Klamath Tribal Health & Family Services

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

BEHAVIORAL HEALTH RECORDS

I hereby voluntarily authorize the disclosure of information from my record, as identified below:	
Patient Name:	**Date of Birth:**
Check applicable status: ☐ **Adult** ☐ **Emancipated Minor** ☐ **Minor**	

Please *initial* the type of exchange: _____ Mutual exchange/release OR _____ One direction

INFORMATION IS TO BE RELEASED BY:	**AND IS TO BE PROVIDED TO:**
Name of Facility/Organization/Person:	Name of Facility/Organization/Person:
Mailing Address:	Mailing Address:
City/State/Zip:	City/State/Zip:
Phone #:	Phone #:
Fax #:	Fax #:

The purpose or need for this disclosure is:

☐ Further Treatment/Care	☐School	☐ Disability	☐ Verbal Discussion of Care
☐ Personal Use	☐ Insurance	☐ Attorney	☐ Other (specify):

Type of information to be released (check appropriate box(es)):

☐ All substance use disorder information	☐ Consultation History & Physical
☐ All psychiatric evaluation/diagnosis/treatment records	☐ Lab Reports
☐ Psychotherapy Notes Only (may not be combined with other information)	☐ Medication List
	☐ Other (specify):

Note: For disclosure of information not related to behavioral health or substance use treatment, please use KTHFS Form #810 HEALTH for Patient Health records.

I have a right to receive a copy of this authorization. I understand that I may revoke this authorization in writing submitted at any time to the Medical Record Department, but if I do, it will not have any effect on actions taken under this authorization before my revocation was received. . I understand I may also make a verbal revocation of this authorization, but KTHFS will seek written revocation when possible, or will at a minimum document my revocation in my health record. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with a right to contest a claim under the policy I understand that the individual/entity releasing this information may not condition treatment, payment, enrollment or eligibility for benefits 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 for disclosure to a third party. If this authorization has not been revoked, it will terminate one year from the date of my signature, unless I have specified a different expiration date or expiration event here (specify):_____. I understand that if I have made a general designation for who should receive my information (*e.g.*, "all my treating providers" or "all programs in which I have received substance use disorder treatment"), I may make a written request to the KTHFS for a list of entities to whom my substance use disorder patient records were disclosed in compliance with this authorization, for such disclosures made for up to a two (2) year period prior to my written request. For any disclosures of my substance use disorder treatment information made through an electronic health record, for treatment, payment, or health care operations purposes, I may make a written request for an accounting of disclosures for up to three (3) years prior to the date on which the accounting is requested. This statement is included with disclosure of substance use disorder patient records: "42 C.F.R. Part 2 prohibits unauthorized disclosure of these records." If the information to be released is not substance use disorder patient records, I understand that if the person/entity authorized to receive the information is not a health plan or health care provider, the released information *may* no longer be protected by federal privacy law.

Signature of Patient:	Date:
Personal Representative (State relationship to patient) or Witness (if signature is a thumbprint or mark):	Date:

THIS SECTION FOR OFFICE USE ONLY	APPROVED BY:	COMPLETED BY:
PATIENT RECORD #	DATE APPROVED:	DATE COMPLETED: