Klamath Tribal Health & Wellness Center
330 Chiloquin Blvd, PO Box 490
Chiloquin, OR 97624

KTHFS Use Only
Chart Number

Authorization to Furnish Information

I authorize the release of all protected health information necessary to process all claims for services provided by Klamath Tribal Health and Family Services that are pertinent to the patient's health care; including but not limited to medical service companies, insurance companies, workers' compensation carriers, welfare agencies and/or the patient's employer. I understand that all health information will be kept in strict confidentially in accordance with Privacy Act of 1974, 5 U.S.C., Sec. 522a and Health Insurance Portability and Accountability Act, Privacy Rules, 45 CFR, Part 164.

Assignment of Benefits

I hereby give Klamath Tribal Health & Family Services my authorization to collect payment from third party payers on my behalf. I assign all medical, dental, behavioral health, pharmacy, transportation and supply benefits to Klamath Tribal Health & Family Services.

Consent for Treatment

General Consent to Treatment: By signing below, I, (or my authorized representative on my behalf) authorize Klamath Tribal Health & Family Services and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries.

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Signature of patient, legal guardian, or policy holder for private insurance Date