CNHSA STANDARD AUTHORIZATION TO USE OR SHARE TRIBAL HEALTH INFORMATION (THI)

Patient Name: _____**HRN:** _____ **DOB:** _____

I hereby authorize _____

Name of Person/Organization Disclosing THI

to release the following information to _____

Name of Person/Organization Receiving THI

_____

Address or Email or Fax of Person/Organization Receiving THI

Information to be shared:

- ☐ Psychotherapy Notes (if checking this box, no other boxes may be checked)
- ☐ Entire Medical Record
- ☐ Billing Information for _____
- ☐ Mental Health Records
- ☐ Substance Use Disorder Records (Specify dates and records allowed to be released) _____
  _____
- ☐ Medical information compiled between _____and_____
- ☐ Other: _____

The information may be disclosed for the following purpose(s) only:

- ☐ Insurance
- ☐ Continued Treatment
- ☐ Legal
- ☐ At my or my representative's request
- ☐ Other: _____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my THI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have communicable and/or non-communicable disease, which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance use disorder information. When applicable, the federal regulations governing the confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, prohibits re-disclosure of such information without written consent or when permitted by such regulations.
- Any other information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the CNHSA Privacy Code of 2021.
- I understand I may revoke this authorization at any time by writing to the person/organization disclosing my THI.
- I understand I cannot restrict information that may have already been shared base on this authorization.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event: _____

_____ _____ _____

Signature of Patient or Legal Representative | Date | Time

_____ _____

Description of Legal Representative's Authority | Expiration date (if longer than one year from date of signature or event is indicated)