Grand Ronde Health & Wellness Center

HIPAA AUTHORIZATION FORM TO DISCLOSE HEALTH INFORMATION

Patient Name_____ **DOB**_____

I hereby authorize **the Confederated Tribes of Grand Ronde, Grand Ronde Health & Wellness Center ("My Provider")** to release/ disclose and/or receive a copy of my Protected Health Information (PHI) via facsimile or other secure transmission, as described below, to:

	RELEASE FROM	**RELEASE TO**
Organization:	_____	_____
Address:	_____	_____
Telephone Number:	_____	_____
Fax:	_____	_____

Covering the period of healthcare from specific date(s): _____ to _____

The following Health Information about me may be used/disclosed (*check "Yes" or "No/NA"*):

	"No" or NA	"Yes"
My entire medical or billing record	☐	☐
Summary of Care	☐	☐
HIV/AIDS testing. diagnosis, and treatment	☐	☐
Sexually Transmitted Disease testing, diagnoses and treatment	☐	☐
Mental Illness diagnoses and treatment	☐	☐
Tuberculosis Information	☐	☐
Genetic testing, results and genetic information about me	☐	☐
Alcohol, Drug or Substance Abuse Records	☐	☐
Other: _____	☐	☐

The Health Information checked **"Yes"** above may be used for the following Purpose(s):

☐ At my request; or

☐ For the Purpose of: _____

I understand that the terms of this Authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA"), as may be amended from time to time. I understand that I have the right to revoke this Authorization, at any time prior to my Health Care Provider's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in my Health Care Provider's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature and that I should send it to my Health Care Provider's Privacy Officer.

I understand that I am <u>not</u> required to sign this Authorization and that my Health Care Provider may not condition treatment on my signing of this Authorization. I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure and, in that case, will no longer be protected by HIPAA. This Authorization expires automatically upon my provider releasing my Health Information as needed to fully accomplish the above-described Purpose(s). I hereby acknowledge receipt of a copy of this Authorization.

____/____/____ _____

Date Signature of Individual (or Authorized Representative)

_____ _____

Printed Name of Individual (or Authorized Representative) Relationship to Patient (if Authorized Representative)