SENECA NATION HEALTH SYSTEM

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

ONE Patient & ONE Facility/Provider PER RELEASE: please fill out separate form for each patient and/or Facility/Provider

Check location:

☐ Cattaraugus Territory Health Center
275 Thomas Indian School Extension
Irving, New York 14081
Phone: (716) 532-5582 Fax: (716) 242-6344

☐ Lionel R. John Health Center
987 R. C. Hoag Drive
Salamanca, New York 14779
Phone: (716) 945-5894 Fax: (716) 242-6345

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone Number: _____

I, _____, hereby authorize the Seneca Nation Health System to:

Check one or both: ☐ **Disclose to** ***or*** ☐ **Obtain** my protected health information as indicated below **to/from**: (if sharing circle to/from)

Facility/Provider/Person Name: _____

Address: _____ Phone Number: _____

Delivery method:

☐ In person ☐ Mail ☐ Phone ☐ Fax: _____ ☐ EMAIL: _____

The **purpose** of this disclosure is for: ☐ Further Medical Care ☐ Attorney ☐ Personal Use ☐ Insurance ☐ School

☐ Disability ☐ Research ☐ At the request of individual ☐ Other _____

Information to be disclosed: ☐ Office Visit Notes ☐ Radiology/Imaging ☐ Lab work ☐ EKG ☐ Medications ☐ Immunizations

☐ Hospital Records-date(s): _____ ☐ Specific dates or other information: _____

☐ Entire Record: (will not include billing records or records not prepared by the SNHS, unless those records are also selected)

Initial on the lines below if you are authorizing disclosure of any of the following sensitive information & **SPECIFY** dates/records below:

_____ Substance Use Disorder Records
_____ Sexually Transmitted Disease
_____ Genetic Testing (ie: Sickle Cell Anemia)
_____ Mental/Behavioral Health Records (Diagnosis, Treatment Plan, Progress Notes)
_____ HIV/AIDS Related Information (Testing, Treatment, Diagnosis)
_____ Psychotherapy Notes Only *(Requires Individual/Separate Release)*

SPECIFIC DATES/RECORDS **for the above requested records**: _____

I, the undersigned, have read the above and authorize the use, disclosure or access of such health information as described herein.
I understand that treatment is not conditioned upon the execution of this authorization, which is covered by the Notice of Privacy Practice signed for use and disclosure of protected health information for purposes of treatment, payment and healthcare operations under the Health Insurance Portability and Accountability Act (HIPAA) 45 CFR Part 160 and 164.
I understand that I may revoke this authorization at any time by providing a written notice to the SNHS Health Information department, except to the extent that action has been taken in reliance upon it or except as otherwise stated in the SNHS Notice of Privacy Practices, by mailing or hand-delivering written notification to the Seneca Nation Health System, Health Information Department, 987 R. C. Hoag Dr. Salamanca, NY 14779
I understand that if I have initialed above for the release of Reproductive Health Information, Alcohol/Substance Use Disorder, Mental Health or HIV records, I have documented what dates and/or records that I specifically authorize the release of such information to the Facility/Provider/Person listed above.
I understand that information disclosed by this authorization, once disclosed, may be re-disclosed. Substance Use Disorder (42 CFR Part 2 – final rule allows redisclosure if under T.P.O. only), Confidential HIV Records (Public Health Law 2782(5)(a) and Mental Health Records (NYS Mental Hygiene Law 33.13(f), which are protected from re-disclosure and only further disclosure is permitted with my written consent.
I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations

*This authorization will expire **one year** from the date of authorization or specify date/event: _____

Printed name of Patient or Legal Authorized Representative: _____

Signature of Patient or Legal Authorized Representative: _____ Date: _____

Relationship to Patient: _____ Witness Signature: _____