Tribal Health CONFEDERATED SALISH AND KOOTENAI TRIBES

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I _____ hereby voluntarily authorize the discloser of information from my medical records.
(Name of Patient)

Patient Name	
Date of Birth	
Address, City, State, Zip	
Phone	
Verified by ID	Initialed by THD staff

The information is to be disclosed by:

Name of Facility: Confederated Salish & Kootenai Tribal Health Department
Address: PO Box 880 Phone: (406) 745-3525
City/State/Zip: St. Ignatius, MT 59865 Fax: (406) 203-9766

The information is to be disclosed to:

Name of Person/Facility or Organization: _____
Address:_____
City/State/Zip:_____ Fax:_____

The information to be disclosed from my medical health record: *Must check all boxes that apply*

□ Complete copy of records
□ Physician visit(s) dated: _____ to _____
□ Lab result(s) dated: _____ to _____
□ Nursing visit(s) dated: _____ to _____
□ Billing must specify dates: _____ to _____
Specify other/type of billing: _____

□ Only information related to:
□ Physical exam(s) dated: _____ to _____
□ Immunization(s) dated: _____ to _____
□ Dental visit(s) dated: _____ to _____
□ Other (specify dates): _____ to _____

The purpose or need of this disclosure is:

□ Continuity of care □ Insurance purposes □ Legal purposes □ Personal □ Other

I understand that I may revoke this authorization in writing submitted at any time to the Medical Records Department, except to the extent that actions have been taken in reliance on this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other lay provided insurer with the right to consent a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different date of expiration. _____

I understand that Tribal Health Services will consider treatment or eligibility for care on my providing the authorization except if such care is: (1) Research related to (2) Provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

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 Information Portability and Accountability Act Privacy Rule [45crf Part 164], and the Privacy Act of 1974 [5usc 552a].

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Authorized Representative or Witness if patient signature is thumb print or mark **Relation to Patient**