SOUTHERN INDIAN HEALTH COUNCIL, INC.
4058 Willows Road Alpine, CA 91901
Mailing: P.O. Box 2128 Alpine, CA 91903
Phone: (619) 445-1188

MR # _____

# Authorization for Use or Disclosure of Health Information

**Complete all sections, sign and date.**

1. I, _____, hereby voluntarily authorize the disclosure of ❑Dental/ ❑Medical information from _____'s record.
   Date of Birth: _____/_____/_____

2. **The information is to be disclosed by:**
   Name: **SOUTHERN INDIAN HEALTH COUNCIL, INC.**
   Address: **PO BOX 2128**
   City/State/Zip: **ALPINE, CA 91901-2128**
   Fax: **(619) 659-3141**

3. **The information is to be provided to:**
   Name of Person/Organization/Facility: _____
   Address: _____
   City/State/Zip: _____

4. **The purpose or need for this disclosure is:** _____

5. **The information to be disclosed from my ❑Dental/ ❑Medical Health Record: (check the appropriate box(s) below)**
   □ Entire Record □ Only information related to (specify): _____
   □ Only the period of events from: _____/_____/_____to: _____/_____/_____
   □ **Psychotherapy Notes ONLY (by checking this box, I waive my psychotherapist patient privilege to the notes)**

   **If you would like any of the following sensitive information disclosed, check the applicable box(s) below:**
   □ Alcohol/Drug Abuse Treatment/Referral □ HIV/AIDS-Related Treatment
   □ Sexually Transmitted Diseases □ Mental Health (other than psychotherapy notes)

I understand that I may revoke this authorization in writing submitted at any time to the Medical Records Department, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides 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 If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date here: _____/_____/_____
(if different from the date below)

I understand that Southern Indian Health Council, Inc. 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 may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

**Signature of Patient/Guardian: _____ Date: _____/_____/_____**

**Relationship of Guardian to Patient: _____ Witness: _____**

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 Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552 a (1) (3).

**SIHC Use Only**:

ROI #: _____ RECEIVED: _____ RELEASED: _____

Original Date: 2013
Revision Date: 8.14.2013
Department Origin: Medical Records

**INSTRUCTIONS FOR COMPLETING THIS FORM**

1. **Print legibly in all fields using black ink.**
2. **Section 1**, print the patient's name, birthdate, and phone number, whose information is to be released.
3. **Section 2,** is already filled in.
4. **Section 3**, print the name and address of the facility releasing the information.
5. **Section 4**, state the reason why the information is needed: further medical care, insurance, attorney, personal use, school, or disability claim, etc.
6. **Section 5**, check ALL appropriate box(s), as applicable.
   A. Entire Record: the complete record except for the sensitive information which includes- alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS related treatment, and mental health (other than psychotherapy notes)
   B. Only information related to (specify): patient specifies specific diagnosis, injury, operations, special therapies, labs, immunizations, CHS, billing, employee health, etc.
   C. Only the period of events from: patient specifies date range, for example: Jan 01, 2010 to Feb 01, 2010.
   D. Psychotherapy Notes Only: in order to authorize the use or disclosure of psychotherapy notes, only this box should be checked. This request may not be made in conjunction with request for any other dental/medical records request. If this box is checked with other boxes, another authorization will be required to authorize the use or disclosure of psychotherapy notes.
      Psychotherapy notes are often referred to as "Process Notes," distinguishable from "Progress Notes" in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate, in order to limit access to them, because they contain sensitive information relevant to no one other than the treating provider.
   E. If you would like any of the following sensitive information (alcohol/drug abuse treatment/referral, HIV/AIDS- related treatment, sexually transmitted diseases, or mental health (other than psychotherapy notes) disclosed: patient must check the appropriate box that corresponds to information to be released
7. If you desire a different date for the expiration of this request, a space is provided above the signature section; otherwise, the request will expire in one year from date indicated next to signature.
8. Sign and date on bottom
9. Relationship of guardian to patient: if you are requesting records for someone other than yourself, state your relationship below your signature, examples include: mother, father, legal guardian, power of attorney, etc.
10. A copy of this completed form will be provided to the patient upon request.