the Chickasaw Nation

Bill Anoatubby
Governor

AUTHORIZATION FOR ACCESS BY PATIENT OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's name: _____ Medical record no: _____

Date of birth: _____ Last 4 digits of Social Security no: _____

Phone no.: _____

I hereby authorize the use or disclosure of the Protected Health Information (PHI) described below to be provided to or obtained by the following (please provide complete address):

Name of individual/facility/company/job title to receive PHI:

_____

Address: _____

City, state, ZIP: _____

Phone no.: _____ **Fax:** _____

Name of individual/facility to disclose PHI:

_____

Address: _____

City, state, ZIP: _____

Phone no.: _____ **Fax:** _____

Portions to Release are: ☐ Health summary ☐ Face sheet ☐ History & physical ☐ Provider's progress notes
☐ Lab ☐ Discharge summary ☐ Cardiology ☐ Operation report ☐ Provider's orders
☐ Nurse's notes ☐ Dental films ☐ Imaging reports ☐ Imaging/X-ray CD/DVD
☐ Behavioral health counseling ☐ Behavioral health CONFIDENTIAL or PSYCHIATRIC notes*
☐ Other (specify): _____

* Please note federal law requires additional authorization from your mental health provider prior to release of this content.

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): _____

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurrence of the following event: _____
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.
- I understand that copies of my health information are allowed by law; however, I do understand that copies requested for the same day of an encounter may not be readily available on that same day, but at a later date, due to documentation requirements.

I understand that my medical information may indicate that I have a communicable or non-communicable disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

ACCIDENT, INJURY OR ON THE JOB INJURY

I authorize the Chickasaw Nation Department of Health to release information contained in its hospital records to the Worker's Compensation Insurance Carrier concerning the diagnosis, treatment and prognosis of the undersigned patient. The records may also be used for any matter involved in the workers' compensation claim, including proof of hospital bills incurred for the treatment of the patient, filling the same in court and furnishing copies to the involved parties.

_____ _____
Signature of patient or legal representative Date/time

_____ _____
Signature of patient or legal representative Date/time

_____ _____
Description of legal representative's authority Expiration date of authorization

NOTICE OF RIGHTS*: Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the U.S. Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the U.S. Department of Health or by law.*