COWLITZ INDIAN TRIBE HEALTH AND HUMAN SERVICES

Authorization for Use or Disclosure of Protected Information

COMPLETE ALL SECTIONS, SIGN AND DATE

Staff _____

The information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law.

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

I authorize COWLITZ INDIAN TRIBE HEALTH AND HUMAN SERVICES to disclose and/or access my protected information, as defined below.

I. The information is to be ☐ Released to ☐ Received from ☐ 2-way Care Coordination

Name of Person/Facility		Address, City, State, Zip
Phone #	Fax #	Email/Other

II. The purpose of this disclosure

☐ Treatment, Payment, and Health Care Operations ☐ Coordination of Care ☐ Court obligations ☐ At the request of the patient

☐ Insurance ☐ Attorney ☐ Disability ☐ School ☐ Other (specify) _____

III. The information to be disclosed

If you would like any of the following sensitive information disclosed, check the applicable boxes

☐ Alcohol & Drug treatment (except SUD counseling notes) ☐ Mental Health (except psychotherapy notes) ☐ Genetic testing ☐ HIV/AIDS & STD related treatment

I understand that I may revoke this authorization in writing submitted at any time to Health Information Management/Medical Records, 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 If this authorization has not been revoked, it will terminate **one year** from the date of my signature unless a different expiration date or expiration event is stated here: _____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 my substance use disorder treatment records are protected under federal law, including 42 CFR Part 2 and HIPAA, and any applicable state laws, and can only be used or disclosed with my written consent, except as permitted by 42 CFR Part 2, HIPAA, and applicable state law.

This form has been explained to me in a language I understand, and I understand that I have a right to get a copy of this form.

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 (examples: Parent, Legal Guardian, POA) X	**Date**
If the signer is a Personal Representative, print name here (proof of authority is required)	Relationship to Patient

NOTE to receiving person or entity if any records we disclose with the patient's consent are substance use disorder records: 42 CFR Part 2 prohibits unauthorized use or disclosure of these records.