Riverside-San Bernardino County
Indian Health, Inc.
Authorization for Use or
Disclosure of Protected Health Information

HR # _____
Date Received____ /____ /_____
Date records sent or given
_____ /_____ /_____
HIM Clerk Initials: _____

I. Patient Name: _____Date of Birth: ____/____/_____
Address: _____ City: _____ State: ___ Zip: _____
E-mail Address: _____ Phone: _____

I request that my protected health information (PHI) from RSBCIHI be disclosed To:
II. Recipient Name/Facility/Clinic: _____
Address: _____ City:_____ State: ____Zip: _____
E-mail Address: _____ Phone: _____
Fax: (healthcare provider only): _____

I authorize RSBCIHI to request the selected protected health information (PHI) From:
Name of person/Organization/Facility:_____
Address: _____ City: _____ State: ___ Zip:_____
E-mail Address: _____ Phone: _____
Fax: (healthcare provider only):_____
III. Patient's protected health information is being used, or disclosed for the following purpose(s):_____

IV. I authorize the following personal health Information to be used or disclosed:

◯ Medical ◯ Dental ◯ Eye Care ◯ BHS *(Use BHS Form)*
◯ Other Specify: _____ **and includes:** *(Check as appropriate)*

- ☐ Most Recent visit
- ☐ Medication list
- ☐ Laboratory test results
- ☐ Covid test results
- ☐ X-Ray film/paper report
- ☐ Immunization/Vaccines
- ☐ Billing records
- ☐ Other specify:_____

Covering the period from Specific Date(s): ____/____/_____ through ____/ _____/ _____

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

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records	◯ **Yes**	◯ **No**	**Date: _____**
HIV Testing and Results	◯ **Yes**	◯ **No**	**Date: _____**
Mental Health Treatment	◯ **Yes**	◯ **No**	**Date: _____**
Psychotherapy Records	◯ **Yes**	◯ **No**	**Date: _____**
Genetic Testing	◯ **Yes**	◯ **No**	**Date: _____**

Disclosure Format *(Paper is default if not marked.):* U.S. Mail - Paper Format, Fax (healthcare provider only), E-mail Encrypted (secure format), E-mail (unsecure format, i.e., Gmail, Yahoo) CD/Flash drive-secure format, Portal, Other (*Please specify*):

_____

By signing this authorization form, I understand that I have the following rights with respect to this Authorization:

I may not be required to sign this Authorization as a condition to obtaining treatment, payment, enrollment or eligibility for benefits. I may inspect or obtain a copy of the information to be used or disclosed. The recipient of the protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

RSBCIHI will provide me with a copy of this Authorization. I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management department at: 11980 Mount Vernon Ave Grand Terrace, CA 92313. Revocation will not apply to information that has already been disclosed in response to this authorization. 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 upon its completion or 12 month from date of signature. Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations. Marketing and Sale of PHI is not applicable.

A copy of this Authorization is valid as an original.

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

_____ _____

Patient Signature or (*Legal Representative)* Date Time

_____ _____

Print Name Relationship to Patient (*if applicable*) Indicate Legal Authority