# Kaniksu Health Services

## AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name ______________________ DOB ____________ SS# ____________

Address ______________________ Phone (     ) ____________

I authorize (provider name and address) ______________________ Phone# ____________ Fax# ____________

to use and/or disclose my health information as identified below to: (Provider name & address) ______________________

______________________ Phone # ____________ Fax# ____________

□ Pick up records   □ Mail Paper Copy   □ Fax   □ Electronic Copy

Purpose(s): □ At the request of the patient □ Doctor/Continued Care □ Attorney □ Financial □ Other as Noted

_____ Please send the medical/dental record (**for the last two years seen**) to the above named recipient.
_____ **Medical /Dental records** from ____________ to ____________   _____ Billing Statements
_____ Laboratory and/or Pathology Reports   _____ Dental X-rays   _____ Diagnostic Imaging Reports
_____ Other ______________________

Federal regulations require a description of how much and what kind of the following information is to be disclosed. The following items must be individually initialed to be included in the use or disclosure of other health information: Federal law prohibits the re-disclosure of such information.

_____ *HIV / AIDS related health information and/or records
_____ *Sexually Transmitted Disease information and/or records
_____ *Birth Control/Pregnancy information and/or records
_____ *Drug/alcohol diagnosis, treatment and/or referral information
_____ *Mental health information and/or records
_____ *Genetic testing information and/or records
_____ Other ______________________
_____ *Restricted protected health information

Agreement must be terminated in writing or documented oral agreement to restrict disclosure.

_____ ***Psychotherapy notes** (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer of Kaniksu Health Services. Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon [Insert applicable date or event of expiration] ______________________. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by federal privacy laws or regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

**SIGNATURE** of Patient ______________________ Date: ____________

Printed Name ______________________

If other than Patient, indicated relationship: □ Parent □ Guardian □ Legal Representative □ Power of Attorney

Identity of patient and/or signature verified with: □ Photo ID □ Matching Signature □ Other ____________
Verified by (print name): ______________________ Date: ____________
Request completed by (print name) ______________________ Date: ____________

Please allow at least 5 business days for records to be prepared. There may be a charge for these purposes.
A copy of this signed form can be provided to the individual and/or the individual's legal representative. An electronic copy may be obtained from our Patient Portal immediately.