DEFENSE HEALTH AGENCY
KENNER ARMY HEALTH CLINIC
700, 24TH STREET
FORT LEE, VIRGINIA 23801

KAHC-Policy Memorandum 25-43
June 25, 2025

MEMORANDUM FOR KENNER ARMY HEALTH CLINIC

SUBJECT: Policy #43 Protecting Health Information.

Reference:
(a) DoDM 6025.18, Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DOD Health Care Programs, March 13, 2019
(b) DODI 8580.02, Security of Individually Identifiable Health Information in DoD Health Care Programs, March 13, 2019
(c) DoDM 5400.11, Volume 2 DOD Privacy and Civil Liberties Programs: Breach Preparedness and Response Plan, May 06, 2021
(d) DODI 5400.11, DOD Privacy and Civil Liberties Program, December 8, 2020
(e) Defense Health Agency (DHA) Procedures Manual 6025.02 Volume 1, DOD Health Record Lifecycle Management, November 23, 2021
(f) DHA Procedural Instruction, 8140.01 Acceptable Use of Defense Health Agency Information Technology, October 16, 2018
(g) DHA Procedure Instruction 6040.04, Guidance for Amendment and Correction of Entries in Garrison Electronic Health Records (EHRs), February 21, 2020
(h) Army Directive 2020-13 Disclosure of Protected Health Information to Unit Command Officials, October 26, 2020
(i) Military Health Systems (MHS), Notice of Privacy Practices (NoPP),October 01, 2013
(j) AR 608-18 Family Advocacy Program (FAP), October 30, 2007
(k) AR 600-85 The Army Substance Abuse Program (ASAP), July 23, 2020
(l) 45 CFR 164-522 (a) (3), 164.522 (a) (2)
(m) Public Law 104-191, Health Insurance Portability and Accountability Act (HIPAA) of 1996
(n) The American and Recovery and Reinvestment Act of 2009
(o) Virginia State Law- Section 32.1.127.1:03; Sections E and F of the Health Privacy Records
(p) Unauthorized Use of Electronic Health Record (EHR) System, KAHC, September 14, 2024

KAHC Policy Memorandum 25-43
June 23, 2025

This policy outlines procedures for privacy protection, disclosures, restrictions, amendments, and sanctions related to Protected Health Information (PHI) and Personally Identifiable Information management at Kenner Army Health Clinic, (KAHC) Fort Lee, VA. This policy applies to all Fort Lee KAHC staff, business associates and patients. The local policy is current, pending updated DHA HIPAA policy review and signature. See appendices A-M.

Please address questions regarding this KAHC-Policy Memorandum to the Patient Administrative Division, HIPAA Compliance Officer Kimberly A. Murell at kimberly.a.murrell.civ@health.mil

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JOANNA A. BAILEY
LTC, USA
Director

Attachments:

A. Protecting Health Information
B. Custody and Control of Medical Records
C. Disclosure Accounting
D. Requests for Personal Health Information
E. Requests to Restrict the Release of Personal Health Information
F. Special Considerations for the Release of Information for Minors
G. Breach Response and Notification
H. Requests for Amendment of Medical Records
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J. Release of Civilian Employee Medical Records
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L. HIPAA Privacy Officer Roles and Responsibilities
M. Unauthorized Use of the Electronic Health Record

Attachment A
Protecting Health Information

1. POLICY

a. One of the goals of the Health Insurance Portability and Accountability Act (HIPAA) is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and to promote quality health care. Additionally, it allows for patients to have access, disclosure, privacy, and amendment rights to their protected health information.

b. DHA policy mandates the confidentiality of Protected Health Information (PHI) of both living and deceased individuals. PHI will only be disclosed as authorized by law and regulation.

c. Access to PHI and Personally Identifiable Information (PII is role based as PHI is viewed by clinical and administrative personnel in carrying out official duties and to maintain health care documentation.

d. The HIPAA Privacy Officer (HPO) will determine by category of personnel the role-based access to PHI. Both immediate supervisors and the HPO must ensure that all staff members with access to PHI/PII receive HIPAA training within 30 days of their assignment to KAHC and annually thereafter.

e. The HPO is responsible to monitoring all HIPAA training in DHA JKO for the Covered Entity (CE) to ensure compliance of its workforce members. HIPAA Privacy and Security training must be made available to the HPO and HIPAA Security Officer (HSO). KAHC staff members who do not maintain compliance will immediately lose access to PHI including access to any DHA computer networks.

f. The HSO and the HPO are responsible for conducting random inspections to ensure staff compliance with applicable policies and regulations regarding the safeguarding of PHI/PII. Inspections and Findings are being tracked.

2. PROCEDURES:

All military, civilian, and contractor personnel including unpaid volunteers and interns must complete initial and annual HIPAA training prior to having access to PHI/PII. DHA Joint Knowledge Online (JKO) is the official training site sanctioned the Department of Defense. The HIPAA and Privacy Act Training Course - DHA-US001 can be accessed at the following link: https://jkodirect. iten. mil/Atlas2/page/login/Login. isf?ORG=MHS. Additionally face to face HIPAA and Privacy Act training is included in the monthly Fort Lee KAHC Newcomer's Brief given the first Tuesday of the month. Any emails containing a limited amount of PHI/PII will be encrypted in Outlook.

There will be no PHI/PII in the subject line along with Controlled Unclassified Information (CUI) markings. In addition to the following disclaimer is added at the bottom of the email:

"This document may contain information covered under the Privacy Act, 5 USC 552(a), and/or the Health Insurance Portability and Accountability Act (PL 104-191) and its various implementing regulations and must be protected in accordance with those provisions. Healthcare information is personal and sensitive and must be treated accordingly. If this correspondence contains healthcare information, it is being provided to you after appropriate authorization from the patient or under circumstances. that do not require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality subjects you to application of an appropriate sanction. If you have received this correspondence in error, please notify the sender at once and destroy any copies you have made. "

a. To send PHI/PII staff will use DOD-SAFE application. This application allows for sending large amounts of PHI/PII encrypted with use of a para phrase to the sender.

b. Whenever hardcopy records or copies thereof are being mailed or couriered a SF 901, CUI Cover Sheet is placed on the front. Any outbound hardcopy records will be shipped United States Postal Service (USPS) Certified for tracking purposes.

c. Staff will reasonably safeguard PHI from any intentional or unintentional use that is in violation of the regulations and standards by implementing administrative, physical, and technical safeguards as applicable.

d. All business arrangements involving the use or exposure (regular and potential) to PHI, whether in the form of contracts as well as more informal Memorandums of Understanding (MOU), will include language outlining responsibilities for protecting patient privacy and safeguarding PHI. All agreements will include the Defense Health Agency's (DHA) Business Associate Agreement (BAA).

e. All new staff members are required to in-process with the HIPAA Privacy Officer (HPO) to ensure the mandatory training will be completed. This will be accomplished by the supervisor attaching DHA JKO training certificate with account requests applications for network access. Access will only be granted upon verification of mandatory training. Violations of the agreement are subject to the HIPAA Sanction Policy.

f. The HIPAA Privacy Officer (HPO) has been granted administrative privileges on JKO to verify training completion utilizing the JKO "Report Builder" menu. In addition, the HPO maintains an Excel spreadsheet for all staff under KAHC and subordinate organizational structure in JKO.

g. Each month, in addition to the reminder email automatically generated by JKO, the HPO will track staff training to ensure compliance.

h. A hard copy of the JKO training certificate for the HIPAA course is filed in each staff member's Competency Assessment Folder (CAF) within the respective section. DHA uses JKO for compliance tracking for its subordinate commands and reports the status at the end of each calendar month.

i. If refresher training has NOT completed training after two days of delinquent date, the Director/Commander has authorized removal of computer access. Extenuating circumstances will be honored on a case-by-case basis.

j. Any user whose account was disabled due to non-compliance in training is reported to their respective OIC, NCOIC, and Deputy of their assigned area. Employee will. complete training in the IMD training classroom. Give a copy of HIPAA certificate to HPO or HSO so that computer access can be restored.

k. Random inspections are conducted by the HPO/HSO to monitor compliance and assess potential risk. Inspections and findings are tracked internally and performed monthly. All violations are documented. The HPO/HSO will notify chain of command and supervisory channels as they maintain responsibility over the recommendations of administrative and disciplinary actions.

Attachment B
Protecting Health Information

1. POLICY:

a. In accordance with DHA PM 6025. 02 Vol 2, beneficiaries are not allowed to hand carry their original Service Treatment Record (STR)/ Non-Service Treatment Record (NSTR) to medical appointments or to another duty station during a Permanent Change of Station (PCS). KAHC utilizes the Armed Forces Health Longitudinal Technology Application (AHLTA)/ MHS Genesis, an electronically based medical record linked to all Department of Defense Health Readiness Platforms (HRP).

b. Beneficiaries may request one (1) copy of their medical records at no charge by submitting a request through the Release of Information (ROI) office. A full record copy requested once and there after only updates for future dates. Service members enrolled in the Independent Disability Evaluation System (IDES) programs will receive a copy from their STR from their Physical Evaluation Board Liaison Officer (PEBLO) in Patient Administration Division located on the 2nd floor.

c. A sponsor cannot receive medical information of adult family members without the adult family member authorizing the release by signing a DD 2870 or presenting a valid Medical Power of Attorney to the medical records office.

d. No information pertaining the identity, treatment, prognosis, diagnosis, or participation in the Substance Use Disorder Clinical Care (SUDCC) will be released in accordance with AR 600-85. Both military and non-military personnel enrolled in SUDCC will be entered electronically in AHLTA/ MHS Genesis. Requests for information from the SUDCC-OMR will be handled strictly by PAD and require completion of a DA Form 5018. SUDCC previously known as the Army Substance Abuse Program in accordance with AR 600-85, 23 July 2020.

e. Reasonable effort will be made to prevent any use or disclosure of PHI of a minor that would be in violation of HIPAA. Unless a legal document such as a divorce decree limits a parent's access, the HPO shall treat each parent as a personal representative regardless of which parent has custody. Under the HIPAA Privacy Rule, a stepparent is required to have a valid medical power of attorney or a written authorization (DD 2870 can be used) to be granted access to the minor stepchild's PHI. Please see matrix below for illustration.

	Access to DEERS	Access to Minors' Medical Records	Schedule Minors' Medical Appt.
Custodial Parent (Tricare Bene.)	Yes	Yes	Yes
Custodial Parent (non-TRICARE Bene.)	No	Yes	Yes
Noncustodial Parent (TRICARE Bene.)	Yes	Yes	Yes
Noncustodial Parent (non-TRICARE Bene.)	Yes	Yes	Yes
Sponsor (Parent)	Yes	Yes	Yes
Sponsor (Step-parent)	Yes	No	No
Step-parent w/ healthcare power of attorney or HIPAA compliant auth. form	No	Yes	Yes

2. PROCEDURES:

a. All requests for copies of Medical Records are initiated at and closed out at Patient Administration for tracking purposes. Requests for PHI must be submitted in writing using DD Form 2870 or a DA Form 4254, respectively. All requesters/recipients are authenticated by proper ID. In addition, valid appointment orders need to be presented if the request is for a formal investigation to the HPO. Release of Information (ROI) staff will record all disclosures made without the patient's authorization in the Military Health System Protected Health Information Management Tool (PHIMT) / Access data base (see Attachment C — Disclosure Accounting) within 24 hours of the disclosure.

b. HPO/ ROI staff will determine the validity of the request and the authorization and assist the requester to complete the form if necessary. If the request is not legible, unclear, or vague, staff will request additional information. Staff will initially screen the request and determine potential urgency or need to expedite. Staff will recognize details of the request and will route the request to other departments who may have additional records responsive to the request (i. e. , FAP/ SUDCC). Only the specific information that provides direct response to the request will be abstracted from the medical record.

c. Prior to release of records ROI staff is responsible to check hard copy and electronic records for any contamination. Any instances of PHI or Pll discovered in an incorrect record will be forwarded to the HPO. The HPO and/or the medical records supervisor will document such instances and notify employee's supervisor for correction.

(1) For errors in Clinical Notes or Current/Previous Encounters the HPO will verify error, request Memorandum for Record (MFR) from the clinician. Once HPO receives MFR, another MFR will be generated for Commanders Signature unless it is delegated to HPO. Once both MFRs are completed will scanned into HPO's email and uploaded with ticket to DHA GSC. Once approved by DHA Tier 3 staff will make the correction and notify the HPO upon correction. The HPO will- verify in AHLTA that all erroneous information has been corrected and inform Tier 3 by email to close out the ticket.

(2) For any incorrectly scanned documentation in Health Artifacts and Image Management Solution (HAIMS) the HPO will remove the erroneous document locally in HAIMS and verify that the document is scanned into the correct patient's record. In cases where the document is missing in the correct record the HPO will forward the respective document to the appropriate supervisor for scanning into HAIMS. Incorrect scanning will also be captured in the KAHC Patient safety Report (PSR).

d. Any requests from patients to access behavioral health records are forwarded to the Behavioral Health Department for approval by the Chief, KAHC Behavioral Health Department. Only the Chief of PAD has authority to release Behavioral Health records. Accordingly, if it is determined that the access to a patient's own record would adversely affect the patient's physical, behavioral, or emotional health the patient will be asked to designate physician to receive the record. However, a patient cannot be denied access to his own record IAW federal law.

ASAP CLIENT'S CONSENT STATEMENT FOR RELEASE OF TREATMENT INFORMATION

For use of this form, see AR 600-85; the proponent agency is DCS, G-1.

SECTION A - CONSENT

I, _____ , this _____ day of _____ 20 ____ ,
(Client's Full Name)

do hereby voluntarily consent to the release of the following information by _____
(Name of Installation ASAP)

pertaining to my identity, diagnosis, prognosis, or treatment from any Army record maintained in connection with alcohol or other drug abuse education, training, treatment, rehabilitation, or research to _____

_____ for the purpose of _____

_____

_____

_____

_____

_____

_____ namely,

_____
(extent or nature of information to be disclosed)

SECTION B - EXPIRATION / REVOCATION
(Check applicable paragraph)

1. ☐ I understand that this consent automatically expires when the above disclosure action has been taken in reliance thereon and that, except to the extent that such action has been taken, I can revoke this consent at any time.

- Or -

(For disclosure to civilian criminal justice officials under the provisions of paragraphs 10-22 and 10-27, AR 600-85)

2. ☐ I understand that this consent automatically expires 60 days from today's date or when my present criminal justice system status changes to _____

_____

Further, I understand that if my release from confinement, probation, or parole is conditioned upon my participation in the ASAP, I cannot revoke this consent until there has been a formal and effective termination or revocation of my release from such confinement, probation, or parole.

SIGNATURE OF CLIENT		DATE
NAME OF WITNESS *(Type or print)*	SIGNATURE	DATE

SECTION C - APPROVAL AUTHORITY FOR RELEASE OF INFORMATION

NOTE: *Other than the MEDCEN/MEDDAC/DHA Commander, approval authority for release of information may be delegated to the Program Physician or the Clinical Director.*

In my judgment, the release of an evaluation of the present or past status of _____
(Client's Name)

in the alcohol or other drug treatment and rehabilitation program will not be harmful to him/her.

NAME OF MEDCEN/MEDDAC/DHA Commander OR DESIGNATED REPRESENTATIVE *(Type or print)*	
SIGNATURE	DATE

DA FORM 5018, SEP 2023 PREVIOUS EDITIONS ARE OBSOLETE. APD AEM v1.00ES

Attachment C
Disclosure Accounting

1. POLICY:

a. In accordance with the current regulations and the Military Health System Notice of Privacy Practices (NoPP) dated 1 October 2013, individuals have a right to receive an accounting of instances when PHI about them is disclosed for up to six (6) years back, except as noted in paragraph b below.

b. Individuals will not receive an accounting where their PHI was used or disclosed for the following purposes:

(1) When provided to the individual.

(2) To persons involved in the individual's care or other notification purposes.

(3) For military operations, national security, or intelligence purposes.

(4) To correctional institutions or law enforcement custodial situations.

2. PROCEDURES:

a. PAD staff will utilize a Protected Health Information Maintenance Tool (PHIMT) for documenting and maintaining an accounting of when patients' protected health information has been disclosed without the patient's authorization for purposes other than treatment, payment, or health care operations.

b. When the PHIMT is not available an entry will be made when system is restored. Ensure that the documentation of each accounting of a disclosure includes as a minimum date, entity or person who received the information (including address if known), description of PHI disclosed, brief statement describing the basis for the disclosure, copy of the individual's written authorization to use or disclose PHI, and a copy of written request for disclosure. In addition, the disclosures will be automatically tracked in MHS Genesis.

c. Within sixty (60) days of a request, provide a written accounting of instances when the requester's protected health information has been disclosed during the six (6) year period prior to the request date. If an extension beyond 60 days is required, provide the requester not later than the 60 days after receipt of the request with a written statement of the reason for the delay. The time to provide the accounting cannot be extended more than once or longer than (thirty) 30 days. Therefore, all disclosure accountings will be processed and issued to the requester no later than sixty (60) days from the date of the request.

d. Document and retain the following for a period of at least six (6) years from the date the accounting is issued to the requester:

(1) The written accounting provided to the requester.

(2) A copy of the written request for the disclosure accounting.

(3) The name of the PAD personnel responsible for receiving and processing the request for the disclosure accounting.

e. The following documentation is given to the patient at the end of each visit by the Providers:

(1) Immunization record.

(2) Medicine reconciliation.

(3) Clinic Synopsis.

(4) Care plan.

Attachment D
Requests for Personal Health Information

1. POLICY:

a. An individual may request to obtain or inspect for accuracy and completeness a copy of their PHI that is contained in a "designated record set" for as long as KAHC maintains the PHI, A "designated record set" contains medical documentation, billing records or any other records the HPO uses for making decisions about that individual.

b. KAHC PAD staff will follow the more stringent standards under federal and state laws governing disclosure of PHI. In all cases and circumstances, the personnel disclosing and receiving PHI must have the required authority to disclose or receive the information with respect to the patient(s) whom the information pertains and the purpose for the disclosure. Personnel will make reasonable efforts to limit disclosure of PHI to the minimum necessary to accomplish the intended purpose and to the fewest people possible. When appropriate for accomplishing the intended purpose, limited data sets will be disclosed in lieu of complete record sets. PHI will be de-identified when appropriate to meet the intended purpose.

c. No KAHC staff member, Military, Civilian, Contractor or Red Cross Volunteer shall access AHLTA/ MHS Genesis or any other records without an official need to know to perform their assigned duties/job. Any PHI/PII accessed without need to know to perform assigned duties will be considered a HIPAA breach which is subject to the sanction policy outlined in Attachment L of this Policy.

d. An individual may at any time request a copy of their medical record by providing a completed and signed DD Form 2870 (Request for Medical/Dental Information) to ROI. Blank forms are available at the KAHC Medical Records window. ROI will process the request within thirty (30) calendar days of receipt of the request. If the PHI requested is not maintained at KAHC, ROI will submit the signed DD Form 2870 accompanied by a DD Form 877 (Request for Medical Records) to the appropriate MT F.

2. PROCEDURES:

a. All KAHC employees (Military, Civilian or Contractor), regardless of job role and AHLTA/ MHS Genesis access are required to request any PHI on themselves or minor family members by submitting a DD Form 2870 to ROI. If a DD Form 2870 -is not available other forms of written authorization can be used. Spouses as well as family members 18 years of age or older must authorize the release by completing and signing DD Form 2870.

b. If a request for access is entirely or partially denied at the KAHC level, the HPO will refer the request through the DHA Small Stand Alone (SSO) at JBSA San Antonio to the Initial Denial Authority.

c. Requests involving Family Advocacy Program (FAP) records are electronically forwarded to the MEDCOM FOIA Office at JBSA San Antonio for processing.

d. KAHC provide copy of medical records through Compact Disc (CD), DOD/SAFE with a personal email address listed on the DD Form 2870 and provide paper copies at patient's request with release criteria.

Prescribed by: DoDM 6025.18

CUI (when filled in)

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

AUTHORITY: Public Law 104-191, Health Insurance Portability and Accountability Act of 1996; 10 U.S.C. Chapter 55, Medical and Dental Care; DoD Manual (DoDM) 6025.18, Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs; and E.O. 9397 (SSN).
PRINCIPAL PURPOSE(S): DD Form 2870 collects patient data and a patient's, or their parent's or legal representative's, authorization for a military treatment facility or dental treatment facility or DoD health plan to use or disclose an individual's protected health information.
ROUTINE USE(S): To third parties or individuals as per your written authorization.
APPLICABLE SORN: EDHA 07, Military Health Information System (June 15, 2020; 85 FR 36190). https://dpcld.defense.gov/Portals/49/Documents/Privacy/SORNs/DHA/EDHA-07.pdf
DISCLOSURE: Voluntary. If you choose not to provide your information, no penalty may be imposed and there will be a non-release of the protected health information. This form will not be used for authorization to disclose substance abuse information or treatment, if any, within your medical records nor will it be used to authorize the use or disclosure of psychotherapy notes, if any, within your medical records.

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)* ☐ BOTH ☐ INPATIENT ☐ OUTPATIENT	

SECTION II - DISCLOSURE

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

a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION	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 ss.
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: ☐ AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:	

DD FORM 2870, NOV 2023
PREVIOUS EDITION IS OBSOLETE.

CUI (when filled in)

Controlled by: DHA
CUI Category: PRVCY
Distribution/Dissemination Control: FEDCON
POC: dha.ncr.bus-ops.mbx.dha-formsmanagement@health.mil

Reset

Attachment E
Requests to Restrict the Personal Health Information

1. POLICY

a. Patients have the right to request restrictions in the use and disclosure of their PHI.

b. The HPO has the right to deny the restriction if it cannot reasonably accommodate the request.

2. PROCEDURES

a. Beneficiaries desiring a restriction of their PHI should submit a signed DD Form 2871 (Request to Restrict Medical or Dental Information) to the KAHC HPO. The request will be processed within thirty (30) calendar days of receipt.

b. The request will be reviewed by the Chief, PAD, or appointee to determine if the requested restriction of information could impede treatment, payment, or healthcare operations. The restriction shall not be effective until approved at the appropriate level where compliance is required. For example, if compliance is only required at the MTF level it can be approved by the Chief, PAD. If compliance would involve the entire Military Health System (MHS), the request will need to be approved by Privacy Officer, Defense Health Agency (DHA). The deciding official will then notify the requester in writing and will take appropriate action to implement the restriction.

c. If the request is denied, as a whole or in part, a written response will be provided to the individual explaining the rationale for the denial.

d. If the agreement of the restriction is terminated by either party the termination will be attached to the original request for the restriction and maintained by the HPO for six (6) years. In the event, that the covered entity initiates the termination of the restriction it is only effective with respect to PHI received and created after the requester has been informed of the termination.

CUI (when filled in)

REQUEST TO RESTRICT 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 patient with a means to request a restriction on the use and disclosure of his/her protected health information.
ROUTINE USE(S): To other entities or physicians for: judicial and administrative purposes; health oversight; research; law enforcement; public health; to avert a serious threat to health and safety; organ, eye, or tissue donation; decedents; Worker's Compensation; victims of abuse, neglect, or domestic violence; specialized government functions; and required by law.
DISCLOSURE: Voluntary. Failure to sign the authorization form may result in a release of the protected health information.

This form will not be used to request restrictions on the use or disclosure of any alcohol or drug abuse patient information from medical records of an alcohol or drug abuse treatment program.

SECTION I - PATIENT DATA

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

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

SECTION II - RESTRICTIONS

6. REQUEST (RESTRICTION) IS DIRECTED TO THE TRICARE HEALTH PLAN OR THE FOLLOWING PHYSICIAN/FACILITY:

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. PURPOSE OF RESTRICTION *(Optional)*

8. REQUESTED DATES OF RESTRICTION *(YYYYMMDD)*	
a. START:	b. END:

9. SPECIFY MEDICAL INFORMATION TO BE RESTRICTED *(Use back for additional space)*

SECTION III - PLEASE READ AND SIGN BELOW

I understand that:
1. The Military Treatment Facility (MTF)/Dental Treatment Facility (DTF)/TRICARE Health Plan is not required to approve this request for restriction.
2. If approved by an MTF/DTF, this restriction only applies to the MTF/DTF that granted approval. It is not transferable to other providers, MTF's or DTF's.
3. If approved, the MTF/DTF/TRICARE Health Plan is not required to abide by this restriction if the health information is needed to provide emergency treatment or services.
4. If approved, this restriction does not prevent me from having access to my own health information or to an accounting of how my health information has been used.
5. If this request for restriction is approved, the MTF/DTF/TRICARE Health Plan still has the right to use or disclose my health information under the following circumstances: judicial and administrative purposes; health oversight; research; law enforcement; public health; to avert a serious threat to health and safety; organ, eye, or tissue donation; decedents; Worker's Compensation; victims of abuse, neglect, or domestic violence; specialized government functions; and required by law.
6. Once approved, this restriction can be terminated under the following circumstances:
   a. If I request the termination in writing.
   b. If I request the termination orally and it is documented by the MTF/DTF.
   c. If the MTF/DTF/TRICARE Health Plan informs me that it has decided to terminate the restriction. In this situation, the termination only applies to the health information created or received after the termination is in effect.

10. SIGNATURE OF PATIENT/GUARDIAN	11. RELATIONSHIP TO PATIENT *(If applicable)*	12. DATE *(YYYYMMDD)*

SECTION IV - FOR PROVIDER/FACILITY USE ONLY

13. X AS APPLICABLE:	14. SIGNATURE OF APPROVING OFFICIAL
☐ REQUEST APPROVED ☐ REQUEST IS DISAPPROVED ☐ RESPONSE ATTACHED	

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

DD FORM 2871, DEC 2003
PREVIOUS EDITION IS OBSOLETE.

CUI (when filled in)

Controlled by: DHA
CUI Category: PRVCY
Distribution/Dissemination Control: FEDCON
POC: dha.ncr.bus-ops.mbx.dha-formsmanagement@health.mil

Page 1 of 2

CUI (when filled in)

9. SPECIFY MEDICAL INFORMATION TO BE RESTRICTED *(Continued)*

DD FORM 2871 (BACK), DEC 2003 CUI (when filled in) Page 2 of 2

PREVIOUS EDITION IS OBSOLETE.

Attachment F
Special Considerations for the Information for Minors

a. Per Virginia Law a minor (person age 17 or younger) can consent to all medical care without involving a parent if they are emancipated, married, have children of their own, or are deemed mature enough to make health care decisions by the provider.

b. Virginia State Law also permits minors to consent to certain health care on their own. These include reproductive care, prenatal care, testing, and treatment for sexually transmitted infections, mental health care, drug and alcohol abuse care, emergency medical care, and sexual assault post evaluation.

c. The provider should inform the patient that billing, payment, and record keeping could compromise confidentiality. When documenting in AHLTA MHS Genesis the provider has the option to mark the encounter as "sensitive" to avoid release to parent.

Attachment G
Breach Response

1. POLICY:

a. KAHC continues to implement policies and procedures to safeguard PII/PHI of patients and staff. This process includes specific reporting and notification requirements in the event of the suspected or actual loss of PII/PHI whether in hard copy and electronic form.

b. A breach or compromise incident occurs when it is suspected or confirmed that PHI/PII has been lost, stolen, compromised or has been otherwise made available to individuals without official need to know.

2. PROCEDURES:

a. The HPO/HSO will initiate the reporting requirements in the following sequence:

(1) Immediately upon discovery draft DHA —Director's Critical Information Report (DCIR) and submit thru Deputy Commander of Administration (DCA) to KAHC Operations. Do not include PII/PHI in the DCIR. Send the DCIR and DPMIS breach report within 4 hours of event and any weekly updates via email to DHA Network 5 Atlantic POC / DHA Privacy and Civil Liberties Office (PCLO) Complaints and Resolutions Office.

(2) Within one (1) hour report if the breach is confirmed as cybersecurity related breach. Non cybersecurity related breaches (i. e. , paper) should no longer be reported to the US-CERT. The online form is available: http://www. us-certqov.

(3) If computer access is unavailable, PHI/Ptl incidents can be reported to DHA Network 5 Atlantic. Forward DCIR and DPMIS documents when system is available. The Defense Health Agency Privacy Office reviews the incident and determines if the breach incident requires additional reporting and oversees other notification processes.

(4) DHA will send to local MTF Breach Risk Analysis Template (BRAT) to determine if low/moderate/high risk or harm determinations. DHA will decide if MTF will make notification of affected individuals. If notification is necessary, letter will be drafted and forward to DHA for approval prior to mailing to the affected individuals.

b. Government Contractors and/or business associates will comply with breach response requirements outlined in the contract or business associate agreement. The breach response steps include immediately notifying the organization upon discovery of the breach; assessing the breach incident; completing the required notifications to include the affected individuals; and taking mitigation actions as applicable.

Attachment H
Requests for Amendment of Medical Records

1. POLICY:

A beneficiary has the right to request an amendment of their outpatient treatment record.

2. PROCEDURES:

a. All staff needs to be vigilant and immediately report any erroneous information detected in any form of medical documentation to the HPO. The HPO will verify and prepare a memorandum to the DHA GSC to have the information removed from AHLTA. if an incorrect document is in HAIMS the HPO can correct the issue locally upon verification.

b. If the error is not detected at some point after the note was entered and signed the patient should make every effort to contact that provider and state, the basis for the request.

c. If the provider agrees and makes the changes the incorrect information will still be visible in the "Change History", The provider should then contact the HPO, who will prepare a memo to DHA-GSC to request an expungement of the information in "Change History".

d. If the provider does not agree to amend the note, the patient can request to have the Deputy for Clinical Services (DCCS) review the note. If the DCCS deems the information accurate the HPO will inform the patient in writing with the reason for the denial and advise the patient of the right to file a written complaint with the DHA. Both the initial request and the denial will be forwarded to DHA for decision.

Attachment I
Disclosure of Protected Health Information to Unit Command Officials

1. POLICY:

a. The HIPAA Privacy Rule provides standards for disclosure of PHI pertaining to members of the Armed Forces without their authorization. These exemptions were established to support the unique requirements of military operations. To meet the intent of the law, PHI disclosures permitted under military exemptions must also comply with the minimum necessary and disclosure accounting standards.

b. PHI disclosure shall provide the minimum amount of information to satisfy the disclosure. In general, this shall consist of the diagnosis; description of treatment prescribed or anticipated impact on duty or mission, recommended duty restrictions, and the prognosis.

c. The military provisions do not apply to non-military personnel such as Family members, retirees, or civilian employees. The only exceptions where Commanders have limited access to Family member information are situations involving EFMP (IAW AR 608-75) and Family Advocacy (IAW AR 608-18).

2. PROCEDURES:

The HPO ensures that staff is familiar with policies and procedures regarding the Disclosure of Protected Health Information to Command Officials by incorporating training regarding the military exemptions in the KAHC Newcomer's Brief. The HPO will participate as a minimum annually in senior leader town hall meetings or division provider meetings to ensure providers and leadership understand the military provisions of the Privacy Rule.

3. PRIVACY RULE:

a. To determine the member's fitness for duty, including but not limited to the member's compliance with standards and activities.

b. To determine the member's fitness to perform any particular mission, assignment order or duty, including compliance with any actions required as a precondition to performance of such mission, assignment, order, or duty.

c. To coordinate sick call, routine and emergency care, quarters, hospitalization, and care from civilian providers IAW DOD 6025. 02 (Health Record Lifecycle Management Vol 2) for the individual sick slip (DD form 689).

d. To report results of physical examinations and profiling IAW AR 40-501 (Standard of Medical Fitness).

e. To screen and provide periodic updates for individuals in personnel reliability/special programs.

f. To review and report IAW AR 600-9 (The Army Weight Control Program). To carry out any other activity necessary to the proper execution of the mission of the Armed Forces.

g. To carry out activities under authority of DOD Directive 6490. 2 Joint Medical Surveillance.

h. To report on casualties in any military operation or activity in accordance with applicable military regulations or procedures.

i. To contribute to the completion of records IAW AR 608-75 (Exceptional Family Member Program) and MEDCOM Circular 40-4 (Education and Develop behavioral Intervention Services: Early Intervention Services).

j. To allow senior commanders to review a Soldier's medical information to determine eligibility for assignment/attachment to the Warrior Transition Unit (WTU).

k. To provide initial and follow-up reports IAW 600-85 (The Army Substance Abuse Program).

Other regulations carrying out any other activity necessary to the proper execution of the mission of the Army.

REQUEST FOR PRIVATE MEDICAL INFORMATION For use of this form, see AR 40-66; the proponent agency is the OTSG	1. Date *(YYYYMMDD)*
2. Patient's Name and SSN.	3. Medical Treatment Facility *(Name and Location)*
4. Reason for Request.	
5. Private Medical Information Sought *(Specify dates of hospitalization or clinic visits and diagnosis, if known)*	
6. Requestor's Name, Title, Organization and SSN.	
FOR USE OF MEDICAL TREATMENT FACILITY ONLY	
7. Check applicable box. ☐ Approved ☐ Disapproved *(State reason for disapproval)*	
8. Summary of Private Medical Information Released.	
9. Signature of Approving Official.	10. Date *(YYYYMMDD)*

Attachment J
Release of Civilian Employee Medical Records

1. POLICY:

In accordance with DOD 6025. 02 Vol 2, civilian personnel must authorize the release fitness for duty examination results to their supervisor and/or personnel office.

2. PROCEDURES:

a. Civilian personnel must complete and sign a DD Form 2870 (Authorization of Disclosure of Medical or Dental information) to release fitness for duty examination results to their supervisor and/or personnel office.

b. In addition, civilian employees must authorize the entry of medical information into the Medical Operational Data System (MODS) with a signed DD Form 2870.

c. Civilian employees may request a copy of their individual Civilian Employee Medical Record from the Occupational Health Clinic by completing and signing a DD Form 2870.

d. The Occupational Health Clinic will send the request and the record to ROI, to have the record copied and available for release within 30 calendar days of the date of request. The original record will be returned to Occupational Health,

3. Privacy Act- Leader Management Team (LMTs)

HIPAA Rules do not apply to employment records, even if the information in those records is health-related, as HIPAA law does not apply to the actions of an employer. The health-related information is protected under the Privacy Act of 1974. All leader management teams are required to safeguard and protect your employee's information. Once documentation is given to employer, information should be stored in a locked area (i.e., cabinet, or locked drawer).

Attachment K
Filing a Privacy/HlPAA Complaint

1. POLICY:

As per the NoPP patients have the right to file a formal complaint if they feel any PHI or PII has been inappropriately disclosed. Staff should advise anyone with a privacy related concern to the HPO.

2. PROCEDURES:

a. The HPO will advise the patient of all options available and provide any necessary forms.

b. The patient has the right to file a written complaint with the HPO by completing (Health Information Privacy Complaint Form).

Attachment L

Roles and Responsibilities of the HIPAA Privacy Officer

Develop policy and procedures for local implementation of DOD Manual 6025. 18.

a. Maintain current knowledge of applicable federal, DOD and state privacy laws, accreditation standards and DOD and Service regulations. Monitor advancements of emerging privacy technologies to ensure that the Health Readiness Platform (HRP)/Dental Treatment Facility (DTF) is positioned to adapt and comply with these advancements.

b. Establish and recognize best practices relative to the management of the privacy of health information.

c. Perform initial and periodic information privacy risk assessments of the flow of protected health information and conduct related ongoing compliance monitoring activities. Report findings as required.

d. Ensure a mechanism is in place with the HRP/DTF for receiving, documenting, tracking, investigating, and acting on all complaints concerning the organization's privacy policies and procedures in coordination and collaboration with other similar functions and, when necessary, legal counsel.

e. Establish a mechanism which tracks access to protected health information, within the purview of organizational policy and as required by law and allows qualified individuals to review or receive a report on such activity.

f. Oversee, direct and ensure delivery of initial privacy training and orientation to all employees, volunteers, clinical staff, business associates, and other appropriate third parties. Record results in compliance with HRP/DTF training documentation policies. Ensure annual refresher training is conducted to maintain workforce awareness and to introduce any changes to privacy policies. Develop and present local privacy practices training.

g. Initiate, facilitate, and promote activities to foster information privacy awareness within the organization and related entities.

h. Serve as the advocate for the patient, relative to the confidentiality and privacy of health information.

i. Understand the decision-making processes throughout the HRP/DTF that rely on health information. Identify and monitor the flow of information within the HRP/DTF and throughout the local healthcare network.

Attachment M
Unauthorized Use of the Electronic Health Record

DEFENSE HEALTH AGENCY
DEFENSE HEALTH NETWORK ATLANTIC
KENNER ARMY HEALTH CLINIC
700, 24TH STREET
FORT LEE, VIRGINIA 23801

June 25, 2025

MEMORANDUM FOR: KENNER ARMY HEALTH CLINIC PERSONNEL

SUBJECT: Unauthorized Use of Electronic Health Record System

IAW DODI 8580.02, Security of Individually Identifiable Health Information in DoD Health Care Programs, the Defense Health Agency (DHA) has purchased and deployed automated auditing software within the Cerner MHS GENESIS platform, Policy, and Procedure (P2) Sentinel. P2 Sentinel audits the actions of all users across multiple applications in the platform and automatically flags certain preset policy violations. Additional audit cohorts can be created to monitor access to specific groups of records. Cases of potential impermissible access will be investigated.

Access to the Electronic Health Record (EHR) is limited to personnel operating in their official capacity in the course of their assigned duties IAW DODI 8580.02, Enclosure 3.8.d and HIPAA, para 3.3-3.3.1. Official uses of the record are for treatment, payment, and health care operations. Staff members are prohibited from utilizing MHS GENESIS to open, view, print, schedule appointments, or modify their individual or family member's record. Staff members will utilize the MHS GENESIS Patient Portal to complete any individual health care operations.

IAW DHA-AI, Number 29, Disciplinary and Adverse Actions. May 24, 2018, Kenner Army Health Clinic (KAHC) will be implementing the following disciplinary actions for any member who violates policies mentioned in para. 2. At any time, members are subject to additional administrative disciplinary actions as leadership deems appropriate. Including but not limited to:

Infraction	1st Offense	2nd Offense	3rd Offense
Inappropriately viewing a chart.	Mil/Civ- Reprimand and training. CTR- Inform Functional Requirements Evaluator Designee (FRED) and training assigned.	Mil/Civ- 3 days suspension and access to systems access removed pending MTF Director review. CTR- Inform Functional Requirements Evaluator Designee (FRED) and to systems access removed pending MTF Director review.	Mil/Civ- Removal of systems access. CTR- Removal of systems access.

SUBJECT: Unauthorized Use of Electronic Health Record System
June 25, 2025

Inappropriately Printing/Copying/Relaying chart information.	Mil/Civ- Reprimand and training. CTR- Inform Functional Requirements Evaluator Designee (FRED) and training assigned.	Mil/Civ- 3 days suspension and access to systems access removed pending MTF Director review. CTR- Inform Functional Requirements Evaluator Designee (FRED) and to systems access removed pending MTF Director review.	Mil/Civ- Removal of systems access. CTR- Removal of systems access.
Modifying your own record or a direct family member.	Mil/Civ- Reprimand and training. CTR- Inform Functional Requirements Evaluator Designee (FRED) and training assigned.	Mil/Civ- 3 days suspension and access to systems access removed pending MTF Director review. CTR- Inform Functional Requirements Evaluator Designee (FRED) and to systems access removed pending MTF Director review.	Mil/Civ- Removal of systems access. CTR- Removal of systems access.
Viewing your own record or a direct family member.	Mil/Civ- Reprimand and training. CTR- Inform Functional Requirements Evaluator Designee (FRED) and training assigned.	Mil/Civ- 3 days suspension and access to systems access removed pending MTF Director review. CTR- Inform Functional Requirements Evaluator Designee (FRED) and to systems access removed pending MTF Director review.	Mil/Civ- Removal of systems access. CTR- Removal of systems access.

SUBJECT: Unauthorized Use of Electronic Health Record System
June 25, 2025

The KAHC HIPAA Compliance Officers (HCO) and HIPAA Security Officers (HSO) are the subject matter experts to provide training, perform ad hoc audits and reports, and conduct legal investigations. The appointed individuals are as follows:

POSITION	NAME	RANK	PHONE	EMAIL
Primary HCO	Kimberly Murrell	Civ	804-734-9197	kimberly.a.murrell.civ@health.mil
Primary HSO	Michael Losoya	Civ	804-734-9544	michael.s.losoya.civ.@health.mil

Please address questions regarding this KAHC-Memorandum to the Patient Administrative Division, HIPAA Compliance Officer Kimberly A. Murrell, kimberly.a.murrell.civ@health.mil

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Date: 2025.08.07 08:12:54 -04'00'

JOANNA A. BAILEY
LTC, USA
Director