KICKAPOO TRIBAL HEALTH CENTER
P.O. BOX 1059
MCLOUD OKLAHOMA 74851
405-964-2081 FAX: 405-964-2722

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Complete all sections, date and sign

I, _____, hereby voluntarily authorize the disclosure of protected health information from my record.
(Name of Patient)

The information is to be disclosed by:	The information is to be provided to:
Name of Facility/Individual	Name of Facility/Individual
Address	Address
City, State	City, State

The purpose or need for this disclosure is:

___Further Medical Care ___Attorney ___School ___ Research ___ Other (Specify) _____
___Personal Use ___Insurance ___ Disability ___Health Information Exchange (IHS/Other) _____

The Information to be disclosed from my health record: (check appropriate box (es)

- ☐ Only information related to (specify) _____
- ☐ Only the period of events from _____ to _____
- ☐ Other (specify) (CHS, Billing, etc.)_____
- ☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box (es) below:

- ☐ Alcohol/Drug Abuse Treatment/Referral
- ☐ Sexually Transmitted Diseases
- ☐ HIV/AIDS related Treatment
- ☐ Mental Health (Other than Psychotherapy Notes)
- ☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

- I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years. _____
  (Specify new date)
- I understand that Kickapoo Tribal Health Center will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.
- I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CPF Part 164), and the Privacy Act of 1974 (5 USC 552a).

_____ _____
Signature of Patient Date

_____ _____
Signature of Authorized Representative (state relationship to patient) or Witness (if signature is thumbprint or mark) Date

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NON COMMUNICABLE DISEASE.

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a (i) (3)). I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseased such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

PATIENT NAME: _____ MEDICAL RECORD #: _____

DATE OF BIRTH: _____ LAST 4 DIGITS OF SOCIAL SECURITY #: _____