



YELLOWHAWK
TRIBAL HEALTH CENTER

Consent for Release of Medical Records Use &
Disclosure of Protected Health Information
FROM A THIRD PARTY

I, _____ / _____ hereby authorize Yellowhawk Tribal Health Center to use and disclose:
(Print Name) (Date of Birth)

- Date specific Portions of my Medical or Dental Record:
From Date: _____ To Date: _____
- 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 Yellowhawk Tribal Health Center, 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 Yellowhawk'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 and dated consent shall be as effective as the original. I release, hold harmless and agree to indemnify Yellowhawk, 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 Yellowhawk 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 or Mental Health
- _____ Not Applicable

From: Facility/Provider: _____
Address/City/State: _____
Phone: _____ 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**
Attention: Medical Records
P.O Box 160
46314 Timíne Way
Pendleton, OR 97801
Phone: 541-240-8736 or 8735
Fax: 541-278-7570

By Patient:

(Print Name) (Signature) Date: _____

Or By Patient's Representative:

(Print name and describe authority) (Signature) Date: _____