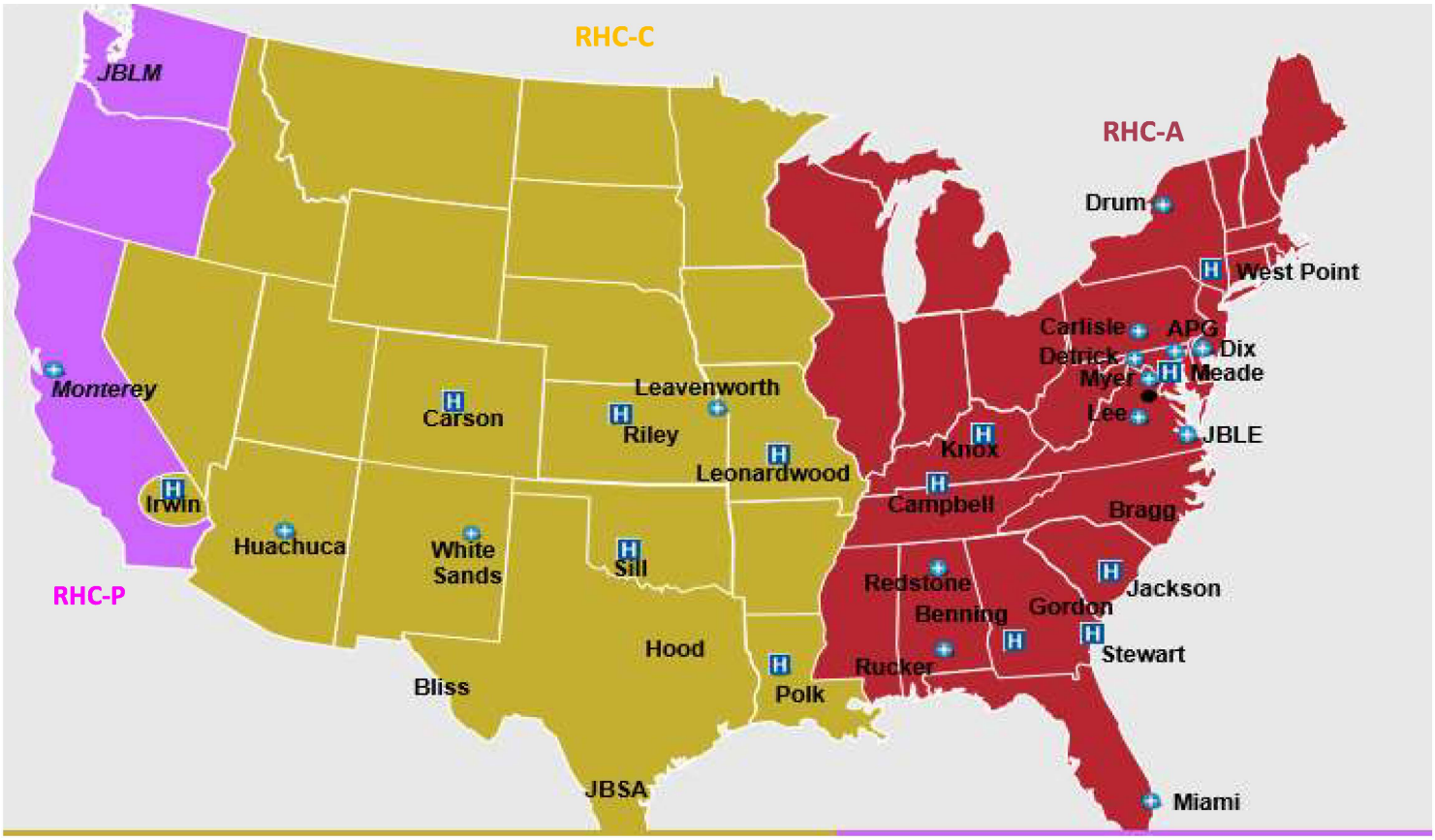
REMOTELY LOCATED SOLDIER'S

PROFILE PACKET

For AD, AGR, or Reserve/NG on Active Duty > 30 days



Tricare Prime Remote Profile Packet: Only one medical diagnosis per profile packet.
Profile packets must have supporting medical documents pertaining to profile request condition. (Dictated doctor's notes from your visit, lab results, x-ray and MRI/radiology reports, etc). Medical provider (**MD, NP, PA**) must fill out ACFT Functional Capabilities Form and Chronological Record Medical Care (Standard Form 600) and sign in highlighted areas.
Note: Pregnancy temporary profiles need to fill out complete packet.
Note: Behavioral Health Profile-See BH profile packet located on MilSuite website: https://www.milsuite.mil/book/groups/ar-mmc
*__Send completed profile packet along with supporting documents encrypted to the MTF via the MHS Genesis Portal__.

Revised Nov 2024

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

PRIVACY ACT STATEMENT: This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique

SUMMARY OF CARE BY NON-MILITARY/ARMY MEDICAL PROVIDER - Note to medical provider: Your patient is a Soldier. This form will become part of their official military health record. Any conditions found that impact your patients' ability to perform his/her functional activities (listed below) may impact the soldier's military medical readiness. This is NOT a workers compensation claim.

1. REASON for visit/planned surgical procedure: _____

2. FUNCTIONAL ACTIVITIES required for service in the Military. (Check all activities the Soldier should NOT perform.)

a.	Physically and Mentally able to carry and fire assigned weapon (rifle) ☐	Run/Sprint ☐
b.	Wear military uniform and boots for up to 12 hours a day ☐	Squat/kneel ☐
c.	Wear helmet (~3lbs), body armor (~30lbs), and equipment (~10lbs) up to 12 hrs a day ☐	Wear a 50 Lbs. Pack ☐
d.	Wear gas mask and full protection (HAZMAT) for at least 2 continuous hours ☐	Climb ☐
e.	Move greater than 40 lbs. while wearing helmet, body armor and equipment up to 100 yards ☐	Rappelling ☐
f.	Live and function without restrictions in ANY geographical or climate area ☐	Jump/Crawl ☐
g.	Ride in a military vehicle wearing helmet, body armor, and equipment for up to 12 hrs a day ☐	Pull-ups ☐
h.	Walk in all terrains with standard uniform, body armor, and equipment (~45lbs) ☐	Lift Weights ☐
i.	Sprint 3-5 seconds while wearing standard uniform & equipment (~45lbs) ☐	Wrestle ☐

3. Army Combat Fitness Test Events (ACFT)

1. Dead Lift X3 (140 lbs. males, 70 lbs. females) ☐
2. *Standing Power Throw ☐
3. Hand Release Push-up ☐
4. **Sprint Drag Carry ☐
5. Plank ☐
6. 2 Mile Run ☐

4. Alternate Cardio Event to be included if Soldier is deemed unable to participate in ACFT Event

1. Ride a stationary bike 12 kilometers ☐
2. Row an ergo-metric rowing machine 5000 kilometers ☐
3. Swim laps in a pool 1 kilometer ☐
4. Walk 2.5 miles at a fast pace ☐

*** Throw a 10 lb. ball from as standing position**
****5-50 meter shuttles, sprint, 90 lbs. sled drag, 2 kettle bell carry (40 Lbs. ea.), sprint**

5. WORK ACTIVITIES (Check least restrictive activity that the Soldier can perform with current injury / illness)

1.	Run at own pace / distance ☐	1.	Do PT with Therapist ☐
2.	Walk at own pace / distance ☐	2.	Use Treadmill / Elliptical ☐
3.	Walk / Run Progression ☐	3.	Swim and own pace and distance ☐
4.	Wear brace / splint ☐	4.	Ice 1-2 times per day ☐
5.	Free weight training and work tolerance ☐	5.	Other (briefly explain) ☐ _____

6. ALTERNATE ACTIVITIES (Check all activities the Soldier can perform with current injury/illness)

1.	Remain at home (indicate time frame) ☐ _____	4.	Work shortened hours to how many hrs ☐ _____
2.	Light duty ☐ _____	5.	Free weight training and work tolerance ☐ _____
3.	Work indoors/outdoors with mod. exertion ☐ _____	6.	Physical limitations are temp/perm ☐ _____

7. TREATMENT PLAN (re-evaluation needed in 30, 60, or 90 days)

_____

_____

1. Expected condition duration? _____
2. Opioid therapy required for > 14 Days? _____

Provider Full Name _____
Specialty _____
Office Number _____

Signature _____

CONTINUED ON NEXT PAGE

8. Name (Last, First, Middle Initial) _____

9. DODID : _____

10. RANK: _____ **11.DOB:** _____

10. Home Phone: ( )_____

13. Patient's Home Address:

_____

_____

_____

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 8/2018)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

FOR OFFICIAL USE ONLY
When Filled Out

PREVIOUS EDITION IS NOT USABLE
AUTHORIZED FOR LOCAL REPRODUCTION

Additional Information if needed:

LAST NAME, FIRST NAME _____

RANK / DATE OF BIRTH _____

AUTHORIZATION FOR DISCLOSURE OF 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 Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

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)*
	[ ] OUTPATIENT [ ] INPATIENT [X] BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE Carl R Darnall Army Medical Center TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
Carl R. Darnall Army Medical Center Case Management (TricarePrime Remote)	509 Medical Center Rd Fort Cavazos, TX 76544-5060
c. TELEPHONE *(Include Area Code)* (254) 287-7623	d. FAX *(Include Area Code)* (254) 288-8479

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

[ ]	PERSONAL USE	[X]	CONTINUED MEDICAL CARE	[ ]	SCHOOL	[ ]	OTHER *(Specify)*
[ ]	INSURANCE	[ ]	RETIREMENT/SEPARATION	[ ]	LEGAL		

8. INFORMATION TO BE RELEASED
Any inpatient medical records, Outpatient medical records, Radiology Studies, or Labs if applicable for continuation of care.
Fax to: (254) 288-8479
Secure Email: usarmy.cavazos.medcom-crdamc.mbx.tricare-prime-remote-program@health.mil

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION DATE *(YYYYMMDD)*	
	[ ]	[X] 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.
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)*
	Self	

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
[ ] AUTHORIZATION REVOKED		

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

Reset

MEDICAL RECORD - CONSENT FORM
Authorization To Send And Receive Medical Information By Electronic Mail

For use of this form see, MEDCOM Supplement 1 to AR 40-66; the proponent agency is MCHO

SECTION I - PATIENT DATA

1. NAME (Last, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. SOCIAL SECURITY NUMBER (Last four only)
4. E-MAIL ADDRESS		5. TELEPHONE NUMBER

SECTION II - CONDITIONS FOR USE OF E-MAIL

Health care providers cannot guarantee but will use reasonable means to maintain security and confidentially of electronic mail (E-mail) information sent and received. You must acknowledge and consent to the following conditions:

1. E-mail is not appropriate for urgent or emergency situations. Healthcare providers will respond within_____.
   Contact the clinic telephonically if you have not received a response after _____.
2. E-mail must be concise. You should schedule an appointment if the issue is complex or sensitive precluding discussion by E-mail.
3. E-mail should not be used for communications regarding sensitive medical conditions such as sexually transmitted diseases. HIV/AIDS, spouse or child abuse, chemical dependency, etc.
4. Medical or dental treatment facility staff may receive and read your messages.
5. E-mails related to health consultation will be copied, pasted, and filed.

SECTION III - RISKS OF USING E-MAIL

Transmitting information by E-mail has risks that you should consider these include, but are not limited to the following risks:

1. E-mails can be intercepted, altered, forwarded. or used without authorization or detection.
2. E-mails can be circulated, forwarded and stored in paper and electronic files.
3. E-mail senders can easily type in the wrong E-mail address.
4. E-mail may be lost due to technical failure during composition, transmission, and/or storage.

SECTION IV - PATIENT GUIDELINES

To communicate by E-mail, the patient shall:

1. Place the category (topic) of the communication in the subject line of the E-mail (for example, appointment, prescription, medical advice, etc.)
2. Include the patient's name, telephone number, family member prefix, and the last 4 numbers of the sponsor's social security number (for example: 30/0858) in the body of the E-mail.
3. Acknowledge receipt of the E-mail when requested to do so by a health care provider.
4. Inform the medical or dental treatment facility of changes in E-mail address by completing a new consent form.
5. Notify the health care provider of any types of information considered by the patient to be inappropriate for E-mail.
6. Take precautions to preserve the confidentiality of E-mail.

SECTION V - PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have read and fully understand the information in this authorization form. I consent to the E-mail conditions and agree to abide by the guidelines listed above. I futher understand that this E-mail relationship may be terminated if I repeatedly fail to adhere to these guidelines.

I understand and accept the risks associated with the use of unsecure E-mail communications. I further understand that, as with all means of electronic communication, there may be instances beyond the control of the family and the health care provider where information may be lost or inadvertently exposed, such as during technical failures, acts of God, acts of war, and so forth.

I understand that I have he right to revoke this authorization, in writing, at any time.

By signing this form I acknowledge the privacy risks associated with using E-mail and authorize health care providers to communicate with me or any minor dependent/ward for purpose of medical advice, education, and treatment.

_____	_____	_____
(Date)	SIGNATURE of Patient or Parent/Guardian	RELATIONSHIP (if other than patient)

PATIENT IDENTIFICATION *(For typed or written entries note: Name-last, first, middle initial; hospital or medical facility)*	Patient's Name		Sex
	Year of Birth	Relationship to Sponsor	Component/Status
	Depart/Service	Sponsor's Name	
	Rank/Grade	FMP-SSAN (Last four only)	
	Organization		