Port Gamble S'Klallam Tribal Health Services

Authorization for use or disclosure of health information (PGST 810)
Please complete all Sections, Date and Sign

I. I _____, Dob_____, I hereby authorize:

II. Information to be disclosed by:

Facility: _____

Address: _____

Phone:_____Fax:_____

And is to be disclosed to:

Facility, Person, or Organization: _____

Address:_____

Phone: _____Fax:_____

III. The purpose or need for disclosure:_____

IV. The information to be disclosed from my health record:

() Entire Record
() Only information related to (specify)_____
() Only the period of events from:_____ to_____
() Other (specify):_____
() Psychotherapy Notes Only (by checking this box, I am waiving any psychotherapist-patient privilege)

If you would like any of the following information withheld please check oval

() Alcohol/drug abuse () HIV/AIDS related
() Sexually transmitted diseases () Mental Health (other than Psychotherapy)

V. I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment of HIV (AIDS virus), sexually transmitted diseases, substance abuse or mental health conditions. I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that actions has been taken as a result or this authorization. If this authorization was obtained as a condition of providing insurance coverage, other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date below. I understand that PGST will not condition treatment or eligibility for care on my providing this authorization except if such care is: 1. Research related 2. Provided solely for the purpose of creating Protected Health Information for disclosure to a third party. I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA)[45 CFR Part 164] and the Privacy Act of 1974 [5 USC 552a].

_____ _____ _____
Patient Signature Date Expiration Date

_____ _____ _____
Signature of Authorized Representative Relationship to Patient Date