



Lake County Tribal Health Pediatrics



359 Lakeport Boulevard • 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, _____, hereby voluntarily authorize the disclosure of information from my health record.
Name of patient

II. The information is to be disclosed by:

And is to be provided to:

Name of Facility / Request Records from

Name of Person / Organization / Facility / Provide Records to

Address

Address

City / State

City / State

Phone

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 If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.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 _____