Tohono O'odham Nation Health Care

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

TONHC-810

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ hereby voluntarily authorize the disclosure of information from my health record.

II.

The information is to be disclosed by:	**And to be provided to:**
Name of Facility	Name of Person/Organization/Facility
Address	Address
City, State	City, State
Phone Number: Fax Number:	Phone Number: Fax Number:

III. **The purpose or need for this disclosure is:**

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research

☐ Personal Use ☐ Insurance ☐ Disability ☐ Other (Specify) _____

IV. **The information to be disclosed from my health record (check appropriate box(es))**

☐ Only information released to (specify) _____

☐ Only the period of events from _____ to _____

☐ Other (specify) (CHS, Billing, Etc.) _____

☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment

☐ Sexually Transmitted Diseases ☐ Mental Health (Other than Psychotherapy Notes)

☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the TONHC Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated: Specify new date: _____

I understand that TONHC will not condition treatment or eligibility for care on my providing this authorization except if such care is: 1) research related or 2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)* **DATE**

SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)* *DATE*

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a TONHC under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

ID verified by:
Known to me DL/STATE/TRIBAL ID
Other: Date: Initials

NAME *(Last, First, MI)* **RECORD NUMBER**

ADDRESS

CITY/STATE **DATE OF BIRTH**

Revised 072016