AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
(Please read and complete both sides of this form)

COQUILLE INDIAN TRIBE COMMUNITY HEALTH CENTER

DIRECT CARE
PHONE: (541) 888-9414
FAX: (541) 888-5556

Patients' Name _____
First Middle Last

Date of Birth _____ SS# _____-_____-_____

PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION

FROM: Name: _____
Address: _____
City & State: _____
Phone: _____ Fax: _____

TO: Name: COQUILLE INDIAN HEALTH CENTER
Address: PO BOX 3190
City & State: COOS BAY, OR 97420
Phone: 541-888-9494 Fax: 541-888-5556

The purpose of this release is:
☐ Diagnostic Evaluation ☐ Follow-up Care
☐ Medical Treatment ☐ Other
☐ Continuity of Care

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

□ Entire Record
□ Only information related to (*specify*): _____
_____
□ Only the period of events from: _____ to _____
□ Other (specify): _____
□ **Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)**

By initialing in the spaces below, I authorize release of the following information:

_____ HIV/AIDS related information
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment, or referral information

Release of the specified information is limited to the following:

□ time period _____
□ treatment dates _____

_____ I consent to transmission of my medical records via FAX machine.

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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, or if this authorization was obtained as a condition of providing insurance coverage, other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date.
Expiration Date: _____

I understand that CITCHC 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 (HIPAA) [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

Signature of Patient: _____ _____
Date

_____ _____
Signature of Authorized Representative (state relationship to patient) Date
or Witness (if signature is by thumb print or mark)