Klamath Tribal Health & Family Services

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I. I, ______________________________ Date of Birth ____________________, hereby voluntarily authorize
Name of Patient
the disclosure of protected health information from my record.

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

____
Name of Facility / Organization

____
Department Name (example - Medical, Dental, Pharmacy, Billing, P/RC, etc.)

____
Mailing Address

____
City / State / Zip Code

( ) ______________________________
Phone #

( ) ______________________________
Fax #

And is to be **provided to:**

____
Name of Facility / Organization / Person

____
Mailing Address

____
City / State / Zip Code

( ) ______________________________
Phone #

( ) ______________________________
Fax #

III. **The purpose or need for this disclosure is:** *(check appropriate box)*

☐ Further Medical Care ☐ Attorney ☐ School
☐ Personal Use ☐ Insurance ☐ Disability
☐ Discuss care and provide paper records when requested
☐ Discuss care only (no paper records to be given)
☐ Other (specify) ______________________________

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

☐ Most recent two year history
☐ Only information related to *(specify)*______________________________
____
☐ Only the period of events from ____________________ to ____________________
☐ Other *(specify)* ______________________________
☐ Entire record

Check the appropriate box(es) and <u>initial</u> next to them below if you would like any of the following sensitive information disclosed:

_____☐ Alcohol/Drug Abuse Treatment/Referral
_____☐ HIV/AIDS related treatment
_____☐ Sexually Transmitted Diseases
_____☐ Mental Health *(other than Psychotherapy Notes)*
_____☐ Psychotherapy Notes **ONLY** (By checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, **<u>it will terminate one year from the date of my signature</u>** unless a different expiration date or expiration event is stated.

____
*(Specified date **<u>must not exceed</u>** one year from the date of this form)*

I understand that KTH&FS 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 for disclosure to a third party.

"I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule, [45 CFR Part 164] or other applicable law. However, if any of this information has been disclosed to you from records protected by Federal confidentiality rules, 42 CFR Part 2 (drug and alcohol records), 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 as otherwise permitted by 42 CFR Part 2. A general authorization for the 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."

SIGNATURE OF PATIENT:	DATE
SIGNATURE OF PERSONAL REPRESENTATIVE *(State relationship to patient)* or Witness *(if signature is thumbprint or mark)*	DATE

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

OFFICE USE ONLY
Patient Record # ______________ Approved by ____________ Completed by ______________ Date Completed ______________

KTH&FS Form #810 (06/2015)

Instructions for Completing KTH&FS Form #810
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

1. Print legibly in all fields using dark ink.

2. Section I, print the name and date of birth of the patient whose information is to be released.

3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility and address that will receive the information.

4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research related projects, etc.

5. Section IV, check the appropriate box as applicable.

    a. **Most recent two year history**

    b. **Only information related to** – specify diagnosis, injury, operations, special therapies, etc.

    c. **Only the period of events from** – specify date range, e.g., Jan. 1, 2015 to Dec. 31, 2015 (date range must not exceed one year from signature date).

    d. **Other (specify)**

    e. **Entire Record**

    f. **SENSITIVE INFORMATION (OTHER THAN PSYCHOTHERAPY NOTES) -** the appropriate box **must be checked and initialed** by the patient.

    g. **PSYCHOTHERAPY NOTES ONLY** – ***in order to authorize the use or disclosure of psychotherapy notes, ONLY this box should be checked on this form. Authorizations for the use or disclosure of other health record information may not be made in conjunction with authorizations pertaining to psychotherapy notes.***

    IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

    Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

6. Section V, If a different *expiration* date is desired, specify a new date not exceeding one year from the date of this form.

7. Section V, Patient must sign and date.

8. Section V, Personal Representative, e.g., legal guardian, power of attorney, etc.

9. A copy of the completed KTH&FS Form #810 will be given to the patient.