Disability Evaluation System Army Legal Assistance

You have elected to receive limited-scope legal assistance consisting of legal advice and document preparation assistance by appointed Army legal counsel or lawyer known as a Soldiers' Disability Evaluation System Counsel (DES), at no expense to you, while processing through the Disability Evaluation System Counsel (DES). You may terminate your DES Counsel, attorney-client relationship at any time and obtain private legal counsel or representation from a Veterans Service Organization (VSO), at your own expense, by changing your election in the Advice of Right to Counsel form and notifying your DES Counsel and PEBLO. For appeals outside the scope of the DES, you will need to obtain your own legal counsel at your own expense. In the event you are undergoing disciplinary action such as an Administrative Separation, you should immediately contact Trial Defense Service (TDS).

The DES provides legal assistance to Soldiers and does not represent the command, Medical Evaluation Board (MEB) or Physical Evaluation Board (PEB). DES scope of legal assistance is limited to proceedings in the DES including MEB, Informal PEB (IPEB), and Veterans Administration Request for Reconsideration (VARR) for ratings of conditions found unfitting by the PEB. DoDM 1332.18-V1, Enc. 6; AR 635-40, para. 4-5. If your originally appointed DES is unavailable, your case will be transferred to another DES and your earlier attorney-client relationship will be terminated. Your attorney- client relationship with your appointed DES will normally terminate upon your DA Form 199 IPEB Proceedings elections and under no circumstance later than your final disposition (not including being placed on the Temporary Disability Retirement List (TDRL)) from the Army. If you elect a FPEB, a Soldiers' Physical Evaluation Board Counsel will be appointed to represent you.

You may be requested to assist your appointed DES with obtaining and developing evidence such as statements, medical records, and other documents by established timelines. Your DES will provide you with legal assistance within a reasonable allocation of time given counsel's caseload and established timelines. You agree to a limited waiver of your attorney-client privilege for the purpose of your Soldiers' Counsel advancing your goals in the DES. If you desire broader scope legal assistance or representation than offered by DES, you should consider obtaining private legal counsel at your own expense or from a VSO.

To facilitate your legal assistance, you have signed agreements permitting the Office of Soldiers' Counsel (OSC) to have access to your protected health information, including medical records, dental records, and behavioral health records. You have also granted OSC permission to send and receive unsecure email messages containing these records along with attorney-client privileged information. You may revoke these agreements at any time by informing your Soldiers' Counsel and your PEBLO in writing.

Last Name	First Name	Signature	Date

(or e-signature, or s-signature /John E. Doe/, or email agreement date)

OFFICE OF SOLDIER'S COUNSEL
NEW CLIENT INTAKE DATA

1. Today's Date _____	Have you ever been to our office before? ___ Yes ___ No

We need your best contact information & personal data
(We need cell phone numbers & Email addresses you actually check)

2. Name (last/first/MI) _____		
3. SSN Last 4 _____	4. Rank _____	5. Date of Birth: _____
6. Best phone number for you? _____		
7. Best e-mail address? _____		
8. Spouse's name & phone number (if any)? _____		
9. Your address? _____		
10. Current (MOS) and Duty Title? _____		
11. Unit of assignment & location? _____		
12. What is your current military status? (Please check all that may apply)		
☐ Active-Duty Army	☐ Active Guard or Reserve (AGR)	☐ IRR
☐ Army Reserve	☐ Army National Guard	☐ IMA
I am attached or assigned to the Soldiers Recovery Unit (SRU)		
13. Basic Active Service Date: _____	Blended or Legacy retirement? _____	
14. Do you have an approved Retirement Packet?	☐ Yes	☐ No
What is the date of your approved Retirement Packet? _____		
15. Do you have a "15 or 20 year letter" from the Army Reserve or Guard?	☐ Yes	☐ No
16. Have you been on any combat zone deployments?	☐ Yes	☐ No
17. Have you received any combat medals/awards/badges?	☐ Yes	☐ No
18. Are you currently on a DA select or automatic promotion list?	☐ Yes	☐ No
19. Are you currently pending any UCMJ or administrative processing?	☐ Yes	☐ No

Is this your first time in the MEB / PEB?

20. If you have been in the MEB/PEB process before: (please check any that may apply)
☐ I was previously found Fit for Duty and/or Returned to Duty.
☐ I was previously placed on Temporary Disability Retired List (TDRL).
☐ I was previously placed on Continuation of Active Duty (COAD) or (COAR) status.
21. What is your goal in the MEB/PEB Process? _____
22. PEBLO's contact information:
Name: _____ Phone number: _____
23. Date you received your MEB results (DA For 3947 / NARSUM)? _____

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 provides the Office of Soldiers' Counsel with the necessary information to represent and defend your interests. ROUTINE USE(S): This information will be used by your attorney to advise you and protect your interests. DISCLOSURE: Voluntary. Failure to complete the form will result in less accurate and less efficient legal representation

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)*
Basic Active Service Date to Completion of the DES	[ ] OUTPATIENT [ ] INPATIENT [X] BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE All Military/Civilian/VA treatment facilities & TRICARE *(Name of Facility/TRICARE Health Plan)* TO RELEASE MY PATIENT INFORMATION TO:

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
Office of Soldiers' Counsel MEB and PEB offices W0KEAA	Office of Soldiers' Counsel, 9275 Gunston Road, Fort Belvoir, VA 22060
c. TELEPHONE *(Include Area Code)* 703-693-1100	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 [X] LEGAL

8. INFORMATION TO BE RELEASED

All medical records, all patient information, all requested documents and information, including but not limited to patient records, medical test results, consultations, appointment summaries, and records. All mental health records.

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION DATE *(YYYYMMDD)*
	[ ] [X] 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:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
[ ] AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	
	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:

OFFICE OF SOLDIERS' COUNSEL
Electronic Communications Consent Form

WARNING: Our offices are not equipped to handle, or store classified documents or media so DO NOT email, send or bring classified material to us. You should not have classified material in your personal possession anyway. If you know of classified material that might help your case, you should give us a brief, unclassified description and the location of the documents. We can make arrangements for a properly cleared person to view the material at the designated facility.

The Office of Soldiers' Counsel (OSC) attorneys and paralegals will communicate with you by telephone and email while we assist you with your disability evaluation case. Under certain circumstances, unencrypted email communication containing your protected health information (PHI) may occur between the OSC staff and you. Email communication containing your PHI will be used if you and the OSC staff agree on this method of communication. The purpose of this form is to receive your consent and acknowledgment.

In order to preserve the security of your personal information, the OSC will use only encrypted emails when communicating with Physical Evaluation Board Liaison Officers (PEBLOs), VA Military Service Coordinators and members of the Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) about your case. We may also use the HIPAA-approved Safe Access File Exchange (SAFE) protocol process when transmitting your protected information to these individuals. Unencrypted email is not a secure means of communication. OSC staff will use the minimum and necessary amount of PHI when responding to your questions or communicating information to you. Unless you give OSC express authorization in writing or via email for each occasion, in no event will any unencrypted email communications to you include highly sensitive PHI such as information relating to HIV/AIDS, spouse or child abuse, or mental health or substance abuse. We will request your written permission before we send you any highly sensitive Protected Health Information (PHI) via unencrypted email.

Unencrypted email is not a secure means of communication. There is some risk that PHI contained in email may be disclosed to, or intercepted by, unauthorized third parties. Use of more secure methods of communications, such as phone or fax, is an alternative that is available. I understand and accept the risks associated with the use of unsecure email communications. My email to/from my attorney(s) is confidential and protected by attorney-client privilege, but it may be shared with OSC paralegals for administrative purposes. OSC paralegals are also bound under attorney-client confidentiality obligations. Both parties are aware of the risks associated with unencrypted email communication. By completing this form, the OSC attorney and I understand and are willing to accept the risks involved with unsecure email communication of my PHI.

DATE: _____

Soldiers Name: _____

Soldiers email address: _____

Soldier's Signature: _____

OSC Attorney's Name: _____

OSC Attorney's Signature: _____