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 Indian Reservation Health Center 36 Thomas Indian School Drive Irving, New York 14081 Phone: (716) 532-5582 Fax: (716) 242-6344	☐ Lionel R. John Health Center P.O. Box 480 Salamanca, New York 14779 Phone: (716) 945-5894 Fax: (716) 242-6345

Patient Name: _____ Date of Birth: _____

Address:_____

Telephone Number:_____

I,_____, herby 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 ☐ EMAIL:_____

☐ Phone ☐ Fax:_____ (e-mail communication will be through the SNHS Patient Portal)

The purpose of this disclosure is for:

☐ Further medical care ☐ Attorney ☐ School ☐ Research

☐ Personal use ☐ Insurance ☐ Disability/SSI ☐ Other:_____

Information to be disclosed:

☐ History and Physical ☐ Labs ☐ EKG ☐ Immunizations

☐ Office Visit Notes ☐ Radiology/Imaging ☐ Medications ☐ Entire Record

Specific dates or other information: _____

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

☐ Alcohol/Drug Treatment/Referral ☐ HIV/AIDS related information: testing, treatment & diagnosis

☐ Sexually Transmitted Disease ☐ Mental/Behavioral Health (Diagnosis, Treatment Plan, Progress)

☐ Genetic Testing (ie: sickle-cell anemia) ☐ 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

Date received by HIM staff: _____

Date completed: _____

HIA Initials:_____

Please make sure that this legal form is completed in its entirety, it will not be valid if not filled out with all the information required. We cannot honor nor accept an INVALID Release of Protected Information Form.

Thank you - SNHS Health Information Department