



CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM

THIS FORM IS FOR INTERNAL USE BY THE INTERNATIONAL SOS GROUP OF COMPANIES

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 1079 and 1086, 32 U.S.C. Chapter 17; 32 CFR 199.17; 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules; and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): To obtain information necessary for the processing of requirements and benefits related to the TRICARE Overseas Program (TOP), including but not limited to medical management, your medical related claims, and proper updates of your medical record.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, these records may specifically be disclosed outside the Department of Defense as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: to the Departments of Health and Human Services, Homeland Security, and Veterans Affairs, and to other Federal, State, local, or foreign government agencies, and to private business entities, including entities under contract with the Department of Defense and individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil or criminal litigation.

DISCLOSURE: Voluntary; however, failure to provide consent may result in the inability of International SOS to provide the full range of services and benefits under the TOP.

BENEFICIARY DETAILS:

Table with 2 columns: Beneficiary First Name, Beneficiary Last Name, Beneficiary Date of Birth, DoD Benefits Number (DBN), Beneficiary Phone Number, Beneficiary Email Address.

Section is to be signed by TRICARE Beneficiaries ONLY

RELEASE OF MEDICAL INFORMATION

International SOS Government Services, Inc. and its affiliated entities (International SOS) is a data processor on behalf of the Defense Health Agency (DHA) of your personal data. You may contact International SOS at any of its locations or methods as identified on http://www.tricare-overseas.com or in the footer below. Your personal data will be used for the following purposes:

- 1. Collection of medical record to load into the United States (U.S.) Government system of record for TRICARE beneficiaries.
2. Translation of medical records to support your continued health care and maintenance of your medical record in the U.S. system of record.
3. Case Management, utilization management, and other medical management activities required under the TRICARE benefit.
4. Claims inquiries and processing in accordance with the TRICARE benefit.

The categories of personal data you are being asked to consent to International SOS' collection and use are your name, address, email address, telephone number, DoD Benefits Number (DBN), Social Security Number, and Personal Health Information. International SOS will share this information on an as needed and required basis with the DHA, the cognizant Military Treatment Facility, third-party medical translation vendors and/or Wisconsin Physician Services Insurance Corporation.

Your personal data will be transferred out of the European Union or other locality you are in and sent to the entities referenced above which are in the U.S. or on U.S. soil. Your personal data will be processed and stored in accordance with U.S., EU, and other applicable laws and record retention requirements applicable to International SOS.

Under our processes and these laws, you have the right to request access to, rectify, erase and restrict the processing of your personal data. You also have the right to revoke this consent to use your personal data. If you feel International SOS has violated your rights under a cognizant privacy regulation, you have the right to file a complaint with the appropriate supervisory authority.

I consent to International SOS using my personal data for the purposes described in this notice and understand that I can withdraw my consent at any time. This consent authorization shall be in force and effect until two (2) years from the date of execution at which time this authorization expires.

[ ] I consent [ ] I do not consent

Signature of Beneficiary or Legally Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

Name and Relationship of Legally Authorized Representative to Patient \_\_\_\_\_

Address of the Beneficiary or Legally Authorized Representative \_\_\_\_\_

Note: If the beneficiary is considered a minor, their legal or authorized representative [the parent/s entitled to custody or guardian, and for adults the person in charge or designee] must sign on behalf of the beneficiary.