CONSENT FOR RELEASE OF MEDICAL RECORDS USE
PLUS DISCLOSURE OF PROTECTED HEALTH INFORMATION to a THIRD PARTY

I, _____, (Name of Patient making Request), hereby authorize Yellowhawk Tribal Health Center (YTHC) to use and disclose:

☐ **Date specific Portions of my Medical or Dental Record, From Date:_____ To Date: _____**
☐ Test Results only
☐ Portions of my Medical or Dental Record, specifically: _____
☐ Other (specify) _____

I acknowledge that YTHC, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical or dental records to the party listed below. I have reviewed YTHC's NOPP and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify YTHC, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize YTHC to use and disclose verbally, by mail, fax or unencrypted email, the following types of ***super-confidential information*** as stated in the NOPP **(initial where appropriate)**:

_____HIV records (including HIV test results) and sexually transmissible diseases
_____Alcohol and substance abuse diagnosis and treatment records
_____Psychotherapy records
_____Not Applicable

REQUIRED TO COMPLETE:
In accordance with HIPAA Omnibus Rule of 2013, I understand that I need to provide the specifics of this release request:

1. Date of this Request: _____

2. Please Release my records to: _____ (Name of Third Party)
   ☐ Send Third Party a copy of my records to this address: _____
   _____
   _____

3. The Records will be obtained by:
   Please allow _____ to pick up a copy of my records (including

   ☐ Third Party will pick up a copy of my records on or after this date: _____

By Patient:

_____ _____ Date: _____
(Print name) (Sign name)
Patient Date of Birth _____
or

By Patient's Representative

_____ _____ Date: _____
(Print name, sign, and describe authority)

Yellowhawk Information: Attn: Medical Records PO Box 160 Pendleton, OR 97801
Phn: 541-278-7501 Fx: 541-278-7570