DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Form Approved: OMB No. 0917-0030
Expiration Date: December 31, 2026
See OMB Statement on Reverse.

Complete all sections, date, and sign

I. AUTHORIZATION

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

II. THE INFORMATION IS TO BE DISCLOSED BY:	III. AND IS TO BE PROVIDED TO:
NAME OF FACILITY KICKAPOO TRIBAL HEALTH CENTER	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS 10365 STATE HIGHWAY 102	ADDRESS
CITY/STATE MCLOUD, OK	CITY/STATE

IV. THE PURPOSE OR NEED FOR THIS DISCLOSURE IS:

☐ Treatment, Payment or Other Healthcare Operations ☐ Attorney ☐ School ☐ Other *(Specify)* _____
☐ Personal Use ☐ Disability ☐ Research ☐ Health Information Exchange *(IHS/Other)* _____

V. 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:

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

VI. AUTHORIZATION

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 If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

(Specify new date (mm/dd/yyyy) or expiration event)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2 (see below), may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SPECIFIC PROVISIONS REGARDING THE USE OR DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS: I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a], and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if I am authorizing the disclosure of my substance use disorder records to a Health Information Exchange pursuant to a general designation, I have the right to receive a list of all such disclosures made from the Health Insurance Exchange.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE *(mm/dd/yyyy)*
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE *(mm/dd/yyyy)*

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)).

PATIENT IDENTIFICATION

	NAME *(Last, First, MI)*	
	ADDRESS	
	CITY/STATE	
	DATE OF BIRTH *(mm/dd/yyyy)*	RECORD NUMBER

Instructions for Completing IHS Form 810
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink.
2. Section I, print your name or the name of patient whose information is to be released.
3. Section II, print the name and address of the facility releasing the information. Section III, provide the name of the person, facility, and address that will receive the information.

    a. If the information is being disclosed to prevent multiple enrollments in a withdrawal management or maintenance treatment program, please provide the name of each central registry, withdrawal management, and maintenance treatment program to which disclosure may be made OR state "any withdrawal management or maintenance treatment program within 200 miles of [IHS Facility permitted to make the disclosure]".

4. Section IV, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc. For an Health Information Exchange (HIE) other than IHS, please provide the name of the HIE, as well as the name or general designation of the HIE participants who may access your records (e.g., a specific provider(s) or "my current and future treating providers").
5. Section V, check the appropriate box as applicable.

    a. Only information related to – specify diagnosis, injury, operations, special therapies, etc.

    b. Only the period of events from – specify date range, e.g., Jan. 1, 2002, to Feb. 1, 2002.

    c. Other (specify) – e.g., Purchased Referred Care (PRC), Billing, Employee Health.

    d. Entire Record – complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).

    e. IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES *MUST* BE CHECKED BY THE PATIENT.

    f. Psychotherapy Notes ONLY – IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES (which are separate from progress notes and contain the therapist's impressions and the content of psychotherapy conversations), ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.

    IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

6. Section VI, if a different expiration date or event is desired, please specify. When you opt-in to share information through the HIE, an expiration date must be entered; it is recommended that a date five (5) years into the future be entered to provide for continuity of care.

    a. If authorizing the release of records for court-ordered substance use disorder treatment, the expiration date/event must be no later than the final disposition of the criminal proceeding.

7. Section VI, Please sign (or mark) and date.
8. A copy of the completed IHS-810 form will be given to you.

OMB STATEMENT