the Chickasaw Nation

AUTHORIZATION FOR ACCESS BY PATIENT OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's name:_____ **Medical record no.**: _____

Birth date: _____ **Last 4 digits of Social Security:** _____ **Phone no.**: (____) _____

Person/organization to receive PHI:

_____

Address: _____

City, state, ZIP: _____

Phone no.: (____) _____ **Fax:** (____) _____

Name of person/organization to disclose PHI:

_____

Address: _____

City, state, ZIP: _____

Phone no.: (____) _____ **Fax:** (____) _____

Records requested: ☐ Health summary ☐ Face sheet ☐ History & physical ☐ Provider's progress notes
☐ Discharge summary ☐ Cardiology ☐ Operation report ☐ Provider's orders ☐ Nurse's notes ☐ Lab
☐ Imaging reports ☐ Imaging CD/DVD ☐ Itemized billing ☐ Dental films
☐ Entire record (additional authorization needed for BH notes) ☐ Behavioral health (family/group counseling may require additional authorization)
☐ Psychiatric/ psychotherapy notes (federal law requires provider's authorization) _____
Provider authorization Date/time
☐ Other (specify): _____

Date(s) of visit(s) needed: _____

The information shall be obtained used or disclosed for the **following purpose(s)** only: ☐ Insurance ☐ Continued treatment ☐ Legal
☐ At the request of the patient or patient's representative ☐ Other (specify): _____

Preferred method to receive records: ☐ Pick up ☐ Mail to receiver above

☐ Email address: _____ **If illegible, email delivery will not be attempted.**
*I understand that email communication may not be secure, creating a risk of improper disclosure to unauthorized individuals. I **accept that risk**, and will not hold CNDH responsible should such incident occur. CNDH reserves the right to restrict certain request not be sent over email for your safety or due to file size of requested PHI.*

I understand that by voluntary signing this authorization:

- I authorized the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include but is not limited to diseases such as hepatitis, syphilis, gonorrhea, HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been disclosed based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the receiver and no longer protected by the privacy regulation.

_____ _____
Signature of patient or legal representative Date/time

_____ _____
Description of legal representative's authority with supporting documentation must be on file with CNDH. *Expiration date* (not to exceed 2 years) or *event*. If not otherwise indicated, authorization **expires in one year**