

Madigan Army Medical Center Primary Care Manger Change Waiver Request

Date of Request:	
Name of Sponsor:	SSN of Sponsor:
Contact Information:	E-mail Address:
Home Phone:	Alternate E-mail Address:
Cell Phone:	
Work Phone:	
Name of 1 st Family Member:	
Name of additional Family Member:	
Name of additional Family Member:	
Name of additional Family Member:	
Name of additional Family Member:	
Do you live in Base Housing? YES NO Approximately how long (in minutes) is your drive from your home to Madigan Army Medical Center:	
Please briefly describe why you are requesting a waiver:	

TO BE COMPLETED BY MADIGAN ENROLLMENT STAFF ONLY.

Action Taken:	
Date:	Signature:

Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by this system and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR 199.17, TRICARE program; and E.O. 9397 (SSN), as amended.

PURPOSE: To collect information from Madigan Army Medical Center beneficiaries in order to determine their eligibility for coverage under the TRICARE Program.

ROUTINE USES: Use and disclosure of your records outside of DoD may occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at:
http://dpclo.defense.gov/privacy/SORNs/blanket_routine_uses.html.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary; however, failure to provide information may result in the denial of enrollment.