AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This form authorizes United Indian Health Services (UIHS) to release your Protected Health Information (PHI). You only need to complete this form if you want UIHS to give your PHI to another person or organization, such as your spouse. PHI is information about you that may identify you and relates to your past, present, or future physical or mental health or condition and related health services. Please print clearly in blue or black ink.

SECTION A: Individual authorizing release of PHI

YOUR NAME: _____ MRN: _____

YOUR TELEPHONE NUMBER: (Day)_____(Evening) _____

YOUR ADDRESS: _____
Street Apartment #

_____
City State ZIP Code

SECTION B: Description of authorization

I hereby authorize United Indian Health Services (UIHS) to release my Protected Health Information (PHI) as described in this authorization. I understand that my PHI may include, but is not limited to the following: medical records, emergency care records, billing statements, laboratory reports, dental records, behavioral health records, and any personal or medical information related to the purpose of this authorization.

I further understand that my PHI may include information related to any of the following: mental health (excluding psycho-therapy notes), HIV/AIDS, prescription medication, pregnancy/maternity, and chemical dependency (including alcohol and drug treatment).

I further understand that this authorization applies to **ALL** PHI, except for the following limitations (if none, please leave blank): _____

SECTION C: Persons/Organizations authorized to receive my PHI

Please tell us who you are authorizing to receive your PHI by completing the table below.

- For "Person's Relationship to You" please give a general description such as "husband" or "attorney."
- The "Start Date" is the date this authorization will begin.
- The "End Date" is the date this authorization will end. If you do not want this authorization to end on a specific date. If you leave the "End Date" box blank, this authorization will remain valid for one year.

Individuals Authorized to Receive Your PHI

Name of Person	Person's Relationship to You	Address	ZIP Code	Telephone Number	Start Date	End Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Purpose for which release is to be made **(NOTE: you are not required to provide a specific purpose; if left blank, UIHS will presume that the release is simply being made at your request):** _____

_____

SECTION D: Terms and conditions of this authorization

I understand that I may refuse to sign this authorization. I understand that if the person(s)/organization(s) authorized to receive my PHI is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I further understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization**.** Unless revoked earlier, this authorization will end on the date specified above or upon departure from the clinic.

SECTION E: Your signature

Signature of Individual: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, please complete the following:

Personal Representative's Name: _____

Relationship to the member (check one of the following):

☐ **Parent.** As the parent of the minor child you are authorized to obtain Protected Health Information (PHI). If you want to authorize another person to receive PHI on this minor child you will need to check this box and write your name in the personal representative field above.

☐ **Legal Guardian, Conservator, or Executor.** Please attach legal documentation showing that you are the legal guardian, conservator or executor.

☐ **Durable Power of Attorney.** Please attach legal documentation showing that you hold a Durable Power of Attorney.

Signature of Witness: _____ Date: _____