MHA TRIBAL INSURANCE

Authorization & Consent for Release of Protected Health Information (PHI)

SECTION A: Who is requesting authorization?

Name of patient

Prior name(s), if any

Street Address

XXX-XX-

Social Security Number *(Last 4 digits only)*

City

Area Code and Telephone Number

State

Zip Code

Date of Birth

SECTION B: Who will provide this information?

SECTION C: Who will receive this information?

Name/Dept.: MHA Nation Tribal Health Insurance

Email: PLewis@mhanation.com /clyessilth@mhanation.com

Phone: 833-551-0859

SECTION D: How will information be sent/received?

- ☐ Mail to address in *Section B to attention of individual in Section C*
- ☐ Pick Up
- ☐ Email: _____
- ☐ Other: _____

The risks of electronic transmission of PHI have been discussed.

SECTION E: Describe the purpose for the request.

- ☐ Attorney/Legal
- ☐ Continued Care
- ☐ Personal Use
- ☐ Insurance
- ☐ Other: _____

SECTION F: Describe the specific Protected Health Information to be used or disclosed, including date(s):

☐ Psychotherapy Notes for date(s) _____ ***If this box is checked, a separate authorization form must be completed in order to authorize release of any other type of protected health information (phi).***

- ☐ Entire Treatment Record — Date(s): _____
- ☐ Billing Statements — Date(s): _____
- ☐ Laboratory Reports — Date(s): _____
- ☐ Diagnostic Images (X-ray, etc.) — Date(s): _____
- ☐ Other (Describe): _____ — Date(s): _____

SECTION G: By signing below I indicate my understanding that:

- This authorization is voluntary. Treatment or payment will not be affected if I do not sign this form, except as provided by law.
- This is a full release including information related to HIV/AIDS, psychiatric care and/or psychological assessment, and alcohol and/or drug abuse treatment (in compliance with 42 CFR Part 2).
- Information may be re-disclosed by the recipient, in which case it may no longer be protected under federal and state privacy protections.
- I may revoke this authorization at any time by notifying in writing the entity listed in Section B. If I do revoke this authorization, the revocation won't have any effect on any release or disclosure that has already been made.

SECTION H: Expiration and Revocation

This authorization will expire (check one): ☐ On (enter date): _____ ***OR*** ☐ (Enter event or date): _____

SECTION I: Signature

I hereby authorize the use or disclosure of the Protected Health Information (PHI) as described above.

Print Name of individual releasing PHI releasing requested PHI

Time

Signature of patient ***OR*** patient's Personal Representative

Date

SECTION J: If Section I is signed by a Personal Representative, please complete the information below:

Print Representative's Name: _____ Relationship to Patient: _____

Signature of Person Verifying Representative's Authority: _____

Print Name of Person Verifying Representative's Authority: _____