Mammogram Scheduling

NHCP Mammography Hours:
Monday-Friday 0800-1600 (Schedule is subject to change).

Annual Screening Appointment Availability:
NHCP Mammogram appointments are currently booking at approximately 30 days and less.

Annual Screening Mammograms:

- 40 years or older
- No new lumps, discharge, or pain

How to Make an Appointment:

- Call Central Scheduling at 760-725-4357 Option #3.

Alternative Appointment Solutions for Annual Screening Mammogram:

- Schedule mammogram at Naval Medical Center San Diego (NMCSD) at (619)-532-7394.
- Referral to civilian network:
    1. Ask your PCM for a referral provider out in the network.
    2. NHCP Radiology can provide a copy of prior mammography images completed at Naval Hospital Camp Pendleton on a disc for providers out in the network for comparison.

How to request prior images:

- Complete Authorization for Disclosure of Medical or Dental Information (DD Form 2870).
- DD Form 2870 can also be found online at TRICARE® For Life Benefits Administration Portal or by stopping by NHCP Radiology Front Desk or Outpatient records.
- DD Form 2870 can be dropped off in person at NHCP Radiology Front Desk, Outpatient records or faxed to 760-719-3969 with a copy of benefit ID card.

You must have the following information to complete the form properly:

1. Your name, signature, and date.
2. Patient ID card is required at the time of pick up.
3. If requesting to be mailed, provide the name of receiving facility and their address.
4. If someone other than patient is picking up images, provide the designated person's name and address. Their ID card is required at time of pick up.

IMPORTANT: If you have a new breast lump, discharge, or pain AT ANY AGE, it's important to get seen by your PCM

For Male Patients:
If you're a male patient in need of a mammogram, see your PCM for referral to General Surgery

NMRTC CAMP PENDLETON
DEPARTMENT OF RADIOLOGY
October 16, 2024

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 ☐ BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ 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)*
c. TELEPHONE *(Include Area Code)*	d. FAX *(Include Area Code)*

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*
☐ PERSONAL USE ☐ CONTINUED MEDICAL CARE ☐ SCHOOL ☐ OTHER *(Specify)*
☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION ☐ DATE *(YYYYMMDD)* ☐ 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)*

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

14. X IF APPLICABLE: ☐ AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:	

Reset