LUNNEY YOUTH CENTER
YOUTH PROGRAM VOLUNTEER REGISTRATION

ALL COACHES AND ASSISTANT COACHES MUST FILL OUT A COACHES APPLICATION INCLUDING SPOUSES

Name & Rank/ Rate:		E-mail Address: **PLEASE PRINT**
Box #:	Cell Phone:	Duty Phone:
MO/YR arrived to Misawa:	Previous Base:	DEROS:

What programs/activities are you interested in volunteering for?______________________________________

What sport are you interested in coaching?____

Have you volunteered with Youth Programs previously? If yes, how many years and in what capacity ?__________

____

What age groups are you interested in volunteering with?________________________________

Are you CPR and First Aid certified?____

(Please provide a copy of certification)

Please complete ALL paperwork required for all volunteers who wish to work in a position of Youth Activities

I UNDERSTAND AND AGREE THAT:

It is the policy of this organization to deny volunteer opportunities for individuals who have been convicted of any violent crime or any crime against person(s).

This organization has a strict confidentiality and appeals process concerning the handling of application of individuals with prior criminal histories.

By submitting this application I, ____________________________ affirm that all foregoing

Please Print

information I have provided is true and correct. ______________________ ____________

Signature Date

Copy of Updated Immunization Record is needed upon application

***Note for Volunteer Coaches: You may be paired up with another coach depending on the need for coaches, and experience level.**

Privacy act authority: title 10, USC section 8013

Principle purpose: to provide background clearance information regarding prospective youth services providers and family members.

Routine uses: no information is disclosed outside Department of Defense (DoD)

Disclosure: disclosure of required information is voluntary. However. If the information is not provided, applicant may be denied to become a youth services volunteer.

If you fail to tell the truth or fail to list all relevant events of circumstances, this may be grounds for you not being able to provide service, or criminal prosecution.

Right to challenge: you have the right to challenge the accuracy of records under provisions of the DOD Directives 5400.11

YOUTH PROGRAMS VOLUNTEER JOB DESCRIPTION

TITLE: Misawa Youth Programs Volunteer

DESCRIPTION:
*Volunteer for Youth between the ages 3-18
*You will be considered a role model for various numbers of youth; therefore a positive attitude, impartiality, sportsmanship, fair play, and full participation are mandatory

RESPONSIBILITIES:
*Assist, plan and supervise activities/practices and events
*Teach and mentor youth in various environments
*Teach the young athletes the fundamentals of the sport
*Encourage the involvement of the parents & youth in the sport
*Schedule and conduct parent and other necessary meetings
*Provide a safe and fun environment for the youth
****Learn and follow all Youth Programs' rules, policies, and procedures***
*Give each player equal playing time
*Be considerate of all youth emotions
****Put the feelings of the players ahead of your desire to win***
*Attend all league functions and participate in league activities
*Be on time for all activities & events
*Communicate effectively with youth & staff

QUALIFICATIONS:
*Successfully complete the application procedure and pass background checks
*Attend any scheduled volunteer trainings and meetings
*Successfully complete the National Youth Sports Coaches Association (NYSCA) Certification Program prior to the beginning of the season
*Be enthusiastic & patient
*Not want to win at all costs
*CPR and First Aid Training/Certified
*Complete child abuse training
***Be organized**
***Be dependable**

INFORMATION: **As a volunteer, you are treated by local, state, and federal law as being an unpaid employee of the agency in which you are associated with; therefore, you must conduct yourself in the same manner as you would your own job. In the same respect, you will receive the same treatment, aside from compensation and benefits, as the employees of Misawa Youth Programs.**

I agree that I have read and understand the above job description for a youth programs volunteer position, and that I accept the terms of the job description.

____________________	____________________	__________
Applicant Signature	**Name (Printed)**	**Date**

Please note: Failure to sign this page will render the application incomplete and unacceptable.

VOLUNTEER AGREEMENT FOR

☐ APPROPRIATED FUND ACTIVITIES ☐ NONAPPROPRIATED FUND INSTRUMENTALITIES

PRIVACY ACT STATEMENT

AUTHORITY: Section 1588 of Title 10, U.S. Code, and E.O. 9397.

PRINCIPAL PURPOSE(S): To document voluntary services provided by an individual, including the hours of service performed, and to obtain agreement from the volunteer on the conditions for accepting the performance of voluntary service.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however failure to complete the form may result in an inability to accept voluntary services or an inability to document the type of voluntary services and hours performed.

PART I - GENERAL INFORMATION

1. TYPED NAME OF VOLUNTEER *(Last, First, Middle Initial)*	2. SSN	3. DATE OF BIRTH *(YYYYMMDD)*
4. INSTALLATION	5. ORGANIZATION/UNIT WHERE SERVICE OCCURS	
6. PROGRAM WHERE SERVICE OCCURS	7. ANTICIPATED DAYS OF WEEK	8. ANTICIPATED HOURS
9. DESCRIPTION OF VOLUNTEER SERVICES		

PART II - VOLUNTEER IN APPROPRIATED FUND ACTIVITIES

10. CERTIFICATION

I expressly agree that my services are being provided as a volunteer and that I will not be an employee of the United States Government or any instrumentality thereof, except for certain purposes relating to compensation for injuries occurring during the performance of approved volunteer services, tort claims, the Privacy Act, criminal conflicts of interest, and defense of certain suits arising out of legal malpractice. I expressly agree that I am neither entitled to nor expect any present or future salary, wages, or other benefits for these voluntary services. I agree to be bound by the laws and regulations applicable to voluntary service providers and agree to participate in any training required by the installation or unit in order for me to perform the voluntary services that I am offering. I agree to follow all rules and procedures of the installation or unit that apply to the voluntary services I will be providing.

a. SIGNATURE OF VOLUNTEER		b. DATE SIGNED *(YYYYMMDD)*
11.a. TYPED NAME OF ACCEPTING OFFICIAL *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*

PART III - VOLUNTEER IN NONAPPROPRIATED FUND INSTRUMENTALITIES

12. CERTIFICATION

I expressly agree that my services are being provided as a volunteer and that I will not be an employee of the United States Government or any instrumentality thereof, except for certain purposes relating to compensation for injuries occurring during the performance of approved volunteer services and liability for tort claims as specified in 10 U.S.C. Section 1588(d)(2). I expressly agree that I am neither entitled to nor expect any present or future salary, wages, or other benefits for these voluntary services. I agree to be bound by the laws and regulations applicable to voluntary service providers, and agree to participate in any training required by the installation or unit in order for me to perform the voluntary services that I am offering. I agree to follow all rules and procedures of the installation or unit that apply to the voluntary services that I am offering.

a. SIGNATURE OF VOLUNTEER		b. DATE SIGNED *(YYYYMMDD)*
13.a. TYPED NAME OF ACCEPTING OFFICIAL *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*

PART IV - TO BE COMPLETED AT END OF VOLUNTEER'S SERVICE BY VOLUNTEER SUPERVISOR

14. AMOUNT OF VOLUNTEER TIME DONATED				15. SIGNATURE	16. TERMINATION DATE *(YYYYMMDD)*
a. YEARS *(2,087 hours = 1 year)*	b. WEEKS	c. DAYS	d. HOURS		
17.a. TYPED NAME OF SUPERVISOR *(Last, First, Middle Initial)*				b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*

 PREVIOUS EDITION IS OBSOLETE. Exception to Standard Form 50 granted by Office of Personnel Management (OPM) waiver.

NAME (Last, First, Middle Initial)	SSAN (Last 4 digits)	DATE

ADDRESS (Include Zip Code)	HOME TELEPHONE #	DATE OF BIRTH	SEX
			FEMALE
			MALE

MARITAL STATUS	EDUCATION *(Highest Grade Completed)*	OCCUPATION *(Employer / School)*	BUSINESS TEL.
SINGLE / WIDOWED			
MARRIED / DIVORCED			

PARENTS OR GUARDIAN (Name and Address. Include Zip Code	HOME TELEPHONE #	BUSINESS TEL.

REMARKS

I, the undersigned, desire to volunteer my services to the MWR programs at Hill Air Force Base.
I expressly agree that such services are offered at no cost to the US Government or any instrumentality thereof. I expect no present or future compensation as a result of the services to be performed by myself. I understand that the performance of services entitle me to no compensation, either in pay benefits, and I agree that I shall not present any claims against the United States or any agency, instrumentality, or employee thereof.

SIGNATURE OF VOLUNTEER

DATE	ACCEPTED BY (Signature)

AF FORM 2040 PREVIOUS EDITION IS OBSOLETE SEPT 78

MWR VOLUNTEER PERSONAL DATA

Personal Reference's

One must be a current/former supervisor

Date: ______________________

____

Applicant Name

Reference # 1

Name ____

City _____________________________ **State** ____________________________

Home Phone _______________________ Please include area code if in U.S.

Work Phone _______________________ Please include area code if in U.S.

E-mail ____

required

Relation: Supervisor Friend Relatives Co-worker Other

Reference # 2

Name ____

City _____________________________ **State** ____________________________

Home Phone _______________________ Please include area code if in U.S.

Work Phone _______________________ Please include area code if in U.S.

E-mail ____

required

Relation: Supervisor Friend Relatives Co-worker Other

BASIC CRIMINAL HISTORY AND STATEMENT OF ADMISSION
(Department of Defense Child and Youth (C&Y) Programs)

OMB No. 0704-0516
OMB approval expires
May 31, 2017

The public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (0704-0516). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM TO THE APPROPRIATE C&Y PROGRAM REPRESENTATIVE.

PRIVACY ACT STATEMENT

AUTHORITY: Executive Order 10450 and/or Section 231 of the Crime Control Act of 1990 (42 U.S.C. 13041); DoD Instruction 1402.5, Criminal History Background Checks on Individuals in Child Care Services; DoD Instruction 6060.2, Child Development Programs.

PRINCIPAL PURPOSE(S): To require each employee, DoD contractor, family child care provider, adult family member of a family child care provider, and specified volunteers of a DoD C&Y program to undergo a background check and to annually self-report changes to his or her criminal history. This form covers a five year period at the end of which a new form must be initiated. When completed, records are covered by one of the appropriate SORNs:
Army: http://dpclo.defense.gov/privacy/SORNs/component/army/A0608-10_CFSC.html
Navy: http://dpclo.defense.gov/privacy/SORNs/component/navy/NM01754-3.html
Air Force: http://dpclo.defense.gov/privacy/SORNs/component/airforce/F034_AF_SVA-C.html

ROUTINE USES: This form is to be used for DoD C&Y programs only. This form will be initiated by C&Y program staff and will be maintained in C&Y program offices.The DoD "Blanket Routine Uses" found at http://dpclo.defense.gov/privacy/SORNs/blanket_routine_uses.html may apply to these records.

DISCLOSURE: Voluntary; however, failure to furnish all requested information may result in an unfavorable adjudication decision and may affect suitability of working with or around children.

1. NAME *(Last, First, and Middle Name) (Do not use initials or abridgements.)*

2. OTHER NAME(S) USED

3. PLACE OF BIRTH *(City, State, Country)*

4. DATE OF BIRTH *(MM/DD/YYYY)*

5. GENDER *(X one)*
☐ Male ☐ Female

6. INSTALLATION/PROGRAM NAME

7. DATE OF HIRE *(To be completed by CDP staff only)*

8.a. Have you ever been arrested, charged, or convicted by Federal, State, or other Law enforcement authorities for any violation of any Federal law, Military law, State law, County or Municipal law, Regulation or Ordinance? (Do not include anything that happened before your 16th birthday. Leave out traffic fines of less than $300.) *(X one)*

☐ Yes ☐ No If you answered "Yes," explain your answer in the space provided below.

b. Have you ever been arrested, charged or held by Federal, State or Other Law Enforcement Authorities for any crime or offense involving any of the following: Mark Yes or No for each category. Failure to provide information may result in an unfavorable adjudication decision. All other charges must be included in the space provided below even if they were dismissed. If you answered "Yes," explain your answer in the space provided below.

CHILD: ☐ Yes ☐ No DRUG OR ALCOHOL: ☐ Yes ☐ No VIOLENT CRIME/ ASSAULTIVE BEHAVIOR: ☐ Yes ☐ No
SEX CRIME: ☐ Yes ☐ No DOMESTIC VIOLENCE: ☐ Yes ☐ No OTHER: ☐ Yes ☐ No

(1) MONTH/ YEAR	(2) OFFENSE	(3) ACTION TAKEN	(4) LAW ENFORCEMENT AUTHORITY OR COURT *(City & Country if outside the United States)*	(5) STATE	(6) ZIP CODE

9. ANNUAL CERTIFICATIONS.
In the past year, I have not been arrested, charged or held by law enforcement in regard to anything mentioned in block 8 above.

☐ Yes ☐ No If you answered "Yes," explain your answer in the space provided on the back of this form.

a. INITIAL CERTIFICATION (1) Signature		(2) Date *(YYYYMMDD)*			
b. 2nd YEAR *(X as above)* ☐ Yes ☐ No	(1) Signature	(2) Date *(YYYYMMDD)*	c. 3rd YEAR *(X as above)* ☐ Yes ☐ No	(1) Signature	(2) Date *(YYYYMMDD)*
d. 4th YEAR *(X as above)* ☐ Yes ☐ No	(1) Signature	(2) Date *(YYYYMMDD)*	e. 5th YEAR *(X as above)* ☐ Yes ☐ No	(1) Signature	(2) Date *(YYYYMMDD)*

Failure to disclose accurate information may be grounds for dismissal, termination, or disbarment from participating in the program.

BASIC CRIMINAL HISTORY AND STATEMENT OF ADMISSION

10. NOTES *(Use this space to enter additional comments.)*

11. AUTHORIZATION AND RELEASE CERTIFICATION

I hereby authorize the Department of Defense and other authorized federal agencies to obtain any information required from the Federal government, and/or state agencies, and/or foreign governments, including but not limited to, the Federal Bureau of Investigation (FBI), the Defense Investigation Service (DIS), the U.S. Office of Personnel Management (OPM), the Department of Homeland Security (DHS), (if applicable), and from the State Criminal History Repository for each state where I have resided and worked. This authorization is valid for one year from the date this form was signed or upon termination of my affiliation with the Federal Government, whichever is sooner.

I have been notified of any employer's or Agency's right to require a criminal history records check as a condition of employment. I understand that I may request a copy of such records as may be available to me under the law. I understand that I have a right to challenge the accuracy and competencies of any information contained in the criminal history records check report. I also understand that pursuant to the Privacy Act, the information collected will be confidential, and disclosure limited to purposes authorized under the Privacy Act - mainly to conduct the background check.

I release any individual, including records custodians, any component of the United States Government or the individual State Criminal History Repository supplying information, from all liability for damages that may result on account of compliance, or any attempts to comply with this authorization. This release is binding, now and in the future, on my heirs, assigns, associates, and personal representative(s) of any nature. Copies of this authorization that show my signature are as valid as the original release signed by me.

I declare under penalty of perjury that the statements made by me on this form are true, complete and correct. In addition to the annual certification, I understand that it is my responsibility to immediately inform my employer/supervisor if I am charged with a crime referenced in block 9 above.

WARNING: False statements are punishable by law and could result in fines and/or imprisonment for up to five years.

a. SIGNATURE	b. DATE SIGNED

INSTRUCTIONS FOR COMPLETING DD FORM 2981

This Department of Defense Form is to be completed by prospective employees and/or volunteers upon application for any position within a Department of Defense Child or Youth Program. The form will be utilized for initial and annual certification that said employee/ volunteer has not been arrested, charged, or convicted by Federal, State, or other Law enforcement authorities for any violation of any Federal law, Military law, State law, County or Municipal law, Regulation or Ordinance, nor have they been arrested, charged or held by Federal, State or Other Law Enforcement Authorities for any crime or offense involving any of the following: Crime involving a child, sex crime, drug or alcohol offense, domestic violence, violent crime/assaultive behavior, or other.

Completion of this form is voluntary; however, failure to furnish all requested information may result in an unfavorable adjudication decision and may affect suitability of working with or around children.

1. Provide your last, first and middle name. Do not use initials or abridgements.

2. Provide any other names used to include maiden name.

3. Provide your place of birth to include city, state and country.

4. Provide your date of birth in mm/dd/yyyy format.

5. Provide gender.

6. Provide the installation or DoD CY program where you seek employment or to volunteer.

7. Provide the date of hire. *This is to be completed by CDP staff only.*

8. a. Place an X in the appropriate box if you have or have not been arrested, charged, or convicted by Federal, State, or other Law enforcement authorities for any violation of any Federal law, Military law, State law, County or Municipal law, Regulation or Ordinance? *(Do not include anything that happened before your 16th birthday. Leave out traffic fines of less than $300.)*

8. b. Place an X in the appropriate box if you have been arrested, charged or held by Federal, State or Other Law Enforcement Authorities for any crime or offense involving any of the following: Mark Yes or No for each category. Failure to provide information may result in an unfavorable adjudication decision. All other charges must be included in the space provided below, even if they were dismissed. If you answered “Yes,” explain your answer in the space provided below.

8. b. 1-6 Provide all specifics to any arrests, charges, or convictions in the provided space. If additional space is needed, use block 10.

9. On an annual basis, place an X in the appropriate box indicating if you have or have not been arrested, charged or held by law enforcement in regard to anything mentioned in block 8 above.

NAF Application Continuation Form

Applicants for positions that require working with children under the age of 18 must complete the following:

1. Have you ever been arrested for or charged with a crime involving children?

   ☐ Yes ☐ No

   If yes, please provide a description of the disposition of the charge or arrest in the space below. At a minimum, state the date and location of the incident giving rise to the charge or arrest, the law enforcement agency that investigated, and the name and address of the court that adjudicated the charge or arrest, and the disposition of the charge or arrest.

2. Have you ever been arrested for or charged with a crime involving drugs or alcohol?

   ☐ Yes ☐ No

   If yes, please provide a description of the disposition of the charge or arrest in the space below. At a minimum, state the date and location of the incident giving rise to the charge or arrest, the law enforcement agency that investigated, and the name and address of the court that adjudicated the charge or arrest, and the disposition of the charge or arrest.

This is to advise that if you are accepted for employment the Air Force is required to request a State Criminal History Repository Check as a condition of your employment. You have a right to obtain a copy of the criminal history report and challenge the accuracy of any information contained in the report.

I declare under penalty of perjury that the foregoing is true and correct. I understand the penalty for perjury is a fine up to $2,000 or imprisonment for up to 5 years, or both.

Signature:____ Date:____________________

Typed or printed Name: __________________________________

ACKNOWLEDGEMENT OF RIGHTS AND CONSENT TO RELEASE RECORDS

AUTHORITY

42 U.S.C. 13041 and 10 U.S.C. 8013

PRINCIPAL PURPOSE

To comply with Public Law 101-647, Section 231, and DoDI 1402.5, Criminal History Background Checks on Individuals in Childcare Services.

DISCLOSURE

Mandatory. In the case of an applicant for employment in a position involved with children under the age of 18, refusal to sign this form shall result in the employer's refusal to consider the application for employment. In the case of an incumbent of a position involved with children under the age of 18, refusal to sign this form shall result in removal from such position.

EMPLOYEE ACKNOWLEDGEMENT

1. I have been advised and understand that the United States Air Force, as a Federal employer, has an obligation to require a record check as a condition of my employment in a position involved with children under the age of 18. I have been further advised that I have a right to obtain a copy of any criminal history report made available to such employer or potential employer and to challenge the accuracy and completeness of any information included in such report.

2. I understand that the record check may include the following:

   a. A State Criminal History Repository Check in the state where I currently reside and in states where I have formerly resided;

   b. An Installation Records Check at all installations I have identified as residences during the preceding 2 years. This records check will include, at a minimum, a file check of Security Forces Management Information System (SFMIS) which affords global background investigative data for all Air Force installations; Family Advocacy's Air Force Central Registry which includes all drug and alcohol program files, medical treatment facility files, mental health, and life skills files; Family Housing files; and any other record checks as appropriate to the extent permitted by law;

   c. A National Agency Check with inquiries, including a Federal Bureau of Investigation fingerprint check; and

   d. A name check of the Dru Sjodin National Sex Offender Registry.

3. I hereby authorize any Federal, State, or local agency or office to release any record relating to me that is necessary to complete the record checks as described above.

[

SIGNATURE: ____ DATE: ____________________

PRINTED NAME: ____________________________________

DEPARTMENT OF THE AIR FORCE
35TH FIGHTER WING (PACAF)
MISAWA AIR BASE, JAPAN

MEMORANDUM FOR SECURITY FORCES/FAMILY ADVOCACY/ALCOHOL AND DRUG PREVENTION AND TREATMENT/AFOSI

FROM: 35 FSS/FSMH

SUBJECT: Installation Records Check

1. The individual listed below has applied for a volunteer, contract, family child care or paid position within Child and Youth Programs. In accordance with DoDI 1402.05 and AFI 34-144, the position is subject to a records review. An Installation Record Check (IRC) is required for individuals with DoD affiliation who work with children under 18 years of age. The IRC must include a records check with **Security Forces (SFMIS)/Alcohol and Drug Prevention and Treatment (ADAPT)/Family Advocacy (Central Registry)/AFOSI (DCII & I2MS)**.

APPLICANT'S NAME: ______________________________ APPLICANT'S SSN: ____________________

ADDRESS: ____ PHONE NUMBER: ______________________

PLACE OF BIRTH: ________________________________ DATE OF BIRTH: ______________________

SPONSOR'S NAME: ________________________________ SPONSOR'S SSN: ______________________

SPONSOR'S SIGNATURE: ____________________________________ DATE: ____________________

2. Do your records indicate any reason why this individual should not perform duties involving children? If so, please provide details in the remarks section.

3. Because applicants must have a favorably completed IRC before they can be appointed to a position, the IRC must be processed as quickly as possible. Any delays in this process could have an adverse affect on Child and Youth Programs. If you have any questions, please do not hesitate to contact our office at 226-3108 or e-mail at 35fss.hro@us.af.mil. Thank you for your assistance.

WENDI L. FINKENHOEFER, GS-11, DAF
HUMAN RESOURCES OFFICER, NAF

Attachment

1st IND

To: 35 FSS/FSMH

1. I certify a records check as required by DoDI 1402.05 and AFI 34-144 has been completed pertaining to the above named individual(s) has been completed and disclosed the following:

_____ No record of applicant _____ Record on file

2. Information which may affect individual's suitability to work with children:____

3. PRINTED NAME/OFF SYM/POSITION/CONTACT NUMBER SIGNATURE/DATE

____

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
	☐ OUTPATIENT ☐ INPATIENT ☐ BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE ________________________________ TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
c. TELEPHONE *(Include Area Code)*	d. FAX *(Include Area Code)*

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

☐ PERSONAL USE	☐ CONTINUED MEDICAL CARE	☐ SCHOOL	☐ OTHER *(Specify)*
☐ INSURANCE	☐ RETIREMENT/SEPARATION	☐ LEGAL	

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION
	☐ DATE *(YYYYMMDD)* ☐ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
☐ AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	
	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:

AUTHORIZATION FOR DISCLOSURE OF SUBSTANCE ABUSE RELATED RECORDS

Privacy Act Statement

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used.
AUHORITY: 42 CFR Part 2; 42 U.S.C 290dd-2; E.O. 9397 (SSAN); DoD 1010.4; Public Law 104-191; DoD 6025.18-R.
PRINCIPLE PURPOSE(S): This form is to provide the Military Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information with respect to Substance Abuse related records.
ROUTINE USES: To any third party or the individual upon authorization for the disclosure from the individual for: legal; continued medical care; security clearance check; personal use; or for other reason.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2; 42 U.S.C 290dd-2) prohibit you from making further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Section 1 – Patient Data

1. NAME (Last, First, Middle Initial)	2. Sponsor's SSN	3. Date of Birth *(YYYYMMDD)*:

4. Patient's Address (Street, City, State, ZIP Code)	5. Patient's Telephone Number
PSC 76 BOX APO AP 96319	

Section 2 – Disclosure

6. I AUTHORIZE **35 MDG** TO RELEASE MY PATIENT INFORMATION TO:

a. NAME OR TITLE OF PERSON OR ORGANIZATION	b. ADDRESS (Street, City, State, ZIP Code)
NAF Human Resources Office 35 FSS/FSMH	UNIT 5019 APO AP 96319
c. TELEPHONE (Include Area Code) 315-226-3108	d. FAX (Include Area Code) N/A

7. Purpose or Need for the Information

	Legal		Continued Medical Care		Security Clearance Check		Personal Use (**COPY OF MY RECORD**)	X	Other (Specify): PRE-EMPLOYMENT CHECK

8. Information to be Released (or Copied for Personal Use):
Pre-employment IRC (Installation Records Check)

9. Start Date *(YYYYMMDD)*:	10: Expiration Date:	Or Action Completed ☐

Section 3 – Release Authorization (I understand that):

a. I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on this authorization. My revocation must be in writing and provided to the facility where my records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF/DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used my protected health information on the basis of this authorization.
b. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR § 164.524.
c. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment, payment, enrollment or eligibility on the failure to obtain this authorization.

11. Signature of Patient or Legal Representative:	Relationship to Patient:	Date *(YYYYMMDD)*:
12. Signature of Witness (If required by State Law):		Date *(YYYYMMDD)*:

Section 4 – FOR STAFF USE ONLY (To be completed only upon receipt of written revocation)

13. Authorization Revoked	14. Revocation completed by	15. Signature	Date *(YYYYMMDD)*: