CONSENT FOR RELEASE OF MEDICAL RECORDS USE
PLUS DISCLOSURE OF PROTECTED HEALTH INFORMATION <u>from</u> a
<u>THIRD PARTY</u>

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

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

I acknowledge that YTHC, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law may receive my specified medical or dental records to the address listed *below*. A copy of this signed, dated Consent shall be as effective as the original. I specifically authorize YTHC to receive verbally, by mail, fax or unencrypted email, the following types of ***<u>super-confidential information</u>*** **(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

From: Facility/Provider: _____
Address/City/State:_____
Phone/Fax: Phn: _____ Fax: _____

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: **Yellowhawk Tribal Health Center**
3. Please send Yellowhawk a copy of my records to this address: **Attn: Medical Records**
   PO Box 160
   Pendleton, OR 97801
   Phn: 541-278-7501
   Fx: 541-278-7570

By Patient:

_____ _____ Date: _____
(Print name and sign)
Patient Date of Birth _____
or

By Patient's Representative

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

TO INCLUDE SUPER CONFIDENTIAL PHI DIRECTLY TO THE <u>PATIENT</u>

I, _____, (Name of Patient making Request), hereby request a copy of my health records and authorize Yellowhawk Tribal Health Center, (hereafter collectively referred to as "YTHC") to use and disclose a copy of my health records to me.

I prefer my records be sent to me in the following format, but understand that by law, the records can be sent in any electronic format similar if the format I desire is not available. I know YTHC will supply me these records within 30 days of this request and will contact me should there be any reason they need to extend this time frame. I understand, by law YTHC and request an extension for more time but, can only request an extension, once for an additional 30 days. The format which I prefer to receive my electronic records in is:

☐ Email a word document to (email address): _____
☐ Email a PDF copy to (email address): _____
☐ Fax or send a hard copy to (fax number)/ (address): _____
☐ I will pick up a copy on or after (date): _____
☐ Date specific Portions of my Medical or Dental Record, From Date:_____ To Date: _____
I specifically authorize YTHC to use and disclose verbally, by mail, fax or unencrypted email, the following types of ***<u>super-confidential information</u>*** as stated in the Notice of Privacy Practice **(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

The undersigned does hereby 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 authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until YTHC is in actual receipt of a signed revocation (cancellation) or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given an opportunity to ask questions; that I have received a copy of the signed authorization; that I may inspect a copy of my protected health information to be used or disclosed under this authorization; that YTHC has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

By Patient:

_____ _____ Date: _____

(Print name and sign) **or**

By Patient's Representative

_____ _____ Date: _____

(Print name, sign, and describe authority below)

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:

☐ Test Results only
☐ Portions of my Medical or Dental Record, specifically: _____
☐ Date specific Portions of my Medical or Dental Record, From Date:_____ To Date: _____
☐ 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:

4. Date of this Request: _____

5. Please Release my records to: _____ (Name of Third Party)

6. 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: _____
   ☐ Send Third Party a copy of my records to this address: _____
   _____
   _____

By Patient:

_____ _____ Date: _____
(Print name and sign)
Patient Date of Birth _____
or

By Patient's Representative

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