COWLITZ INDIAN TRIBE HEALTH AND HUMAN SERVICES

Authorization for Use or Disclosure of Protected Information

COMPLETE ALL SECTIONS, SIGN AND DATE

Staff _____

Patient Name		**Address**	**City/State/Zip**
Date of Birth	**Record Number**	**Phone #/Email/Other contact information**	

I. I _____ hereby voluntarily authorize COWLITZ INDIAN TRIBE HEALTH AND HUMAN SERVICES to disclose and/or access client/patient protected information, 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
Phone #	Fax #	Email/Other

III. The purpose or need for this disclosure is

☐ Treatment, Payment, and Healthcare Operations ☐ Coordination of Care ☐ School
☐ Insurance ☐ Attorney ☐ Disability ☐ Research ☐ Other (specify) _____

IV. The information to be disclosed (check all appropriate boxes)

☐ Information related to (indicate specific injuries or conditions):	
☐ For the period of events dated from:	to:
☐ Other:	☐ Entire Record

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

☐ Alcohol & Drug treatment _____ (other than SUD clinician notes) ☐ Mental Health _____ (other than psychotherapy notes) ☐ Genetic testing _____ ☐ HIV/AIDS & STD related treatment _____

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 laws 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 If this authorization has not been revoked, it will terminate **one year** from the date of my signature unless a different expiration date or expiration event is stated here: _____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].

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a], and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if I am authorizing the disclosure of my substance use disorder records to a Health Information Exchange pursuant to a general designation, I have the right to receive a list of all such disclosures made from the Health Insurance Exchange.

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