YELLOWHAWK
TRIBAL HEALTH CENTER

Consent for Release of Medical Records Use & Disclosure of Protected Health Information

TO 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, please specify: _____
- ☐ 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, 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 ***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

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)
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: _____
- ☐ Send Third Party a copy of my records to this address: _____
  _____
  _____

_____ _____ Date: _____

(Print name) (Signature)

Or By Patient's Representative

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