Klamath Tribal Health & Family Services

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT 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	

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)):

☐ Most recent two-year history
☐ Only information related to (specify):
☐ Only for the following time frame: (specify dates)
☐ Entire record
☐ Other (specify):

Sensitive information: **Initial** on the line if you authorize any of the following sensitive information disclosed:

____ Sexually transmitted diseases _____ HIV/AIDS related information _____ Genetic testing information

Note: For disclosure of mental health, psychotherapy notes, or substance use treatment information, please use KTHFS Form #810 BH for Behavioral 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. 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. I understand that if the person/entity authorized to receive this information is not a health plan or health care provider, the released information *may* no longer be protected by federal privacy law. If this authorization has not been revoked, **it will terminate one year from the date of my signature**, unless I have specified a different expiration date or expiration event here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):_____(must not exceed one year from the date of this form). Information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

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: