Citizen Potawatomi Nation Health Services

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AUTHORIZATION TO RELEASE MEDICAL INFORMTION

Patient:_____DOB:_____SSN_____CPNHRN_____

I authorize _____to release information contained in medical records

and charts to the following provider or facility_____.

I authorize the releasing provider to release:

- ☐ ALL Medical records including: __office notes __Radiology __Labs __Med List __Immunization records __Sleep Studies __other:_____
- ☐ Last 2 Years of records from Date signed.
- ☐ Last 1 year of records from Date signed.
- ☐ Colonoscopy including any pathology report
- ☐ EGD including any pathology report
- ☐ Well women exam records including labs, pap smear, and HPV reports.
- ☐ ALL prenatal care records including labs, imaging, and office notes.
- ☐ ALL mammogram reports, images, and breast ultrasounds
- ☐ Release records covering the period beginning on _____ and ending on _____
- ☐ Release information relating treatment, hospitalization, and/or outpatient care for substance abuse for the period(s) Specified above.

These records will be used for:_____

Release records or information including; to have verbal and written communication with CPNHS including access to medical records, medication pickup, and discuss insurance needs with a Benefit Specialist.

This authorization expires on _____ or one year from today's date. I can revoke this authorization at any time although information already released in compliance with this authorization is not subject to revocation. **I understand that my medical records may contain entries which may indicate I have a communicable or non-communicable disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the Human Immunodeficiency Syndrome (AIDS).** With this knowledge, I freely consent to release the information in my medical records specified above, including information related to my identity. I release the Citizen Potawatomi Nation and the CPN Health Services as well as their agents and employees from any liability in connection with the release of information to which I have consented.

_____/_____ _____

Patient Signature/Date Expiration Date From Above

The patient named above is unable to sign this consent because he/she: _____

_____/_____ _____/_____

Signature of Parent/Guardian/ Legal Representative/Medical Surrogate Date Witness Signature/Date

Photo reproductions and facsimile copies of the above signatures have the full force and effect of the originals.

NOTICE TO RECIPIENT OF COPIES OF MEDICAL RECORDSPROHIBITION AGAINST REDISCLOSURE: THIS INFORMATION IS TAKEN FROM MEDICAL RECORDS AND IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATION 42 CFR PART 2 PROHIBITS YOU FROM MAKING FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION HELD BY ANOTHER PARTY IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL REGULATIONS STATE THAT ANY PERSON WHO VIOLATED ANY PROVISION OF THIS LAW MAY BE FINED NOT MORE THAT $5000 FOR EACH OFFENSE. Drug Abuse Office and Treatment Act of 1972 (21 USC 1175). Comprehensive Alcohol Abuse Prevention, Treatment, and Rehabilitation Act of 1970 (42 USC 4582). Federal Register, Vol. 40, No. 127 Tuesday, July 1, 1975.

"Authorization to Use or Disclose Protected Health Information." Disclosure made is bound by federal law and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 USC, 290dd-s; 42 CFR, Part 2) and that recipients of the information may receive and redisclosure it only in connection with their official duties with respect to the particular criminal proceeding and may not be used in other proceedings, for other purposes, or with respect to other individuals.