YELLOWHAWK
TRIBAL HEALTH CENTER

Authorization for Use & Disclosure of Protected Health Information to Include

Confidential PHI Directly to the Patient

RECORD RELEASE TO PATIENT

I, _____, _____ hereby request a copy of my health records.
(Print Name) (Date of Birth)

In addition, I authorize Yellowhawk Tribal Health Center 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 Yellowhawk 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, Yellowhawk can 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:

☐ Date specific portions of my Medical or Dental Record - From Date: _____ To Date: _____
☐ Fax or send a hard copy to (fax number)/ (address): _____
_____
☐ I will pick up a copy on or after: _____
(date)

I specifically authorize Yellowhawk Tribal Health Center to use and disclose verbally, by mail, fax or unencrypted email, the following types of ***super-confidential information*** 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 or Mental Health
_____ Not Applicable

The undersigned does hereby release, hold harmless and agree to indemnify Yellowhawk Tribal Health 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 Yellowhawk 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 Yellowhawk 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) (Sign name)

By Patient's Representative

_____ _____ Date: _____
(Print name) (Sign name)