**AUTHORIZATION TO DISCLOSE and/or**

**OBTAIN PROTECTED HEALTH INFORMATION**

**Complete ALL Sections, Date, and Sign**

|  |  |  |
| --- | --- | --- |
| *Patient Name* | *Date of Birth* | *Medical Record Number* |
| *Address* | | |

**I, or my authorized representative, hereby authorize the HIIM Services and/or the provider(s) and caregiver(s) of the Health & Wellness Department of San Felipe Pueblo to:**

**Disclose Information to:** **Obtain Information from:**

|  |  |
| --- | --- |
| NAME OF FACILITY/INDIVIDUAL/ORGANIZATION | NAME OF FACILITY/INDIVIDUAL/ORGANIZATION |
| ADDRESS | ADDRESS |
| CITY/STATE | CITY/STATE |

**The purpose to disclose/obtain is:**

\_\_\_\_\_ Continuation of Care \_\_\_\_\_ Attorney \_\_\_\_\_ School

\_\_\_\_\_ Attorney/Legal \_\_\_\_\_ Insurance \_\_\_\_\_ Disability

\_\_\_\_\_ Research \_\_\_\_\_ Health Information Exchange \_\_\_\_\_ Other

If other, Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The information to be disclosed from my health record is/are:**

\_\_\_\_\_ Only information related to (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Only the period of events From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Other (Specify) (CMS, Billing, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Entire Record

**If you would like any of the following sensitive information disclosed, please select below (Indicate by Initialing):**

\_\_\_\_\_ Alcohol/Drug Abuse Treatment/Referral \_\_\_\_\_ HIV/AIDS-related Treatment

\_\_\_\_\_ Sexually Transmitted Diseases \_\_\_\_\_ Mental Health Information (other than Psychotherapy Notes)

\_\_\_\_\_ Psychotherapy Notes Only (by selecting this, I am waiving any Psychotherapist-Patient privilege)

I understand that I may revoke this authorization in writing submitted at any time to the Health Informatics & Information Management of the Health & Wellness Department of the San Felipe Pueblo, except to the extent that action has been taken upon reliance on this authorization. If this authorization was obtained as a condition of insurance coverage or a policy of insurance, other law(s) 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 of expiration event is stated.

(Specify new date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the providers of the Health & Wellness Department of the San Felipe Pueblo will not condition treatment or eligibility of 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 health information disclosed by this authorization, with the exception of Alcohol and Drug Abuse information as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 Privacy Rule [45 CFR Part 164] and the Privacy Act of 1974 [5 USC 552a].

This information is to be released only 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 protected health information or any health record concerning a patient or tribal member of the San Felipe Pueblo under false pretenses shall be guilty of a misdemeanor [5 USC 552a(i)(3)].

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF AUTHORIZED REPRESENTATIVE RELATIONSHIP TO PATIENT

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)* DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF WITNESS POSITION

**Privacy Statement**

*In order to release sensitive information regarding alcohol/drug abuse treatment/referral, HIV/AIDS-related treatment, sexually transmitted diseases, mental health information (other than psychotherapy notes), the appropriate item must be initialed or marked.*

*Psychotherapy Notes Only – In order to authorize the use or disclosure of Psychotherapy Notes, only this item must be initialed or marked on this form. Authorization for the use and disclosure of other health record information may not be made in conjunction with authorizations pertaining to Psychotherapy Notes.*

*If you have a complaint about the policies and procedures regarding health information, you may file such a complaint with the Executive Tribal Administrator, the Director, or the Privacy Officer of the Health & Wellness Department of the Pueblo of San Felipe. You may also file a complaint directly to the Department of Health and Human Services, Office for Civil Rights; or with the Secretary, Department of Health and Human Services, Washington, DC 20201.*

*This form and subsequent information pertaining to this request will become part of your permanent health record.*

*Public reporting burden for this collection of information is estimated to average 30 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless there is a valid signature and/or authorization from the patient. Please send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the:*

*Privacy & Compliance Officer*

*Health & Wellness Department*

*3 Cedar Road*

*San Felipe Pueblo, NM 87001*

*Email: inunez@sfpueblo.com*