Eastern Band of Cherokee Indians

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Complete all sections, date, and sign

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

II. The information is to be disclosed by:

Name of Facility: ____________________

Address: ____________________

City/State: ____________________

And is to be provided to:

Name of Person/Organization/Facility **Cherokee Indian Hospital**

Address: **Caller Box 268 C**

City/State: **Cherokee, NC 28719**

Fax: **828-497-2215**

III. The purpose(s) of this use/disclosure is/are:

____

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

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 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)

I understand that I may revoke this authorization in writing submitted at any time to the Medical Records Department, except to the extent that action has been taken in reliance on this authorization, or 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 If this authorization has not been revoked, it will terminate one year from the date of my signature.

I understand that EBCI will not condition treatment or eligibility for **direct care** on my providing this authorization. I further understand that I may refuse to sign this authorization.

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 and the Privacy Act of 1974.

Signature of Patient: ____________________ ____________________
Date

____________________ ____________________

Signature of Authorized Representative (state relationship to patient) Date
or Witness (if signature is by thumb print or mark)

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. *This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part. 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 2.12(c)(5) and 2.65.*

PATIENT IDENTIFICATION	NAME (First, MI, Last)	RECORD NUMBER
	ADDRESS	City/State/Zip
	Date of Birth:	

INSTRUCTIONS TO COMPLETE FORM 810, "AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION PER PATIENT'S REQUEST"

1. Print legibly in all fields using ink.

2. Section I, print name of patient whose information is to be released.

3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility and address that will receive the information.

4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, etc.

5. Section IV, check the appropriate box as applicable.

   a. **Entire Record** – the complete record except for the sensitive information (Alcohol/Drug Abuse Treatment/Referral, Sexually Transmitted Diseases, HIV/AIDS related treatment, and Mental Health other than psychotherapy notes)

   b. **Only information related to** – specify diagnosis, injury, operations, special therapies, etc.

   c. **Only the period of events from** – specify date range, e.g., Jan 1, 2002 to Feb 1, 2002.

   d. **Other (specify)** – e.g., CHS, billing, employee health, etc.

   e. **Psychotherapy Notes ONLY** – IN ORDER TO RELEASE PSYCHOTHERAPY NOTES, ONLY THIS BOX MUST BE CHECKED ON THIS FORM. NO OTHER REQUESTS FOR INFORMATION CAN BE MADE IN CONJUNCTION WITH PSYCHOTHERAPY REQUESTS.

   IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED. AN ADDITIONAL AUTHORIZATION MUST BE USED TO RELEASE PSYCHOTHERAPY NOTES ONLY.

   Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

   F. IN ORDER TO RELEASE SENSITIVE INFORMATION, ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), YOU MUST CHECK THE APPROPRIATE BOX!

6. Section V, sign and date.

7. Section V, Authorized Representative, e.g., a parent signing for minor children, legal guardians, power of attorney, etc.

8. Provide a copy of the completed form to the patient.

9. Our policy requires us to verify your identity prior to release of information.