**COMPLETE ALL SECTIONS, DATE, AND SIGN**

**I.** I, *(Name*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, *(DOB)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,* hereby voluntarily authorize the disclosure of information from my health record.

**II. The information is to be disclosed by: And is to be provided to:**

|  |  |
| --- | --- |
| **NHBP Health Department** | **Name of Facility** |
| **1474 Mno Bmadzewen Way** | **Street Address** |
| **Fulton, MI 49052**  **Fax 269-729-4460** | **City, State, Zip, Fax #** |

**III. The purpose or need for this disclosure is:**

**□** Further Medical Care □ Attorney □School □Research

□ Personal Use □ Insurance □ Disability □Other (*Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**IV. The information to be disclosed from my health record:** *(check appropriate boxes)*

□ Entire Record

□ Only Information related to (*Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*□* Only the period of events from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other (*Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**If you would like any of the following sensitive information disclosed, check the application boxes below:**

□ Alcohol/Drug Abuse Treatment/Referral □ HIV/AIDS – related Treatment

□ Sexually Transmitted Diseases □ Mental Health (*Other than Psychotherapy Notes)*

**V.** I understand that I may revoke this authorization in writing submitted at any time to the Nottawaseppi Huron Band of the Potawatomi Tribe’s Health Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other laws may provide 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 If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Enter if different from* ***one year after*** *date below)*

I understand that NHBP will not condition treatment or eligibility for care on my providing this authorization except if such care is:

(1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that the information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

|  |  |
| --- | --- |
| SIGNATURE OF PATIENT | DATE |
| SIGNATURE OF PERSONAL REPRESENTATIVE (State relationship to patient) or Witness (if signature is thumbprint or mark) | DATE |

This information will be disclosed from records protected by Federal Confidentiality rules (42 CFR part 2). The Federal rule prohibits individuals from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

|  |  |
| --- | --- |
| NAME(L*ast, First, MI)* | RECORD NUMBER |
| ADDRESS | |
| CITY/STATE | DATE OF BIRTH |