

**AUTHORIZATION AND TREATMENT STATEMENT**

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - See Reverse)

<b>I. ADMISSION (CLINIC PERSONNEL OR PROVIDER FILLS IN CIRCLED ITEMS)</b>													
1. REGISTER NO.		NBSUF		2. NAME (Last, First, Middle Initial)				3. RELIGION					
4. FACILITY CODE		5. MEDICAL TREATMENT FACILITY				6. TIME OF ADM		7. DATE OF ADM		8. TYPE OF CASE			
9. FMP		SSN		10. BENEF TYPE		11. GRADE	12. AFSC	13. AVIATION SVC CODE		14. RATING	15. LENGTH OF SVC		16. AGE
17. SEX	18. MARITAL STATUS	19. RACE/COLOR	20. ZIP CODE		21. CURRENT ORGANIZATION				22. INPATIENT UNIT				
23. FAC INT ADM CODE		24. FACILITY OF INITIAL ADMISSION				25. DATE INITIAL ADM		26. ROOM		27. BED			
28. PRIOR ADM <input type="checkbox"/> YES <input type="checkbox"/> NO		29. CLINIC SERVICE (S)				30. ADMISSION CLERK							
31. EMERGENCY ADDRESSEE/RELATIONSHIP						32. NAME AND ADDRESS OF SPONSOR							
33. PRIMARY ADMISSION DIAGNOSIS						34. SECONDARY ADMISSION DIAGNOSIS							
35. CAUSE OF INJURY													
36A. DEPOSIT VALUABLES FOR SAFEKEEPING <input type="checkbox"/> YES <input type="checkbox"/> NO		36B. I have read and understand the Privacy Act and Disengagement Statements on the reverse of this form.			SIGNATURE OF PATIENT OR SPONSOR				37. ADMITTING PROVIDER				
<b>II. TREATMENT</b>													
38. DIAGNOSES - PROCEDURES										39. PROVIDERS OF CARE			
LOD: <input type="checkbox"/> YES <input type="checkbox"/> EPTS, LOD not applicable <input type="checkbox"/> AF Form 348 (Check <input type="checkbox"/> if continued on reverse)										(Check <input type="checkbox"/> if continued on reverse)			
40. ADMINISTRATIVE DATA (Change in physical profile required <input type="checkbox"/> YES (Prepare AF Form 422) <input type="checkbox"/> NO)										(Meal Card <input type="checkbox"/> YES <input type="checkbox"/> NO)			
										(Check <input type="checkbox"/> if continued on reverse)			
41. DISPOSITION			42. DATE OF DISPOSITION	43. TIME OF DISPOSITION	44. CC OF WHOLE BLOOD		45. CC OF PACKED CELLS		46. CONVALESCENT LEAVE				
									TAKEN	RECOMMENDED			
47. SIGNATURE OF ATTENDING HEALTH CARE PROVIDER						48. SIGNATURE OF PATIENT AFFAIRS OFFICIAL							

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### **About the ITAOP/savePDF Method**

The traditional Field-by-Field creation process is extremely ineffective and slow.

The only realistic option to create high-quality forms is the Insert-Text-Anywhere-on-Page (ITAOP) method.

The field creation process is about 10,000 times faster than the traditional method; the list of ITAOP features is not even available for the traditional method.

ITAOP savePDF method proved to be very simple and completely reliable for millions of users all over the world (incl. individuals, companies, organizations, government employees).

**PRIVACY ACT STATEMENT - HEALTH CARE RECORDS**

*THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU*

1. **AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)**  
*Section 133, 1071-87, 3012, 5031, and 8012, Title 10, United States Code and Executive Order 9397.*
  
2. **PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED**  
*This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.*
  
3. **ROUTINE USES**  
*The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignment; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.*
  
4. **WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION**  
*In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.*  
  
*This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.*  
  
*YOUR SIGNATURE ON THE FRONT OF THE FORM ACKNOWLEDGES THAT YOU HAVE BEEN ADVISED OF THE ABOVE. IF REQUESTED, A COPY OF THIS FORM WILL BE FURNISHED TO YOU.*

**DISENGAGEMENT STATEMENT**

*I Hereby acknowledge that my admission to this medical facility is subject to the availability of space and capabilities of the medical staff. I further acknowledge that, upon determination by the Commander of this hospital that space is no longer available or that the medical staff is no longer capable of providing me the required care, I may be discharged or transferred to a civilian source of care under the COST-SHARING PROVISIONS OF CHAMPUS, OR AT MY OWN EXPENSE (active duty personnel are excepted). In such event, if time and circumstances permit, either I or my next of kin will be consulted concerning my options prior to my discharge or transfer.*