Riverside-San Bernardino County Indian Health, Inc.

Authorization for Release, Use, or Disclosure of Health information

HR # _____

D.O.B. _____

Date Received _____

Date Sent/Faxed _____

Each section of this Authorization must be completed. Completion of this form authorizes the release, use, or disclosure of your health information. Failure to provide all information requested may invalidate this Authorization. In accordance with HIPAA compliance, RSBCIHI will take all reasonable precautions to protect the health information contained herein.

I. I, (or name of patient if other than you)_____, hereby request the release, use, or disclosure of my health information from my record.

II. Please **Request** Health Information **From**:

Name of Facility:_____

Address: _____

City/State: _____ Telephone: _____

Please **Send** Health Information **To**:

Name of Person/Organization/Facility: _____

Address: _____

City/State: _____ Telephone: _____

III. The purpose(s) or need for this release, use, or disclosure is_____

_____

IV. The information to be released, used, or disclosed is from my (Please check and initial the appropriate box):

☐ Medical Record ☐ Dental ☐ Eye Care ☐ Behavioral Health
☐ Other *(Specify):* _____

and includes: *(Check as appropriate)*

☐ The entire record, including any information on alcohol or drug abuse contained herein;
☐ All health information pertaining to my medical history, mental or physical condition and treatment received —**or**—
☐ Exclude information on alcohol or drug abuse; ***(continued on backside)***

☐ Only information related to (specify): _____

_____

☐ Only the period or events from: _____ to _____

☐ X-Ray (check one or both): ☐Films ☐Reports

☐ Laboratory results ☐ HIV test results

☐ Alcohol/Drug treatment information

☐ Mental health treatment information

** A separate authorization is required to authorize the release, use, or disclosure of psychotherapy notes.

V. I understand that I may revoke this Authorization at any time, in writing, except to the extent that action that has been taken in reliance on this Authorization. If this Authorization has not been earlier revoked, it will terminate one year from the date of my signature or on _____ (date).

I understand I am entitled to a copy of this Authorization. The copy is for me to keep. I also understand I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or services or condition my eligibility for treatment or services.

A copy of this Authorization is valid as an original.

VI. In consideration of such release, use, or disclosure, I hereby release you (in your individual or institutional capacity) from any and all liability arising from the release, use, or disclosure of otherwise confidential information.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Indicate Legal Authority (If Signed by Other than Patient)

If this Authorization is requested for a purpose other than continuing care or for insurance reimbursement, RSBCIHI reserves the right to require the signature of the person authorizing this release be notarized. In some circumstances, HIPAA and other privacy laws may not prohibit the further disclosure by the recipient of information obtained pursuant to this Authorization.