Lake County Tribal Health

925 Bevins Court • Lakeport, CA 95453 14440 Olympic Drive • Clearlake, CA 95422

LCTH USE ONLY

PATIENT ID	NAME (Last, First, MI)	DATE OF BIRTH	RECORD NO.

ADDRESS	CITY / STATE

AUTHORIZATION FOR RELEASE OF INFORMATION

Complete all sections, date and sign.

I. I, _____, hereby voluntarily authorize the disclosure of information from my health record.
Name of patient

II. The information is to be disclosed by:

Name of Facility / Request Records from
Address
City / State
Phone

And is to be provided to:

Name of Person / Organization / Facility / Provide Records to
Address
City / State
Phone

III. The purpose or need for this disclosure is:

◯ Further Medical Care ◯ Personal Use ◯ Other *Specify* _____

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

◯ Entire Record (does not include sensitive information not marked below)
◯ Only information related to: *Specify* _____
◯ Only the period of events from:_____ to:_____
◯ Other: *Specify – Billing, CHS, etc.* _____

_____

If you would like any of the following sensitive information disclosed, check applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-Related Treatment ☐ Sexually Transmitted Diseases
☐ Mental Health *(Other than Psychotherapy Notes)* ☐ Psychotherapy Notes ONLY *By checking this box, I am waiving any psychotherapist-patient privilege.*

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management 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 law 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 If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.
Specify new date:

I understand that Lake County Tribal health will not condition treatment or eligibility of care upon me 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, except for Alcohol and Drug Abuse is 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 V Part 164}, and the Privacy Act of 1974 [5 USC 552a].

_____ / _____
Signature of patient or personal representative *State relationship to patient* *Date*

_____ / _____
Signature of witness *If signature of patient is a 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)).

STAFF USE ONLY Method of Delivery: ◯ Patient Pick-up (_____) ◯ Certified Mail (_____)
Patient received on Date mailed