AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE AND SIGN

I. I, _____
(Print full name of patient)
, hereby voluntarily authorize the disclosure of information from my record.

II. The information is to be disclosed by: **And is to be provided to:**

NAME OF FACILITY		NAME OF PERSON/ORGANIZATION/FACILITY	
ADDRESS	PHONE:	ADDRESS	PHONE:
	FAX:		FAX:
CITY/STATE/ZIP		CITY/STATE/ZIP	

III. The purpose or need for this disclosure is:

_____

IV. The information to be disclosed from my health record: (check appropriate box(es))

- ☐ Entire Record
- ☐ Only information related to (specify) _____
- ☐ Only the period of events from _____ to _____
- ☐ Other (specify) _____
- ☐ Psychotherapy Notes ONLY (by cheking this box, I am waiving my psychotherapist-patient privileges)

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

- ☐ Alcohol/Drug Abuse Treatment/Referral
- ☐ Sexually Transmitted Diseases
- ☐ HIV/AIDS-related Treatment
- ☐ Mental Health (other than Psychotherapy Notes)

V. I understand that I may revoke this authorization at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer woth the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one (1) year from the date of my signature unless I have specified a different expiration date *or expiration event.*
Enter date if different from one year after date below: _____

I understand that IHS 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 (PHI) for disclosure to a third party.

I understand that information disclosed by this authorization my be subject to redisclosure by the recipient and no longer be protected by the Health Insurance Portablility and Accountability Act (HIPAA) Privacy Rule [45 CFR 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 watermark)	**Date**

This information is to be released for the purpose stated above and may not be used for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretense shall be guilty of a misdemeanor [5 USC 552a (i)(3)]

PATIENT IDENTIFICATION

NAME (Last, First, MI)	RECORD NUMBER
ADDRESS	
CITY/STATE/ZIP	DOB