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:
(Name of Patient) (Date of Birth)

☐ Send the most recent records (1 year)
☐ 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 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 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 records
_____ 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
46314 Timíne Way
Pendleton, OR 97801
Phone: 541-966-9830 | Fax: 541-240-8751

By Patient:

_____ _____ Date: _____
(Print name) (Signature)

Or By Patient's Representative:

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