Military Medical History Release Request Form

Directions: Please complete all sections of this form to request the release of military medical records. Once completed, print this form, sign, and date the authorization section.

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1. Service Member / Veteran Information

Full Name (Last, First, Middle):

Social Security Number (SSN):

Military Service Number (if applicable):

Date of Birth (MM/DD/YYYY):

Branch of Service (e.g., Army, Navy, Air Force, Marines, Coast Guard, Space Force):

Active Duty Service Dates (From - To):

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2. Contact Information

Current Mailing Address:

City, State, Zip Code:

Phone Number:

Email Address:

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3. Medical Records Requested

Specify Military Treatment Facility (MTF) or Location where cared for:

Treatment Date Range (From - To):

Specific Records Requested (e.g., Outpatient, Inpatient, Dental, Immunizations, or "All Records"):

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4. Recipient Information (Where to send the records)

Name of Recipient (Person, Organization, or Facility):

Recipient Mailing Address:

City, State, Zip Code:

Recipient Phone Number:

Recipient Fax Number (if applicable):

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5. Authorization and Signature

I hereby authorize the release of my military medical history as specified above. This authorization is valid for one year from the date of signature unless otherwise revoked in writing.

Printed Name of Signatory:

Relationship to Service Member (Self, Next of Kin, Legal Representative):

Handwritten Signature (Sign after printing):

Date of Signature (MM/DD/YYYY):