COWLITZ INDIAN TRIBE

Authorization for Use or Disclosure of Protected Health Information

COMPLETE ALL SECTIONS, SIGN AND DATE

Patient Name	Date of Birth	Record Number

Address	City/State/Zip	Other contact information

I. **I** _____ **hereby voluntarily authorize COWLITZ INDIAN TRIBE to disclose/access information from the above patient's health record, as defined below.**

II. **The information is to be** (check all that apply) ☐ **released to** ☐ **received from** ☐ **2-way Care Coordination**

NAME OF PERSON/FACILITY	
ADDRESS	CITY/STATE/ZIP
FAX #	PHONE #

III. **The purpose or need for this disclosure is**

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Coordination and Continuity of Care

☐ Further Mental Health Care ☐ Insurance ☐ Disability ☐ Other (specify) _____

IV. **The information to be disclosed from my health record (check all appropriate boxes)**

☐ Only Information related to (specify):
☐ Only the period of events dated from: to:
☐ Other (specify - CHS, Billing, etc.):

If you would like any of the following sensitive information disclosed, check the applicable boxes and initial beside them

☐ Alcohol/ Drug Treatment/ Referral _____	☐ HIV/AIDS related Treatment _____	☐ Genetic Testing Results _____
☐ Sexually Transmitted Diseases _____	☐ Mental Health (other than psychotherapy notes) _____	

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management 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 If this authorization has not been revoked, it will terminate **one year** from the date of my signature unless a different expiration date or expiration event is stated here: _____

I understand that Cowlitz Indian Tribe 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, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re- disclosure by the recipient and may not be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

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 a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

Signature of Patient or Personal Representative	Relationship to Patient	Date
Signature of Witness (**ONLY if signature is a thumbprint or mark**)	Printed Name of Witness	Date