Tribal Health CONFEDERATED SALISH AND KOOTENAI TRIBES

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I. I _____ hereby voluntarily authorize the discloser of information from my records.
(Name of Patient) Patient's DOB:

II. The information is to be disclosed by:

Name of Facility: _____

Address: _____

City/State/Zip: _____ Fax: _____

And is to be provided to:

Name of Person/Facility or Organization: _____

Address: _____ Phone: _____

City/State/Zip: _____ Fax: _____

III. The information to be disclosed from my health record: ***Check appropriate box(es)***

___Complete copy of records; or only information related to:

___Physician visits dates: _____to_____ ____Physician exam dates: _____to _____

___Lab Results dates: _____to _____ ____Immunization dates: _____to _____

___Nursing visit dates: _____to _____ ____Dental visit dates: _____to _____

___Billing (specify) dates: _____to _____ ____Other (specify) dates: _____to _____

Specify other/ type of billing: _____

IV. The purpose or need of this discloser is:

☐ Continuing Care ☐ Insurance Purposes ☐ Legal Purposes ☐ Personal ☐ Other

V. 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 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 If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date. _____

I understand that THHS 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 [45cfr 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 **Relationship to Patient** **Date**

INSTRUCTIONS TO COMPLETE FORM THHS-810 AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

1. Print legibly in all fields using black or blue ink.
2. Section I: Print your name of the patient whose information is to be released.
3. Section II: Print the name and address of the facility releasing the information, also, provide the name of the person, facility and address that will receive the information.
4. Section III: Check the appropriate box as applicable.
    a. Entire records: the complete records includes medical clinic, labs, x-ray records; it does not include sensitive information (alcohol/drug abuse treatment/referral, sexually transmitted diseases', and HIV/AIDS related treatment.
    b. Only information related to specify diagnosis, injury, operations, special therapies, etc.
    c. Only the period of events from specify date range, e.g. Jan. 1, 2002 to Feb. 1, 2002.
    d. Other (specify): e.g. Pharmacy, Nutrition/Diabetes visits.
5. Section IV: Check the appropriate box explaining why the information is needed.
6. Section V: Sign and date. If a different date is desired, specify new date.
7. Section V: Authorized Representative, e.g. Legal Guardian, Power of Attorney, etc.
8. A copy of the completed form THHS-830 will be provided to the patient upon request.

<table>
<tr><td rowspan="5">Picture ID</td><td colspan="2">Name: (last, First, MI)</td></tr>
<tr><td colspan="2">Address:</td></tr>
<tr><td colspan="2">City/State/Zip:</td></tr>
<tr><td>Record No.:</td><td>Date of Birth:</td></tr>
<tr><td colspan="2">Phone:</td></tr>
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Copy of Form THHS-810 provided to patient: Yes _____ No _____

Patient Identification verified by: _____ Picture ID: _____