

Exceptional Family Member Program (EFMP)
SUPPLEMENTAL AUTHORIZATION FOR DISCLOSURE OF
MEDICAL INFORMATION TO INSTALLATION EFMP PERSONNEL

PURPOSE: In order for installation EFMP personnel to more easily identify specific Federal, State, public and private resources to assist my Exceptional Family Member (EFM), those persons may need access to health information contained in Form 2792 and 2792-1. The following is a voluntary grant of additional authority for HQMC EFMP to release that information to installation EFMP personnel. *Failure to provide this consent will prevent installation EFMP staff from effectively providing you assistance in obtaining Federal, State, public and private resources and preclude access to some EFMP services, including but not limited to, EFMP respite care.*

WHO MAY GIVE AUTHORIZATION FOR DISCLOSURE: Each adult family member must sign for the release of his/her own health information. The sponsor or spouse cannot authorize the release of information for those dependent family members who have reached the age of majority.

- a. In addition to the authorization for disclosure granted by me in DD Form 2792 signed and dated _____, I hereby authorize HQMC EFMP to release health information contained in that DD Form 2792 and in Form 2792-1 signed and dated _____ **TO INSTALLATION EFMP PERSONNEL** who require it in the performance of their duties in supporting the needs of my EFM. They may not disclose this information to anyone else without my express authorization.
- b. I give this authorization with the understanding that neither my Personally Identifying Information (PII) nor Privacy Act protected information will be stored on thumb drives or lap to computers without encryption.
- c. By signing this authorization, I understand that I may withdraw this consent at anytime in writing by contacting DC M&RA (MRZ-2), at 3280 Russell Road, Quantico, VA 22134, or (866) 464-6110, or by contacting my installation EFMP Manager.
- d. This authorization begins on the date I have signed below and will expire when my EFMP enrollment ends or when I revoke the authorization in writing.

Signature: _____
Signature of EFM, parent or guardian

Date: _____

Name: _____
Name(s) of Signature (& I/A EFM)

Sponsor's Name: _____

Preferred Email Address: _____