



Child and Youth Programs
Air Force Services

Volunteer Packet

Instructions for filling out DD Form 2870:

Fill out the sections as followed:

1 self explanatory

2 self explanatory

3 self explanatory

4 dates should be first date entered into DEERS until present

9 Date you are signing form

11 Signature (parent signature if volunteer is a minor)

12 Relationship to applicant (if volunteer is a minor)

13 Date signing form

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) <input checked="" type="checkbox"/> OUTPATIENT <input type="checkbox"/> INPATIENT <input type="checkbox"/> BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE Family Advocacy, Mental Health and Substance Abuse program TO RELEASE MY PATIENT INFORMATION TO:
 (Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN 31 FSS/FSFY Aviano Youth Program	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) Installation Records Check
 INSURANCE RETIREMENT/SEPARATION LEGAL

8. INFORMATION TO BE RELEASED
 Release any potentially disqualifying information pertaining to whether or not I have favorable or unfavorable results in my Mental Health, Family Advocacy, Substance Abuse or Central Registry files/records.

9. AUTHORIZATION START DATE (YYYYMMDD)	10. AUTHORIZATION EXPIRATION <input type="checkbox"/> DATE (YYYYMMDD) <input checked="" type="checkbox"/> ACTION COMPLETED
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SECTION III - RELEASE AUTHORIZATION

I understand that:

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

14. X IF APPLICABLE: <input type="checkbox"/> 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:

VOLUNTEER APPLICATION

NAME: _____

SSN (**Required): _____

PSC 103 BOX _____

D.O.B. (**Required): _____

CELL PHONE: _____

HOME PHONE: _____

EMAIL (To be used for distro and parent info): _____

SPONSOR'S NAME: _____

SQUADRON: _____

SSN (**Required): _____

DUTY #: _____

VOLUNTEER REQUEST

School Age Open Rec Teen Center GPAB/KNO Special Events Any Activity

DAY OF THE WEEK Mon Tues Wed Thurs Fri No Preference

In order for Youth Programs to accept you as a volunteer we require that you provide three references, one of which must be from your/your sponsor's Commander or First Sergeant.

Commander's Name: _____

Duty Phone: _____

First Sergeant's Name: _____

Duty Phone: _____

Local Reference #1: _____

Duty/Home Phone: _____

Local Reference #2: _____

Duty/Home Phone: _____

Do you have past volunteer experience? If so, please describe?

What are your hobbies and interests?

What type of volunteer commitment are you willing to make to the Youth Programs?

I, the undersigned, desire to volunteer my services to the Aviano Youth Program. I expressly agree that such services are offered at no cost to the US Government or any instrumentality thereof. I expect no present or future compensation as a result of the services to be performed by myself. I understand that the performance of services entitle me to present any claims against the United States or any agency, instrumentality or employee thereof.

Signature of Volunteer

Date

Signature of Witness

Date

Application Expiration Date: _____

**ACKNOWLEDGEMENT OF RIGHTS
AND
CONSENT TO RELEASE RECORDS
FOR
YOUTH VOLUNTEER POSITIONS**

AUTHORITY: 42 U.S.C. 13041 AND 10 U.S.C. 8013

PRINCIPLE PURPOSE: To comply with Public Law 101-647. Section 231. and DoDI.1402.5.Criminal History Background Checks on individuals in Child Care Services: and Air Force Instruction 34-249. Youth Program: Air Force Instruction 34-804. Air Force Youth Sports Program. Volunteer Positions 4.1.

DISCLOSURE: Mandatory. In the case of an applicant for a position, either paid or volunteer, involved with children under the age of 18, refusal to sign this form shall result in the employer's refusal to consider the application for employment. In the case of an incumbent of a position involved with children under the age of 18, refusal to sign this form shall result in removal from such position.

EMPLOYEE VOLUNTEER ACKNOWLEDGEMENT:

1. I have been advised and understand that the United States Air Force, as a Federal employer, has an obligation to require a record check as a condition of employment, paid or volunteer, in a position involved with children under the age of 18. I have been further advised that I have a right to obtain a copy of any criminal history report made available to such employer or potential employer and to challenge the accuracy and completeness of any information included in such report.

2. I understand that the record check will include the following:

I have identified an Installation Records Check (IRC) at all installations as residences during the preceding two years. This records check will include, as a minimum, inquiries of the Security Policy, Medical Treatment Facility, the Family Housing Office, the Social Actions Office, and the Family Advocacy Office.

I hereby authorize all Federal, State, or local agency offices to release any record relating to me, with is necessary to complete the record checks described above.

Signature

Date

Printed Name: _____

Bases Assigned during the past two (2) years:
