Armed Forces Health Surveillance Branch
11800 Tech Road #200, Silver Spring, MD 20904

Clinical Data Request Form

Fill out all applicable areas of the form, sign, and submit via DoD SAFE (https://safe.apps.mil). Follow the prompts to upload the document(s). Please include a note to the recipient identifying the request as a "Test History Request" and select "Encrypt every file" as is required for PII/PHI.

Please allow 2 business days for a response. For urgent requests, call (DSN) 285-3240 or (301) 319-3240.

Section A: Requestor Information

Name (Last, First, MI):	
Rank/Service/Component:	
MTF/Location:	
Email Address:	
Phone (Comm/DSN):	

Section B: Patient Information (fill out one form per patient)

Name (Last, First, MI):			
Rank/Grade:			
Service/Component:			
Date of Birth (DD/MON/YYYY):			
FMP:		SSN:	

Section C: Requested Data (check all that apply)

Dates of care (DD/MON/YYYY): from_____ to _____

☐ 1. Deployment Health Assessment ☐ 2. Ambulatory Care ☐ 3. Inpatient Care

☐ 4. HIV Results ☐ 5. Other (including serum): _____

Reason for Request:

Serum Volume (if applicable):

Comments: _____

Section D: Signature

1. The requestor is aware of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 pertaining to safeguarding personal or protected health information. The requestor will assure these requirements are followed to protect the confidentiality of the data and prevent unauthorized disclosure, use, or access to it.
2. The requestor will not disclose, release, or otherwise disseminate the data and certifies that it is necessary to provide medical care to the patient.

_____

Signature of Data Requestor Date