UNITED INDIAN HEALTH SERVICES, INC.

AUTHORIZATION

FOR RELEASE OF PROTECTED HEALTH INFORMATION TO UNITED INDIAN HEALTH SERVICES, INC.

With my signature below, I hereby authorize United Indian Health Services to:

REQUEST a copy of my records FROM:

Place: _____

Address: _____

City/State/Zip _____

Telephone: _____

Fax: _____

☐ For all the following records:

- Labs from last 2 years, most recent labs if duplicates.
- X-Rays-all, most recent if duplicates
- CT/MRI- all
- EKG- most recent
- Pathology Reports-all
- Hospital Discharge Summary-most recent
- Operative Reports-all
- Consult Notes-all
- Immunization Records
- Medication and Allergy Lists-as of most recent visit
- Outpatient clinic visit note-most recent visit

☐ Dental

☐ Other:_____

_____

SEND a copy of my records TO:
(Choose one)

☐ **Potawot Health Village**
1600 Weeot Way (707) 825-5065
Arcata, CA 95521 (707) 825-6815 FAX

☐ **Crescent City Medical Clinic**
1675 Northcrest Drive (707) 464-2750
Crescent City, CA 95531 (707) 464-2668 FAX

☐ **Klamath Health Clinic**
241 Salmon Road (707) 482-2181
Klamath, CA 95548 (707) 482-3655 FAX

☐ **Weitchpec Health Clinic**
Hwy 96 (530) 625-4300
Weitchpec, CA 95546 (530) 625-4308 FAX

☐ **Smith River Clinic**
501 North Indian Road (707) 487-0215
Smith River, CA 95567 (707) 487-3003 FAX

☐ **Eureka Clinic**
2332 Harrison Ave. Suite C&D (707) 442-0380
Eureka, CA 95501 (707) 442-0381 FAX

☐ **Elk Valley Clinic**
2298 Norris Avenue (707) 464-2919
Crescent City CA 95531 (707) 464-8218 FAX

The requested information is authorized to be disclosed for the purpose(s) of my transfer of care.

SIGNATURE: I have read BOTH SIDES of this authorization and I understand it. I also understand that if UIHS requests copies of my records from another facility, that facility may charge a fee for these records. I will be responsible for this fee.

_____ _____ am / pm

Client or legal/personal representative signature Date Time

_____ _____

Please Print Name Legibly Date of Birth

_____ _____

Identification (optional)
(i.e. Valid Driver's License Number)

If not signed by the client, description of
legal/personal representative's authority

With my initials placed here [_____] I authorize release of my HIV/AIDS/STD status.

IMPORTANT NOTICE ON REVERSE SIDE

For Office Use Only

CLIENT NAME: _____DOB:_____HR#:_____

NOTICE OF RIGHTS AND OTHER INFORMATION

Unless revoked earlier, this authorization will EXPIRE after a period of one year from the date noted on the reverse. I understand I have the right to revoke this authorization at any time. I understand, if I revoke this authorization, I must do so in writing delivered to UIHS' Client Records Coordinator, 1600 Weeot Way, Arcata, CA 95521-4734. I understand such revocation will take effect upon receipt and will not apply to information which has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

UIHS, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law. If I have questions about disclosure of my health information, I can contact UIHS Client Records.

I understand that I may request a copy of this authorization, and I may inspect or request copies of information disclosed by this authorization, as provided by CFR§164.508(d)(l),(e)(2). I understand that if UIHS requests copies of my records from another facility, that facility may charge a fee. I will be responsible for this fee.