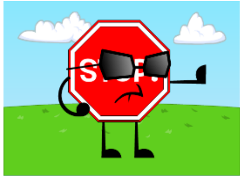

Before You Start:

Please note, all medical records requests must be send with a valid photo ID, so that we can verify identity.

Who Can Request Information?

Per South Carolina law, any person **sixteen years old or above** must request their own medical documentation. A parent, family member, sponsor or spouse cannot sign an authorization for the person age 16 or older without a **Medical Power of Attorney** on file. If you do not have a Medical Power of Attorney, the patient can authorize you to receive their records for them by specifying you in Box 6a of the form. These requests must be presented with a valid photo ID from **both the patient and the recipient.**

How to fill out the DD form 2870

Below are step-by-step instructions explaining what information goes in each box in the form.

1. **Name** - Name of person whose information is being requested (yourself, dependent, applicant)
2. **Date of Birth** – Date of birth of person whose information is being requested
3. **Social Security Number** – SSN or DOD ID of the Patient, or of the patient's sponsor
4. 4. **Period of Treatment** – Time frame in which you're looking for records. (E.g. "20170428 to 20180825" if you only need documentation for the stated date range, or "All" if you are requesting all documentation on file for you.)
5. **Type of Treatment** – Documentation from outpatient care, inpatient care, or both.
6. **"I Authorize _____"** – Who is releasing your information. If you are requesting your information from Moncrief, leave this box as is. If you are requesting information from an outside facility to be sent to Moncrief, enter the name of that facility.
   a. **Name of Physician, Facility, or Tricare Health Plan** – The person the information will be sent to. If you are picking up a copy of your records, put your name here. If you are authorizing another person to pick up your records, put their information here.
   b. **Address** – mailing and/or email address the records will be sent to.
   c. **Telephone** – the contact phone number for the person receiving this documentation
   d. **Fax** – the fax number, if applicable, that the records will be sent to.
7. **Reason for Request/Use of Medical Information** – check the box that explains how your records copy will be used.
8. **Information to be Released** – The specific documentation you are requesting (e.g. "all bloodwork results," "recent MRI report," or "all medical records")*
9. **Authorization Start Date** – The day you are authorizing us to release these records. This day will always be the same date you fill out the form.
10. **Authorization Expiration** – One year from the day you authorized us to complete the request (e.g., if your authorization start date is 20220817, your authorization end date is 20230817)

11. **SIGNATURE OF THE PATIENT/PARENT/LEGAL REPRESENTATIVE** – signature of individual authorized to request these records, such as yourself, the parent/sponsor, or the person who hold the patient's medical power of attorney.
12. **RELATIONSHIP TO PATIENT** – How the signer is related to patient. If you are the patient, put "self"
13. **DATE** – the date you are completing the form.

*please see Additional Requirements below to learn which types of information may need additional documentation on the form.

ADDITIONAL REQUIREMENTS

If you are requesting certain types of documentation, additional information is needed on the form, even if you have indicated that you want all of your records.

1. **MENTAL HEALTH (MH) /PSYCHIATRIC DOCUMENTATION** – If you have ever been seen for mental health, or have had a psychiatric evaluation, please add that you need Mental Health to box 8. This information must be reviewed by the providers here before it can be released, and that specific information is required.
2. **FAMILY ADVOCACY PLANNING (FAP)/SOCIAL WORK** – If you have any social work documentation in your record, you must add that you need FAP in box 8, and explain why you need this documentation.
3. **ALCOHOL AND SUBSTANCE ABUSE PROGRAM/SUBSTANCE USE DISORDER CLINICAL CARE PROGRAM (ASAP/SUDCC)** – If you need documentation related to substance abuse treatment, indicate that you need your ASAP/SUDCC documentation in box 8, and why you need it.
4. **RADIOLOGY IMAGING** – If you need radiology reports (the written note of what was found on your ultrasound/xray/mri), this does not need to be specified. However, radiology imaging (the pictures from the ultrasound/xray/mri) must be specially requested, as they can only be provided on discs generated from the radiology department. Please note, special software is required to read the imaging discs, so most patients will not be able to read their own discs. Please take this into account before requesting imaging.