



SENECA NATION HEALTH SYSTEM

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

Check location: <input type="checkbox"/> Cattaraugus Indian Reservation Health Center 36 Thomas Indian School Drive Irving, New York 14081 Phone: (716) 532-5582 Fax: (716) 242-6344	<input type="checkbox"/> Lionel R. John Health Center P.O. Box 480 Salamanca, New York 14779 Phone: (716) 945-5894 Fax: (716) 242-6345
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Patient Name: _____ Date of Birth: _____

Address: _____

Telephone Number: _____

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

Check: disclose obtain my protected health information as indicated below to/from:

Facility/Provider Name: _____

Address: _____

Delivery method: In person Mail Fax
 Phone Email (SNHS Patient Portal ONLY) Other: _____

The purpose of this disclosure is for:

- | | | | |
|---|------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Further medical care | <input type="checkbox"/> Attorney | <input type="checkbox"/> School | <input type="checkbox"/> Research |
| <input type="checkbox"/> Personal use | <input type="checkbox"/> Insurance | <input type="checkbox"/> Disability/SSI | <input type="checkbox"/> Other: _____ |

Information to be disclosed:

- | | | | |
|---|--|--------------------------------------|--|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Labs | <input type="checkbox"/> EKG | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Office Visit Notes | <input type="checkbox"/> Radiology/Imaging | <input type="checkbox"/> Medications | <input type="checkbox"/> Entire Record |

Specific dates or other information: _____

Check below if you are authorizing release of any of the following information:

- | | |
|--|---|
| <input type="checkbox"/> Alcohol/Drug Treatment/Referral | <input type="checkbox"/> HIV/AIDS related information: testing, treatment & diagnosis |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Mental/Behavioral Health (Diagnosis, Treatment Plan, Progress) |
| <input type="checkbox"/> Sickle-cell anemia | <input type="checkbox"/> Psychotherapy Notes Only (requires individual release) |

I understand that I may revoke this authorization in writing at any time by submitting a request to the Health Information Department, except to the extent that action has already been taken on a previous authorization. Unless otherwise noted, this authorization will expire one year from the date of authorization or on _____ and I understand that information disclosed by this authorization, except for Alcohol & Drug Abuse as 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 (HIPAA) 45 CFR Part 160 & 164, and the Privacy Act of 1974.

Healthcare treatment is not conditioned on this authorization but covered by the general consent signed for use and disclosure of protected health information for purposes of treatment, payment and healthcare operations under 45 FRC Part 160 and 164.

Signature of Patient or Authorized Representative _____

Date _____

Relationship to Patient _____

Witness _____