IHS-810 (4/03)
FRONT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 09/30/2003
*See OMB Statement on Reverse.*

# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ (*Name of Patient*), hereby voluntarily authorize the disclosure of information from my record.

| II. The information is to be disclosed by: | And is to be provided to: |
|---|---|
| NAME OF FACILITY: Spirit Lake IHS Clinic<br>Attn: Medical Records | SPIRIT LAKE VOC REHAB<br>PO BOX 519<br>FT. TOTTEN, ND 58335<br>PH: 701-766-4446<br>FAX: 701-766-1310 |
| ADDRESS: P.O. Box 309<br>Ft. Totten, ND 58335 | |
| CITY/STATE | |

III. The purpose or need for this disclosure is: Eligibility for Voc Rehab

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

- ☐ Entire Record
- ☐ Only information related to *(specify)* Current Medical Information, Diagnosis, Vocational Limitations
- ☐ 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 sensitive information disclosed, check the applicable box(es) 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 Health Records Department, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or 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 If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date *or expiration event.* _____
*(Enter if different from one year after date below)*

I understand that IHS 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 information disclosed by this authorization may be subject to redisclosure 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 AUTHORIZED REPRESENTATIVE *(State relationship to patient) or Witness (if signature is thumbprint or mark)* | DATE |

This information is to be released for the purpose stated above and may not be used by the recipient for any other 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)).

PATIENT IDENTIFICATION

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

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