldier is being processed for overseas PCS. (See AR 600–110 for complete testing requirements.) HIV test results for the ARNGUS and USAR will be annotated on SF 600, which will be posted in the medical record. The HIV test date and result will be annotated on DD Form 2808 (Report of Medical Examination), item 49, if the test was performed in conjunction with a physical exam.

b. Results of routine adjunct testing will always be recorded in the medical record using SF 557 (Miscellaneous) or electronic version. The slip will be clearly stamped either "HIV positive" or "HIV negative." Specimens which are enzyme–linked immunosuppressant assay (ELISA) positive by local testing only will not be reported as HIV positive. These specimens will be reported as "pending results" to the ordering physician, and finally reported as HIV positive or negative only after receipt of confirmatory test results (Western Blot or other supplementary tests).

c. The medical and dental record jacket for all HIV–infected soldiers will be marked only by affixing a DA Label 162 (Emergency Medical Identification Symbol) in accordance with chapter 14 of this regulation. DD Form 2766 will be annotated "Donor Ineligible–V72.62."

d. The losing HIV program point of contact will ensure that copies of medical records pertaining to the patient's diagnosis and evaluation of the HIV infection are forwarded by mail or courier. Care will be taken to protect the confidentiality of the records by sealing them in an envelope marked "Sensitive Medical Records—To Be Opened by Addressee Only," and then inserting the envelope into a carrier addressed directly to the attention of the receiving HIV program point of contact, by name when known.

3–11. Recording psychiatric conditions

Psychiatric conditions will be recorded using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised (or current edition), as nomenclature (app A).

3–12. Recording injuries

a. Details to be recorded.

(1) The same details will be given and the same terms used when both battle and nonbattle injuries are recorded. To be complete, the recording of an injury must include the details given in *(a)* through *(g)*, below. (For information needed for proper coding, see Tri–Service Disease and Procedure ICD–9–CM Coding Guidelines (app A).) Record on DA Form 3647 (Inpatient Treatment Record Cover Sheet), item 33, CHCS, CHCS II, or CIS electronic equivalent, the details listed in *(c)* through *(g)*, below.

(a) The nature of the injury. Record the exact nature of the injury as well as the medical condition caused by it. Explain conditions, such as traumatic bursitis, traumatic neuritis, traumatic myositis, or traumatic synovitis, by describing the original injury. For example, record a contused wound resulting in bursitis as bursitis due to contusion.

(b) The part or parts of the body affected. In the case of fractures and wounds, state whether any nerves or arteries were involved; name major nerves or blood vessels.

(c) The external causative agent. In the case of acute poisoning, name the poison.

(d) How the injury occurred. State what the person was doing when injured (for example, in action against the enemy, work detail, marching, drilling, or motor vehicle accident, etc.). For motor vehicle accidents, state the kinds of vehicles involved and whether military owned or otherwise.

(e) Whether the injury was self–inflicted. If the injury was deliberately self–inflicted, state whether it was an act of misconduct (to avoid duty) or an act of the mentally unsound (a suicide or attempted suicide).

(f) The location where the person was injured. If on post, state the building or area (for example, barracks, mess, or motor pool); if off post, state the exact location where the accident occurred (such as name of business, city, State) or location of motor vehicle accident (city, State, etc.), and the person's status (for example, home or leave or in transit while absent without leave (AWOL)).

(g) The date of the injury.

(2) Examples of properly recorded diagnoses are provided in *(a)* and *(b)*, below.

(a) "Fracture, open comminuted, upper third of shaft of femur, left, no nerve or artery involvement; bullet entering anterior upper portion of left thigh and lodging in femur. Caused by rifle bullet, accidentally incurred when patient's rifle discharged while he was cleaning it in Barracks A, Fort Hood, TX, 8 Jul 98."

(b) "Bursitis, acute, knee, right, due to contusion, anterior aspect. Accidentally incurred when patient tripped and fell, striking knee on floor while entering Barracks 26, Fort Lewis, WA, 2 Dec 98."

b. Wound or injury incurred in combat.

(1) In addition to the details described in *a*, above, records on wounds or injuries incurred in combat must state—

(a) Whether the wound resulted from enemy action. The abbreviation "WIA" will be used; however, "WIA" by itself is not acceptable as a diagnosis.

(b) The kind of missile or other agent that caused the wound.

(c) The time that the wound occurred.

(d) The general geographic location where the person was wounded. Entries such as "near Taegu, Korea" are sufficient; map coordinates alone are not.

(2) The following example is a correctly recorded WIA case: "WIA wound, penetrating, left arm; entrance, posterior lateral, proximal third, severing brachial artery without nerve involvement. Incurred during search and destroy mission when struck by enemy mortar shell fragments, 16 Dec 69 near Kon Found, Republic of Vietnam."

c. Injuries or diseases caused by chemical or biological agents or by ionizing radiation.

(1) For these injuries, record the name of the agent or type of ionizing radiation (if known). If the agent or radiation is not recognized, record any known properties of it (for example, odor, color, or physical state).

(2) Record the date, time, and place where contamination took place.

(3) Estimate and record the time that lapsed between contamination and self-decontamination or first aid (if any). Describe the procedures used.

(4) For injury by ionizing radiation, estimate and record the distance from the source. If the exposure is to external gamma radiation, state the dosage (for example, "measured 200r"). If not known, the dosage should be estimated (for example, "est 150r").

(5) State, if known, whether exposure was through airburst, ground burst, water surface burst, or underwater burst.

d. Occupational injury and illness. This term includes all injury or illness incurred as the result of performance of duty for military and civilian personnel, including those identified in *c*, above. In addition to the details in *a*, above, identify the injury or illness as "occupational."

3–13. Recording deaths

a. Recording deaths of unknown cause. The following terms will be used to record deaths when the cause is unknown:

(1) "Sudden death."Used in the case of sudden death known not to be violent.

(2) "Died without sign of disease." Used in the case of death other than sudden death known not to be violent.

(3) "Found dead." Used in cases not covered by (2) above when a body is found.

b. Recording underlying cause of death. The underlying cause of death is a disease, abnormality, injury, or poisoning that began the train of morbid events leading to death. For example, a fatal case with a diagnosis of cerebral hemorrhage, hypertension, and myocarditis would have hypertension as the underlying cause. The diagnosis that describes the underlying cause of death should be identified as the underlying cause on DA Form 3647, CHCS, CHCS II, or CIS electronic equivalent.

(1) The train of events leading to death will be recorded in items 7a and b of DA Form 3894 (Hospital Report of Death). The immediate cause will be entered in item 7a, and the underlying cause will be entered in item 7b. Only one cause should be entered on each line of items 7a and b; no entry is needed in 7b if the immediate cause of death given in 7a describes completely the train of events. To record the example given in *b*, above, cerebral hemorrhage would be entered in 7a as the condition directly leading to death; hypertension would be entered in 7b(1) as the antecedent cause or condition leading to the immediate cause; and myocarditis would be entered in 8a as the condition contributing to death but not related to the cause.

(2) The diagnosis given as the underlying cause of death on DA Form 3647, CHCS, CHCS II, or CIS electronic equivalent should be the same as the diagnosis given on DA Form 3894 and on the Certificate of Death. On the Certificate of Death, the underlying cause of death is shown on line c. If line c has no entry, it is on line b; and if lines b and c are blank, it is on line a. (For more information, see the Physicians' Handbook on Medical Certification of Death (app A).)

c. Recording neonatal deaths. When recording deaths of infants under 28 days of age, use the term "neonatal death," and state the infant's age at death. For deaths in the first 24 hours of life, state the age in number of hours lived; for deaths after the first day of life, state the number of days lived. Examples of these entries are "Neonatal death less than one hour after birth," "Neonatal death, age 22 hours," and "Neonatal death, age 26 days." (For more information, see the Hospitals' and Physicians' Handbook on Birth Registration and Fetal Death Reporting (app A).)

d. Detainee documentation.

(1) Accurate and complete outpatient and, when required, inpatient medical records on each detainee shall be created and maintained according to the provisions of this regulation and AR 190–8. The detainee identification number will be used as the patient identification number. Medical records will be maintained at the MTF with responsibility for the detainee's health care. If a detainee is transferred to another U.S. Armed Forces detention facility, the medical records will be forwarded to the appropriate depository for MTF. All detainee medical records remain the property of the U.S. Army. An appropriate depository for inactive detainee medical records will be established.

(2) Entries should be made into detainee medical records as they would for any other patient. Detainees are entitled to copies of their medical records upon release from detention. Before copies of records are released, all health care provider information, including names of all who provided care of any nature, and other identification must be stricken from the copied medical records.

3–14. Recording cases observed without treatment, undiagnosed cases, and causes of separation

a. Observation without need for further medical care. A record must be made when a patient shows a symptom of an abnormal condition but study reveals no need for medical care. That is, observation reveals no condition related to the symptom that would warrant recording and no need for any treatment. In such a case, the proper diagnosis entry is "Observation." After this entry, give the name of the suspected disease or injury; after this entry, enter either "No disease found" or "No need for further medical care."

(1) A diagnosis of "Observation" is used even when a condition unrelated to the one suspected is diagnosed and recorded. For example, a patient is admitted for possible cardiac disease, but a specific cardiac diagnosis is not made. While in the hospital, however, the patient is also treated for arthritis. In such a case, "Observation, suspected..." is entered as the cause of admission; arthritis is given as the second diagnosis.

(2) A diagnosis of "Observation" is not used for patients lost to observation before a final diagnosis is made, and it is not used for a medical examination of a well person who has no complaint and who shows no need for observation or medical care.

b. "Undiagnosed" or "undetermined diagnosis" (nonfatal cases). When a patient is admitted or transferred and an immediate diagnosis is not possible, give the symptoms or the name of the suspected condition. Replace these terms with a more definitive diagnosis as soon as possible. When a final or more definitive diagnosis cannot be made, use the condition or manifestation causing admission.

c. Recording cause of separation. For a noninjury patient separated or retired for physical disability, the cause must be recorded. If there is more than one diagnosis, select the one that is the principal cause of separation, and enter after it "principal cause." For an injury patient, the residual disability (the condition causing separation) must be recorded. If there is more than one residual disability, the one that is the principal cause of separation must be stated. The diagnosis that is the "underlying cause" must also be recorded, that is, the injury causing the residual disability. For example, if a leg injury leads to amputation, the leg injury is stated as the underlying cause.

3–15. Recording surgical, diagnostic, and therapeutic procedures

Principles for coding and sequencing surgical, diagnostic, and therapeutic procedures are found in the Tri–Service Disease and Procedure ICD–9–CM Coding Guidelines (app A).

3–16. Recording therapeutic abortions

10 USC 1093 states that funds available to DOD may not be used to perform abortions except when the mother's life would be endangered if the fetus were carried to term. To ensure compliance with 10 USC 1093, the following are required.

a. Before the procedure, physicians performing therapeutic abortions in Army hospitals will document in the clinical record that the abortion is being performed because the mother's life would be endangered if the fetus were carried to term.

b. The same documentation will be placed in the medical record of a patient referred out on supplemental care.

c. As an added control, the chief of obstetrics and gynecology, deputy commander for clinical services, or the hospital commander must countersign the physician's statement before the procedure is performed. The legal advice of a judge advocate will be solicited if deemed necessary.

d. For guidance on all other categories of abortion, see AR 40–400, paragraph 2–18.

3–17. Recording use of restraints/seclusion

Documentation of the use of restraints/seclusion will conform to local policy and the current Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards.

3–18. Recording videotaped documentation of episodes of medical care

a. When an episode of health care (for example, surgical procedures, medical evaluation, telemedicine consultation, and so forth) is to be documented on videotape, the patient must provide written consent for the taping (unless the taping is for the documentation of neglect or abuse). The patient (if identifiable) must provide written consent.

b. Consent will be recorded on an OF 522 or a State–mandated consent form in accordance with paragraph 3–3*q*.

c. The episode of health care will be documented in the medical record as is normally done. Written documentation of the consultation will be done by providers on both ends of a telemedicine encounter. The videotape will be erased after standard documentation is complete, unless the videotape is required for a specified interval for a specific reason, such as documentation of neglect, abuse, or possible criminal activity. In cases where adverse administrative, nonjudicial, or judicial proceedings may be contemplated because of possible criminal activity, consult with the local judge advocate before erasing the videotape. The provider will indicate in the final documentation whether or not the image was erased, or where the videotape will be maintained. The videotape will not become part of the medical record.

d. Exceptions to the prohibition against retaining videotapes may be permitted for cases with exceptional educational value or cases where adverse administrative, nonjudicial, or judicial proceedings may be contemplated because of possible criminal activity. Tapes are not usually filed by any type of personal identifier. If they are, then all Privacy Act regulations must be followed. Any MTF which chooses to keep such images on file for educational purposes must develop appropriate policies and standing operating procedures and review them periodically.

Section IV
Records for Carded–for–Record–Only Cases and Absent–Sick Status

3–19. Carded–for–record–only cases

a. Certain cases not admitted to an MTF will be carded–for–record–only (CRO) cases and will be documented both in the medical record and through the Standard Inpatient Data Record (SIDR). This includes only the deaths of active duty military personnel. These deaths will be reported in one of the following ways:

(1) If an active duty soldier dies during a hospital stay, it is considered a hospital death and is reported through the SIDR.

(2) If the soldier dies while hospitalized in a civilian hospital, it is reported as an absent–sick death and reported through the SIDR.

(3) If the soldier is dead on arrival (DOA), it is reported as a CRO through the SIDR.

(4) If the soldier dies in the emergency room, it is reported as a CRO through the SIDR.

b. The MTF with geographic control is responsible for initiating the CRO and is required to monitor and coordinate with the civilian facilities in that geographic area. Coordination must occur through the respective command surgeon's office.

c. For these cases, DA Form 3647, CHCS, CHCS II, or CIS electronic equivalent, or DD Form 1380 (U.S. Field Medical Card) will be prepared. A register number will be assigned to each CRO case. When DA Form 3647 is used, items 7, 10, 14, 24, 27, and 30 and the name of the admitting officer do not need to be completed. When DD Form 1380 is used, block 17 does not need to be completed.

d. Deaths of other than active duty military personnel may be CRO if they are considered to have medical, legal, or other significance. However, they are CRO cases only if an ITR has not already been prepared for them.

3–20. Absent–sick status

An Army patient admitted to a nonmilitary treatment facility is in an absent–sick status. (See AR 40–400, para 10–11*a*.)

a. Only Active Army members, RC members in the Active Guard/Reserve program, RC members on tours of duty for 30 days or more, and U.S. Military Academy cadets can be classified in an absent–sick status.

b. DA Form 3647, CHCS, CHCS II, or CIS electronic equivalent and DA Form 2985 (Admission and Coding Information) for absent–sick status are prepared much the same as for a direct admission but with the exceptions noted in the Individual Patient Data System (IPDS) User's Manual (app A). Additional information on absent–sick patients placed in quarters by civilian physicians is given in DA Form 3647 and DA Form 2985 do not need to be completed for these cases.

Table 3–1
AR 25–400–2, Army Records Information Management System (ARIMS)
File numbers, record keeping requirements

File number	Title
11–9	Personnel dosimetry files
40	General medical services correspondence files
40–5h	Civilian Employee Medical Files
40–66a	Health records
40–66b	Dental health records
40–66c	Register number files
40–66e	Foreign national inpatient treatment records
40–66f	Military inpatient treatment records
40–66g	Civilian inpatient treatment records
40–66i	NATO personnel inpatient treatment records
40–66j	Military outpatient records
40–66k	Civilian outpatient records
40–66m	Foreign national outpatient records
40–66p	Army Reserve and ROTC outpatient records
40–66q	NATO personnel outpatient records
40–66s	Field medical cards
40–66u	Medical care inquiries
40–66v	USMA applicant x rays
40–66w	Installation x–ray indices
40–66x	Troop and health clinic clinical record cover sheets
40–66y	Photograph and duplicate medical files
40–66z	Procurement and separation x rays
40–66aa	Applicant and registrant x–ray film
40–66bb	Patient treatment film
40–66cc	Occupational health surveillance x rays
40–66ee	Medical records access files
40–66ff	PHI releases
40–66gg	Nominal indexes
40–66hh	Tubercular applicant and registrant x rays
40–66ii	Military dental files
40–66jj	Civilian dental files
40–66kk	Foreign national dental files
40–66mm	American Red Cross dental files
40–66pp	Army Substance Abuse Program outpatient records
40–216h	Electroencephalographic tracings
40–216i	NATO consultation service cases
40–216k1	Mental Health Records (Adults)
40–216k2	Mental Health Records (Minors)
40–407f	Register of operations

Chapter 4
Filing and Requesting Medical Records

4–1. Filing by Social Security number and family member prefix

An 11–digit number is used to identify and file medical records under the terminal digit filing system. This number consists of the sponsor's SSN and an FMP.

a. The first two digits of the file number are the FMP. These digits identify the patient, as shown in table 4–1.

b. The other nine digits of the file number are the sponsor's SSN broken into three groups. The first group is the first five digits of the SSN; the second group is the next two digits of the SSN; and the third group is the last two digits of the SSN. For example, PFC Ernie Jones's SSN: 390–22–3734, would be identified as 20 39022 37 34; his wife's number would be 30 39022 37 34; his third oldest child's number would be 03 39022 37 34. As shown in the example, the sponsor's SSN will be used for beneficiaries. When both parents are on active duty, a newborn child's number will be the same SSN as that used on the mother's records. When a newborn infant has no entitlement to continued medical care (for example, a newborn infant of a daughter family member or of a civilian emergency patient), the FMP assigned to the infant will be 90–95, and the SSN will be the one that the mother uses.

c. Pseudo or artificial 11–digit numbers will be given to patients not described in *b*, above and in table 4–1. These numbers will also be given to patients who do not have an SSN. The pseudo or artificial SSN will be constructed according to the patient's date of birth. The following format will be employed: (80 +(0–9) + YYMMDD), where 80 is constant in every case, and the third digit is used for sequencing of multiple same birthdate admissions. For example, a birthdate of 21 Sep 46 is formed 800–46–0921; a second patient requiring a pseudo SSN with the same birthdate is distinguished by the third digit, 801–46–0921. (Civilian emergency patients who have an SSN are described in rule 13 of table 4–1 and will not be given an artificial number.)

Other medical or dental records important to the patient's care, including advance directives (durable powers of attorney for health care, living wills, etc.). (See paras 6–2i, 9–2c(2), and 10–3a(4).)

DD Form 2005[2]
Privacy Act Statement—Health Care Records. DA Form 2005 is always the bottom form or is printed on the folder. (See paras 4–4a(9), 5–27a, 7–4a, and 10–3a(1).)

Notes:
[1]This form must be included in all nonmilitary dental records.
[2]Instructions for completing this form are self-explanatory.

Figure 6–3. Forms and documents of the nonmilitary dental record—Continued

Chapter 7
Occupational Health Program Civilian Employee Medical Record

Section I
General

7–1. Compliance

The purpose of this chapter is to explain how the initiation, maintenance, and disposition of CEMRs will meet the requirements of DODI 6055.5, the Occupational Safety and Health Administration (OSHA) (29 CFR 1904, 29 CFR 1910, and 29 CFR 1960), and regulations of the Office of Personnel Management (5 CFR 293.501, Subpart E).

7–2. Definition and purpose of the civilian employee medical record

a. The CEMR is defined as a chronological, cumulative record of both occupational and non–occupational information about health status developed on an employee during the course of employment. It includes personal and occupational health histories, exposure records, medical surveillance records, Office of Workers' Compensation Programs (OWCP) records, and the written opinions and evaluations generated by health–care providers in the course of examinations, treatment, and counseling.

b. The purpose of the CEMR is to provide a complete medical and occupational exposure history for employee care, medicolegal support, research, and education.

c. CEMRs are not maintained on soldiers. Occupational health–related documentation, such as exposure records, medical surveillance records, x–ray reports, and so forth, are filed in the OTR.

d. The original documentation will be retained at the MTF where the treatment was rendered. Continue to maintain an additional legible, chronological, longitudinal record copy of all treatment episodes.

7–3. For whom prepared

A CEMR will be prepared for each permanent civilian employee upon employment. A medical record will be prepared for all nonpermanent employees who receive any type of occupational health services.

7–4. Civilian employee medical records folder and forms

a. The CEMR may be maintained either in the terminal digit filing system DA Form 3444–series or the SF 66D during the course of employment. When the DA Form 3444–series folders are used, they will be prepared and filed according to chapter 4. When the SF 66D folders are used, they will be filed alphabetically by last name. The name (last, first, middle initial), date of birth, and SSN of the employee will be typed on a label and affixed to the SF 66D on the indicated space on the folder. Attach an NOPP acknowledgment label to the center of the back outside cover of the SF 66D. Ensure the civilian employee completes a separate DD Form 2005 regardless of the type folder used. The CEMR will be retired or transferred in the SF 66D folder; therefore the employee does not need to complete the preprinted DD Form 2005 on the inside of the folder when the DD Form 3444–series is used.

b. The forms authorized for use in CEMRs are listed in figure 7–1. These forms will be filed from top to bottom in the order they are listed in the figure. Copies of the same form will be grouped and filed in reverse chronological order (the latest on top). Specialized occupational health forms may be maintained in CEMRs, but they must have prior approval by the supporting MEDDAC/MEDCEN (chap 3, sec I). When it is necessary to use a DD form, DA form, or

SF that is not listed in figure 7–1 but is listed in this regulation, file it in the order listed in the relevant figure shown in chapter 5 or chapter 6.

(1) SF 78 (U.S. Civil Service Commission, Certificate of Medical Examination) will be used to record preemployment physical examination results for appropriated fund employees, and it may be used to record periodic job–related physical examination results. Parts A, B, and C of the SF 78 are authorized for filing in the CEMR, and parts D, E, and F are forwarded to the Civilian Personnel Office (CPO).

(2) DD Form 2807–1 will be used to obtain a health history from civilian workers and to initiate a medical record on employment and subsequent job–related medical surveillance or other purposes, as required.

(3) DA Form 3437 (Department of the Army Nonappropriated Funds Certificate of Medical Examination), will be used to record preemployment physical examination results for nonappropriated funds employees and may be used to record periodic job–related physical examination results. DA Form 3437 is authorized for filing in the CEMR.

(4) DD Form 2766 and DD Form 2766C provide a summary of known past and current diagnoses or problems, and currently or recently used medications. (See paras 5–13 and 5–32*a* for instructions on completing and using these forms.)

(5) DD Form 2795, DD Form 2796, and DD Form 2844 (TEST) may be used to record the results of pre– and post–deployment health assessments for civilians who are deployed. (See paras 5–32*a*, 5–35, and 5–36*a* for instructions on using these forms.)

(6) DD Form 1141 or ADR is used to record results of all personal monitoring, to include film badge readings for each person occupationally exposed to ionizing radiation. DD Form 1141 or ADR is a medical record and is filed in the CEMR (para 5–21*b*(5)).

(7) DA Form 4515 and DA Form 3180 are used according to AR 50–5 and AR 50–6 to identify and evaluate all individuals working in the nuclear or chemical surety programs.

(8) The mandatory OSHA Respirator Medical Evaluation Questionnaire will be used according to 29 CFR 1910.134. The use of this questionnaire (or medical examination that obtains the same information as the OSHA questionnaire) is used to determine an employee's ability to use a respirator.

(9) Copies of the following OWCP medical forms are authorized to be maintained in the CEMR:

(a) Department of Labor (DOL) Form CA–16 (Authorization for Examination and or Treatment).

(b) DOL Form CA–17 (Duty Status Report).

(c) DOL Form CA–20 (Attending Physician's Report).

(10) In addition, a copy of DOL Form CA–1 (Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation) is maintained in the CEMR when the employee files a claim with OWCP for an occupational traumatic injury, but the original DOL Form CA–1 is placed in the medical record if a claim is not filed. A copy of DOL Form CA–2 (Federal Employee's Notice of Occupational Disease and Claim for Compensation) is authorized to be maintained in the CEMR when the employee is claiming an occupational disease (5 CFR 293.501).

(11) Copies of the following nonmedical forms may be filed in the CEMR to provide supplementary medical data:

(a) OF 345 (Physical Fitness Inquiry for Motor Vehicle Operators).

(b) DA Form 3666 (Department of the Army Nonappropriated Funds Statement of Physical Ability for Light Duty Work).

Section II
Maintaining, Transferring, and Disposing of Civilian Employee Medical Records and Retention of Job–Related X–Ray Films

7–5. Custody and maintenance of civilian employee medical records

The MTF commander is the official custodian of all medical records, including CEMRs, at his or her facility. The Chief, Patient Administration Division, of an MTF will act for the commander to handle medical records. The CEMRs will usually be maintained in the outpatient record room of the MTF when the occupational health service/clinic is collocated with a hospital. The CEMRs will be maintained in the U.S. Army Health Clinic or Occupational Health Clinic or Occupational Health Nursing Office when the clinic is not collocated with a hospital.

7–6. Medical record entries

Medical record entries in the CEMR will be made in accordance with paragraph 3–4.

7–7. Recording occupational injuries and illnesses

a. Record all injury or illness incurred as the result of performance of duty by individual personnel. Identify the injury or illness as "occupational." The recording of an occupational injury must include the following details:

(1) The exact nature of the injury.

(2) The part or parts of the body affected.

(3) The external causative agent. In the case of acute poisoning, the poison must be named.

(4) How the injury occurred.
(5) The place where injured. State the building and or area.
(6) The date of the injury.

b. For the recording of injuries or diseases caused by chemical or biological agents or by ionizing radiation, see paragraph 3–12*c*.

7–8. Cross–coding of medical records

a. Civilian employees who are military medical beneficiaries will have two medical records, the CEMR and the OTR. These records will be cross–indexed to identify the dual status, to facilitate care, and to ensure appropriate identification and reporting of occupational illnesses and injuries.

b. In those facilities using the Pharmacy Data Transaction Service, the CEMRs of civilian employees who are also family member beneficiaries will be electronically merged with the family member record in the CHCS, CHCS II, or CIS. This will result in one CHCS, CHCS II, or CIS record for these patients, which will be identified under the sponsor's SSN. A paper CEMR will continue to be maintained under the civilian employee's SSN or name.

7–9. Transferring and retiring civilian employee medical records

The CEMR of an employee transferring to another Federal agency or separating from Federal service will be forwarded to the CPO identified in the SF 66D within 10 days of transfer or separation (AR 25–400–2). The CPO will forward the CEMR to the appropriate custodian.

7–10. Retention of job–related x–ray films

a. Legal and regulatory requirements dictate that x–ray films performed for exposure to work place hazards must be preserved and maintained for at least the duration of employment plus 30 years, or for 40 years, whichever is greater (29 CFR 1910.20, 5 CFR 293.501, and DODI 6055.5).

b. Civilian employee x–ray films performed for exposures to work place hazards are part of the CEMR. X–ray films 8 1/2– by 11–inches or smaller will fit within the CEMR file folder and will be transferred to another Federal employing agency or retired with the medical record. Oversized chest/torso x–ray films cannot fit into the CEMR and will not be sent with the record to storage; however, they will be sent with the CEMR to a new Federal employing agency. When the CEMR is sent to storage, oversized films must be retained in their original state by the last MTF that provided occupational health services to the employee until such time as they may be destroyed. (See *a*, above.) Radiographic results will be included in the CEMR and a notation will be entered on the SF 600 and include the location of any film not present in the record and how it can be obtained. A microfiche copy of any type x ray except chest may be placed in the CEMR instead of the original x ray. 29 CFR 1910.20(d)(2) requires that chest x–ay films be preserved in their original state.

c. See paragraphs 6–4*d*(2) and 6–6*c* for transfer and retention of x–ray films taken for medical surveillance purposes on military members exposed to toxic substances or harmful physical agents in their work environment.

Section III
Confidentiality of PHI, Access to Civilian Employee Medical Records, and Performance Improvement

7–11. Protection of confidentiality and disclosure procedures

a. All CEMRs and PHI pertaining to civilian employees will be treated as private information. The provisions of chapter 2 of this regulation will be followed in protecting the confidentiality of PHI contained in CEMRs and in responding to requests for the disclosure of such information. In addition, OSHA and OPM rules (29 CFR 1910.20; 5 CFR 293.504, 5 CFR 297.204–205, and 5 CFR 297.401(c)) provide for access by the employee or his or her representative as designated in writing, and by OSHA representatives (compliance officers and National Institute for Occupational Safety and Health personnel) to examine or copy PHI that bears directly on the employee's exposure to toxic materials and harmful physical agents. The employee or his or her designated representative must be provided one copy of this data upon request without cost to the employee or his or her representative. The information must be provided within 15 working days of the employee's request.

b. Workers' compensation claims directly involve the employer and all facts relevant to the case become the concern of management. All medical records relating to the injury, illness, or death of an employee entitled to Federal Employee Compensation Act benefits are the official records of the Office of Personnel Management and are not the records of any agency having the care or use of such records (5 CFR 293.506). For all OWCP cases that are treated by a physician, a medical report is required. This report may be made on DOL Forms CA–16, CA–17, or CA–20; a narrative report on the physician's letterhead stationary; or in the form of an EC/ED summary. A copy of these reports is maintained in the CEMR.

c. When required, with the knowledge and permission of the employee, an interpretation of medical findings may be given to the CPO or responsible management personnel to assure safe and effective use of manpower.

7–12. Civilian employee medical record review

CEMRs will be included in the Patient Administration Division performance improvement processes. Medical records will be reviewed for accuracy, timeliness, completeness, clinical pertinence, and adequacy as medicolegal documents. All guidance and standards in paragraph 12–3 that are applicable to the CEMR will be used in this review.

All forms should be filed in an upright position on both sides of the folder. Order given below is from top to bottom of the record.

LEFT SIDE OF FOLDER

DD Form 2766[1]
Adult Preventive and Chronic Care Flowsheet (cut sheet construction). (See paras 3-10c, 4-4d, 5-13, 5-19, 5-26b(2), 5-32a, 5-36a, 5-7f, 7-4b(4), 10-7b, and 12-3a(9).)

DD Form 2766C, SF 601[1]
Adult Preventive and Chronic Care Flowsheet-Continuation Sheet, Health Record-Immunization Record. If using the folder construction of DD Form 2766 (deployable civilians), attach DD Form 2766C, SF 601, and any automated immunization tracking system printout to the inside fastener of DD Form 2766. If using the cut sheet construction of DD Form 2766 (nondeployable civilians), place DD Form 2766C below DD Form 2766 and place SF 601 and any automated immunization tracking system printout where noted below. (See paras 5-13a(2), 5-13b(3)(b), 5-13c(10), 5-13d, 5-19, 5-27c(1), 5-32a, 5-36a, and 6-7b.)

DA Form 5571
Master Problem List. This form is obsolete; use for file purposes only if already in existence.

DA Form 6007-R
Individual Medical History. This form is obsolete; use for file purposes only if already in existence. (See para 5-13b.)

DA Form 3180
Personnel Screening and Evaluation Record. (See AR 50-5, AR 50-6, and paras 5-21b(8), 5-30a, 5-31c, and 7-4b(8) of this regulation.)

DA Form 4186
Medical Recommendation for Flying Duty. (See AR 40-501 and para 5-21b(6) of this regulation.)

Documents and correspondence on flying status; that is, restrictions, removal of restrictions, suspensions, and termination of suspensions. (See AR 600-105.)

DD Form 1141, ADR
Record of Occupational Exposure to Ionizing Radiation; Automated Dosimetry Record. (See paras 5-21b(5) and 7-4b(6) of this regulation.)

DD Form 2493-1
Asbestos Exposure Part I-Initial Medical Questionnaire. (See AR 40-5 and para 5-21b(9) of this regulation.)

DD Form 2493-2
Asbestos Exposure Part II-Periodic Medical Questionnaire. (See AR 40-5 and para 5-21b(9) of this regulation.)

OF 345
Physical Fitness Inquiry for Motor Vehicle Operators. (See AR 40-5 and para 7-4b(11)(a) of this regulation.)

DA Form 3655
Department of the Army Nonappropriated Funds Statement of Physical Ability for Light Duty Work. (See AR 215-3 and para 7-4b(11)(b) of this regulation.)

Figure 7–1. Forms and documents of the CEMR using DA Form 3444–series jackets or SF 66D folders

SF 177
Statement of Physical Ability for Light Duty Work. This form is obsolete; use for file purposes only if already in existence.

SF 601[1]
Health Record—Immunization Record. Place this form here only if using the cut sheet construction of DD Form 2766. File any automated immunization tracking system printout here. (See paras 5–19, 5–25e(3), 5–27a(1), and 6–7b.)

Automated laboratory report forms. File like forms in reverse chronological order. (See paras 3–2 5–15, and 9–25.)

SF 512[1]
Clinical Record—Plotting Chart. (See para 5–15.)

SF 545[1]
Laboratory Report Display. (See paras 3–2 and 9–25.) Instructions for completing this form are provided in tables 9–2 and 9–3.

SF 546, SF 547; SF 548; SF 549, SF 550; SF 551, SF 552, SF 553; SF 554, SF 555; SF 557 Chemistry I, Chemistry II, Chemistry III (Urine), Hematology, Urinalysis, Serology, Parasitology, Microbiology I, Microbiology II, Spinal Fluid, Miscellaneous. Attach to SF 545 in reverse chronological order. (See para 9–25.) Instructions for completing these forms are provided in tables 9–2 and 9–3.

SF 556
Immunohematology. SF 556 is obsolete, use for file purposes only if already in existence.

SF 507[1]
Medical Record—Report or Continuation of SF. File with the standard form being continued.

SF 519–3[1]
Radiographic Consultation Request/Report. (See para 9–37.)

SF 519, SF 519A
Medical Record—Radiographic Report. SF 519 and SF 519A are obsolete; use for file purposes only if already in existence.

OF 520[1]
Clinical Record—Electrocardiographic Record (formerly SF 520). Reports of electrocardiograph examinations with adequate representative tracings should be attached to the back of OF 520 or on another attached sheet of paper. CAPDD or other automated tracings may substitute for the OF 520.

DA Form 5551-R
Spirometry Flow Sheet. (See TB MED 509.)

DA Form 4060
Report of Optometric Examination. DA Form 4060 is obsolete; use for file purposes only if already in existence.

DD Form 741[1]
Eye Consultation.

Figure 7–1. Forms and documents of the CEMR using DA Form 3444–series jackets or SF 66D folders—Continued

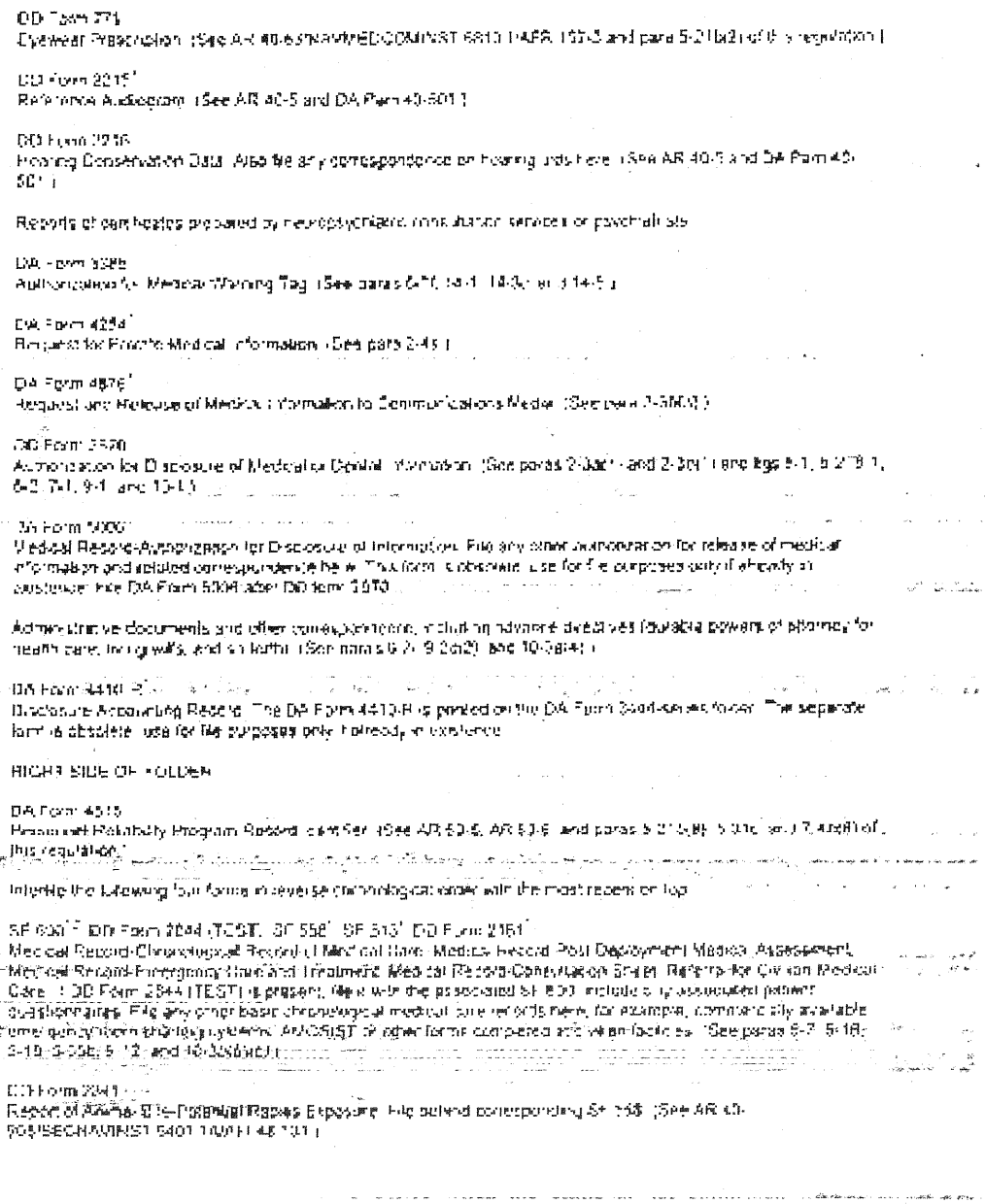

Figure 7–1. Forms and documents of the CEMR using DA Form 3444–series jackets or SF 66D folders—Continued

DA Form 5008
Telephone Medical Advice Consultation Record. Attach to and file with SF 600 in chronological order. (See paras 5–6 and 10–3b(6)(a).)

Other SF 500 series forms. File here in numerical sequence with like form numbers together in reverse chronological order.

DA Form 4700
Medical Record—Supplemental Medical Data. When DA Form 4700 is used, it should be referenced on SF 600. Undersized reports should be mounted on DA Form 4700 display sheets and filed with reports to which they most closely relate. (See paras 3–7a, 3–8, 5–21b(7), 9–2b, and 12–4b(4).) File here any other forms used to record the results of atmospheric sampling.

DD Form 2808
Report of Medical Examination. (See AR 40-501 and paras 3–10g, 5–18d, 5–21b(1), and 5–25a(5) of this regulation.)

SF 88
Report of Medical Examination. This form is obsolete; use for file purposes only if already in existence.

DD Form 2795; DD Form 2796
Pre-Deployment Health Assessment; Post-Deployment Health Assessment. File any DD Form 2795 and the associated DD Form 2796 as a set. (See paras 5–32a, 5–35a, 5–36a(2), and 7–4b(5).)

OSHA Respirator Medical Evaluation Questionnaire. (See para 7–4b(2).)

SF 78
U.S. Civil Service Commission, Certificate of Medical Examination. (See para 7–4b(1).)

DA Form 3437
Department of the Army Nonappropriated Funds Certificate of Medical Examination. (See para 7–4b(3).)

DD Form 2807-1
Report of Medical History. File any other medical history form here. (See AR 40-501 and paras 5–21b(1), 5–25a(5), and 7–4b(2) of this regulation.)

SF 93
Report of Medical History. This form is obsolete; use for file purposes only if already in existence.

DOL Form CA-1
Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation. (See para 7–4b.)

DOL Form CA-2
Federal Employee's Notice of Occupational Disease and Claim for Compensation. (See para 7–4b.)

DOL Form CA-16
Authorization for Examination and/or Treatment. (See para 7–4b.)

DOL Form CA-17
Duty Status Report. (See para 7–4b.)

Figure 7–1. Forms and documents of the CEMR using DA Form 3444–series jackets or SF 66D folders—Continued

DOL Form CA-20
Attending Physician's Report. (See para 7–15.)

DD Form 2005[2]
Privacy Act Statement—Health Care Records. DD Form 2005 is always the bottom form in the CEMR. (See paras 4–4e(9), 5–2a, 7–4a, and 10–3a(1).) A separate DD Form 2005 must be in the CEMR as the CEMR must be rested or transferred in SF 66D folder, which does not have a preprinted DD Form 2005.

Notes:
[1]Instructions for completing this form are self-explanatory.
[2]This form must be included in all CEMRs.

Figure 7–1. Forms and documents of the CEMR using DA Form 3444–series jackets or SF 66D folders—Continued

Chapter 8
Army Substance Abuse Program Outpatient Medical Record

Section I
General

8–1. For whom prepared
An ASAP–OMR will be prepared for each patient enrolled in the ASAP.

8–2. Access
All personnel having access to ASAP–OMRs will protect the privacy of PHI. Care will be taken to prevent unauthorized release of any information on the treatment, identity, prognosis, or diagnosis for substance abuse patients. Requests for release of information will be handled in accordance with chapter 2 of this regulation and AR 600–85, chapter 6, using DA Form 5018–R (Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) Client's Consent Statement for Release of Treatment Information).

8–3. Disclosure of information
a. Requests for release of information from ASAP–OMRs will be handled by the Patient Administration Division in accordance with AR 600–85 and chapter 2 of this regulation. DA Form 5018–R must be completed. Information will be released only under the authority of the Patient Administration Division.

b. The following drug and alcohol laws take precedence over other directives pertaining to access to drug and alcohol rehabilitation information.

(1) 42 USC 290dd–2 prohibits the disclosure of records of the identity, diagnosis, prognosis, or treatment of any patient maintained in connection with a Federal substance abuse program, except under the following circumstances:

(a) The patient consents in writing;

(b) The disclosure is allowed by a court order; or

(c) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

(2) 42 USC 290dd–2 provides no exceptions for civilian employees participating in the Nuclear or Chemical Surety Personnel Reliability Programs (AR 50–5 and AR 50–6), or any DOD or Army personnel security program (AR 380–67).

(3) A "patient" is defined in 42 CFR 2.11 as "any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a Federally–assisted program and includes any individual who, after arrest on a criminal charge, is identified as an alcohol or drug abuser in order to determine that individual's eligibility to participate in a program." An employee does not have to be enrolled in the program in order to be protected by the provisions of 42 USC 290dd–2, so long as the employee falls within this definition of patient.

(4) During the initial screening, or as soon thereafter as possible, the patient will be notified of the Federal confidentiality requirements and will be given a summary in writing of the Federal laws and regulations. A sample notice is contained in 42 CFR 2.22.

(5) A patient may have access to his or her own records, including the opportunity to inspect and copy any records