Seattle Indian Health Board

For the Love of Native People

AUTHORIZATION FOR RELEASE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION:

Patient Name: _____ SIHB No.: _____

(former name or AKA): _____ Social Security No. _____

Address: _____

Daytime Phone: _____ Birth Date: _____ Age: _____

INFORMATION TO BE RELEASED FROM:

I, _____ hereby authorize disclosure or release of PHI for _____
Patient or Legally Authorized Representative — Patient Name

FROM THE FOLLOWING:

☐ Seattle Indian Health Board (SIHB) ☐ Thunderbird Treatment Center (TTC)
☐ Other (Specify)_____

RELEASE TO:

Individual or Class of Individuals: _____ Organization_____

Relationship to the Patient: ☐ Self ☐ Treating Provider(s) ☐ Third-Party Payer: ☐ NOT a treating provider or Third-Party Payer

Address: _____

Phone_____ Fax _____

Note: I understand that I have the right to request a list of entities to whom my Part 2 patient-identifying information (PII) has been disclosed pursuant to the general designation. I further understand that this request must be made in writing (either electronic or paper documentation).

PURPOSE OF DISCLOSURE:

☐ Legal/Attorney ☐ Insurance/Payment ☐ Provider/Continuity of Care ☐ Personal
☐ Other (Specify)_____

DATES TO BE RELEASED:

☐ Most recent five years ☐ Most recent two years ☐ All dates

☐ Specific dates of care received From _____/_____/_____ Through _____/_____/_____

INFORMATION TO BE RELEASED:

MEDICAL
- ☐ Progress Notes
- ☐ Medication List
- ☐ Problem List
- ☐ Diabetes Flow Sheet
- ☐ History and Physical
- ☐ Lab Results
- ☐ X-ray Reports
- ☐ EKG
- ☐ Immunization List
- ☐ Other _____

MENTAL HEALTH
- ☐ Intake Assessment
- ☐ Progress Notes
- ☐ Treatment Plan
- ☐ Correspondence
- ☐ Consents
- ☐ Other _____

DENTAL
- ☐ Progress Notes
- ☐ Treatment Plan
- ☐ X-rays
- ☐ Other _____

CHEMICAL DEPENCENCY
- ☐ Intake Assessment
- ☐ Treatment Plan
- ☐ Discharge Summary
- ☐ Other _____

☐ All Records to Include identity, dates, diagnosis, prognosis, assessments, recommendations, treatment rendered, progress notes, treatment summary, status, and coordination for medical conditions, mental health/psychiatric conditions, dental conditions, and/or chemical dependency treatment.

PATIENT'S ADDITIONAL AUTHORIZATION

I understand that my records are protected under Federal, State, and County confidentiality regulations and my express consent as documented here is required to release any and all health care information relating to testing, diagnosis and/or treatment for HIV/AIDS, sexually transmitted disease, psychiatric disorders/mental health, substance use disorder, or genetic testing unless specifically excluded as noted below.

Please check if you **DO NOT** want this information released.
- ❑ HIV/AIDS
- ❑ Sexually transmitted disease
- ❑ Substance use disorder history
- ❑ Psychological information
- ❑ Genetic testing

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I understand I do not have to sign this authorization in order to receive health care benefits (treatment, payment or enrollment). However, I do have to sign this authorization form if I am taking part in a research study or receiving health care when the purpose is to create health care information for a third party.

FEES: I understand a fee may be charged for copies of my medical record according to State law (RCW 70.02.010 and WAC 246-08-400)

REVOCATION: I may revoke this authorization at any time to SIHB in writing or completing the Revocation of Authorization form. I understand that if f I revoke this authorization, it will not affect any actions taken by the Seattle Indian Health Board based upon this authorization before SIHB received my revocation letter, e.g. SIHB cannot rescind disclosures already made and may use my health information as necessary to bill and collect for services rendered, except as noted in 42 CFR Part 2 for substance use disorder information. I may not be able to revoke this authorization if its purpose was to obtain insurance.

RE-DISCLOSURE: I understand that once my healthcare information is disclosed, the person or organization that received it may re-disclose it. HIPAA Privacy laws may no longer protect it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient is prohibited from disclosing identifiable substance abuse information.

EXPIRATION: This authorization will expire once the request has been filled or on this date: _____/_____/_____. In the case of either **Patient Portal (FollowMyHealth)** or **HopeLink** this authorization will not expire unless revoked by the patient or legally authorized representative.

MINORS: A minor patient's signature is required in order to release the following information:

1) Conditions relating to the minor's reproductive care.
2) Sexually transmitted diseases (if age 14 or older)
3) Substance use disorder and mental conditions (if age 13 or older)

PROHIBITION ON CONDITIONING OF AUTHORIZATION: SIHB will not condition treatment on your signing this authorization unless

1) You are receiving research-related treatment, or
2) The only reason the facility is providing you with healthcare is to make a report to a third party, such as your employer (e.g. fitness to return to work) or school (e.g. PE physical)

Signature of patient / Legally authorized representative	Relationship to Patient	Date
Witness	Date	

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by these regulations.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

FOR STAFF USE ONLY

Request received by _____Date: _____/_____/_____

Copy of Authorization provided: ☐Yes ☐No Fee schedule provided: ☐Yes ☐No

The Legally Authorized Representative presented the following documentation to demonstrate their authority to act on behalf of the patient:

☐ Durable Power of Attorney ☐ Death Certificate ☐ Executorship ☐ Court Order

Patient or Authorized Legal Representative notified that records were ready on date: _____/_____/_____ Staff Initials _____

_____ `_____/_____/_____

Signature of person picking up records Date

Type of photo identification verified ☐ Driver's License ☐ Military ID ☐ Other_____ Staff Initials_____