EMPLOYEE / FAMILY MEMBER MEDICAL SUMMARY FOR FORT SILL EMERGENCY PLANNING

(To be completed by Service member, adult Family member, or civilian employee. Read Instructions before completing this form)

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Public Law 104 -191 - Health Insurance Portability and Accountability Act (HIPPA) of 1996; The Freedom of Information Act, 5 U.S.C. § 552; Telephone Consumer Protection Act 47 U.S.C. § 227.

PRINCIPAL PURPOSE: Information will be used by Fort Sill personnel (with a specific need-to-know) to evaluate and document the special medical, functional or access needs of all civilian employees and Family Member for Emergency planning, response and recovery purposes. This information will enable: (1) Exceptional Family Member Program (EFMP) staff(s) (RAHC and DFMWR) to have the information to assist the installation in emergency planning, (2) the Fort Sill Emergency Management Office to identify and assist employees, military personnel and/or Family members in preparedness, response and recovery action for emergency or disaster situations, and (3) applicable first responder and medical staff to be able to adequately respond to employees and Family members with special needs, functional or access needs or identified needs during emergency or disaster situations.

ROUTINE USES: Solely to be used by the EFMP staff, medical staff, Emergency Management staff, and first responders to plan, prepare, respond, and provide recovery services to those in need. By providing the information in this form the employee, sponsor or Family member agrees to the release and use of the information by the individuals mentioned above. All information provided will be held and processed by applicable requirements of the HIPAA.

DISCLOSURE: Providing requested information is **voluntary** for civilian employees, military and Family members. However, without this information, timely assistance in an emergency or disaster may be delayed. Contents shall not be disclosed, discussed, or shared with individuals unless they have a direct need-to-know in performance of their official duties. Deliver this document directly to the intended recipient. **DO NOT** drop off, send to an unauthorized third-party or send via e-mail un-encrypt. Sending Personally Identifiable Information (PII) via regular e-mail is highly discouraged. Regular e-mail is sent "in the clear" and therefore is subject to interception by hackers. There are many other options for sending private, sensitive information or PII securely through e-mail. Please research these options and use them accordingly. This document contains personal or privileged information and should be treated as "Controlled Unclassified Information (CUI)".

I, , authorize Fort Sill staff to utilize this patient information for inclusion into installation emergency planning purposes only. Any other use of the information is not authorized and in violation of the agreement and terms of this form. The benefit to myself or my family in providing this information is understood and accepted.

The authorization applies to the summary data included on the medical summary form, and subsequent updates as applicable. If additional clarification or information is needed, I authorize contact to gain clarifying information. Access to the information is limited to representatives of the EFMP offices, Emergency Management offices, medical departments and first responder/ emergency service offices. Summary data may be transmitted (e.g. encrypted electronic mail or faxing) using authorized secure media transfer.

Start Date: The authorization start date is the date that you sign form authorization release of information.

Expiration Date: The authorization shall continue until the employee, Family member no longer meets the criteria to qualify as a dependent, or the sponsor is no longer in active military service or in the employment of the U.S. Government or leaves Fort Sill, OK.

I understand that:

a. **I have the right to revoke this authorization at any time.** My revocation must be in writing to the DFMWR EFMP office or the Emergency Management office. I am aware that if later revoke this authorization, the person(s) I name herein will disclosures made prior to the revocation.

b. I have a right to inspect and receive a copy of my own or my family member's form or 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.

Name of Employee/Patient	Signature of Employee/Patient/Parent/Guardian	Relationship to Patient (*if applicable)*	Date:YYYY-MM-DD

EMPLOYEE / FAMILY MEMBER MEDICAL SUMMARY FOR FORT SILL EMERGENCY PLANNING

INSTRUCTIONS: To be completed by the Employee, Sponsor, Parent/Guardian or adult Patient. Complete one form for each person requiring assistance.

1. Employee/Family Member/Patient Name (Last, First, Middle Initial)	2. Sponsor Name (Last, First, Middle Initial)	3. DODID #

4. Gender	5. Employee/Family Member Date of Birth (YYYY-MM-DD)	6. Primary Language Specify other languages:
☐ Male ☐ Female		☐ English ☐ Other:

7. Employee Work / Family Member Physical Address (Street, Apt. #. City, State, Zip Code)	8. Employee/Sponsor Organization/Unit/ Current Assignment	9. Primary Telephone # and E-mail Address

10. Other Point of Contact/Emergency Contact (Name, phone number, email address)	11a. Primary Diagnosis (other diagnoses may be added)

11b. Specified Medical Conditions / Needs (*Check all that apply*)

- ☐ Allergies
- ☐ Asthma
- ☐ Autism (Verbal / Non-Verbal)
- ☐ Blindness / Low Vision
- ☐ Blood Disorders
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Intellectual Disability
- ☐ Depression / Anxiety
- ☐ Deaf / Hearing Impairment
- ☐ Diabetes
- ☐ Electrical Dependent
- ☐ Epilepsy
- ☐ Food Allergies
- ☐ Heart / Cardiac
- ☐ High Blood Pressure
- ☐ Kidney / Dialysis
- ☐ Learning Disability
- ☐ Mobility
- ☐ Oxygen Dependent
- ☐ PTSD / Mental Health
- ☐ Respiratory
- ☐ Seizures
- ☐ Sensory Processing Disorders
- ☐ Non-Verbal
- ☐ Visual Processing Disorders

☐ Other - Please Specify:

	YES	NO
12a. In an emergency or disaster situation, do you anticipate needing assistance from the installation before 24 hours? (please include needs in block 13, be as specific as possible)	☐	☐
12b. Do you have supplies, kits, etc. to sustain yourself and your family for the first 24-48 hours?	☐	☐
12c. If you had to leave your residence and take shelter in another on post or off post facility for a temporary period, do you anticipate needing assistance from the installation with DME equipment?	☐	☐

13. Do you have Durable Medical Equipment ((DME) needs? (Check all that apply)

- ☐ Bili Blankets or Lights
- ☐ Kidney Machine
- ☐ Monitors
- ☐ Portable Oxygen
- ☐ Scooter
- ☐ Specialized Bed
- ☐ Walker / Cane
- ☐ Wheelchair
  - ☐ Manually Powered
  - ☐ Battery Powered
- ☐ Ventilator
- ☐ Other-Please Specify

14. Please provide any additional information that services / responders need to be aware of to plan for assistance or to provide assistance during a time of emergency or disaster.

15. Please provide a list of medications, in case you are evacuated or have to go to a shelter and you were unable to take the necessary medications with you.

Medication	Dosage	Prescribing Physician

EMPLOYEE / FAMILY MEMBER MEDICAL SUMMARY FOR FORT SILL EMERGENCY PLANNING

INSTRUCTIONS: Use only for continuation of information from the original form. Please reference the section number in which the information corresponds.

1. Employee/Family/Member/Patient Name (Last,First,Middle Initial)	2. Sponsor Name (Last,First,Middle Initial)	3.DODID #