☐ **Fred Leroy Health and Wellness Center** ☐ **Ponca Hills Health and Wellness Center**

2602 J Street, Omaha, NE 68107 1800 Syracuse Ave, Norfolk, NE 68701

Authorization for RELEASE OF INFORMATION

Signature of the patient is required of all patients 18 years of age or older. A parent or legal guardian may provide authorizing signature if the patient is a minor or when patient is physically or mentally incompetent.

Patient Name:_____ Phone:_____

Address:_____

Patient Date of Birth: _____ / _____ /_____ Patient Chart #: _____

The following individual or organization is authorized to make the disclosure:(who records are being requested from)

Name:_____

Phone:_____ Fax:_____

Address:_____

Specific information and/or dates of treatment to be disclosed:

_____

_____

Date information is needed: _____ / _____ /_____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization(who records are to be sent to)

Name:_____

Phone:_____ Fax:_____

Address:_____

For the purpose of (purpose not required for personal requests):

A copying fee may be charged on requests for purposes other than patient care.

☐ Continued Healthcare ☐ Personal ☐ Other: _____

I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

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 and Accountability Act Privacy Rule(45 CFR Part 164), and the Privacy Act of 1974 (5 USC 552a)

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Signed:_____ Date: _____ / _____ /_____

(SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE)

_____

(PRINT)

_____

(RELATIONSHIP TO PATIENT)

_____

(Witness)

PONCA TRIBE OF NEBRASKA