YELLOWHAWK
TRIBAL HEALTH CENTER

Consent for Release of Medical Records
Disclosure of Protected Health Information

FROM A THIRD PARTY

I, _____(Name of Patient)/(DOB)_____ , hereby authorize Yellowhawk Tribal Health Center (YELLOWHAWK) to use and disclose:

☐ 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, 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 above. 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 ***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

From: Facility/Provider: _____
Address/City/State: _____
Phone/Fax: PH: _____ 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**
Attn: Medical Records
PO Box 160
Pendleton, OR 97801
PH: 541-240-8736 or 541-240-8735
Fax: 541-240-8751

By Patient:

_____ _____ Date: _____
(Print name and sign)

Or

By Patient's Representative

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

Form updated: 07/01/2019