United Indian Health Services, Inc.

AUTHORIZATION

FOR RELEASE OF PROTECTED HEALTH INFORMATION FROM UNITED INDIAN HEALTH SERVICES, INC.

For: (Name) ___________________________ (or Child's Name:)__________________________DOB:_____________

With my signature below, I hereby authorize United Indian Health Services to:

REQUEST a copy of my records **FROM:**	**SEND** a copy of my records **TO:**
United Indian Health Services, Inc. **1600 Weeot Way** **Arcata, CA 95521** **Phone: (707) 825- 5065** **Fax: (707) 825-6815**	Place: ______________________________ Address: ______________________________ City/State/Zip ______________________________ Name of client: ______________________________ Phone: ______________________________ Fax: ______________________________

For the following records:

From:______/______/______ To:______/______/______

- ☐ Recent Outpatient visit note
- ☐ Labs last 2 years, most recent if duplicates.
- ☐ Recent Hospital Discharge Summary
- ☐ X-Rays-all, most recent if duplicates
- ☐ Medication/ Allergy Lists
- ☐ Dental Record
- ☐ Operative Reports-all
- ☐ Pathology Reports-all
- ☐ Immunization Records
- ☐ Other ____
- ☐ Vision Record
- ☐ Consult Notes-all
- ☐ CT/MRI- all
- ☐ EKG- most recent

____

SIGNATURE: I have read BOTH SIDES of this authorization and I understand it.

_______________________________________ Client or legal/personal representative signature

_______________________________________ am / pm
Date Time

_______________________________________ Please Print Name Legibly

_______________________________________ Date of Birth

_______________________________________ Photo Identification
(i.e. Valid Driver's License Number, Passport, etc.)

_______________________________________ If not signed by the client, description of legal/personal representative's authority

With my initials placed here [________] I **authorize** release of my **HIV/AIDS/STD** status.

IMPORTANT NOTICE ON REVERSE SIDE

For Office Use Only

CLIENT NAME: ____________________________________**DOB:**________________**HR#:**_______________

☐ Potawot Health Village	☐ Eureka Clinic	☐ Smith River Clinic	☐ Crescent City Clinic	☐ Elk Valley Clinic	☐ Klamath Health Clinic	☐ Weitchpec Health Center
1600 Weeot Way	2332 Harrison Ave SuiteC&D	501 North Indian Road	1675 Northcrest Drive	2298 Norris Avenue	241 Salmon Road	Hwy 96
Arcata, CA 95521-4734	Eureka, CA 95501	Smith River, CA 95567	Crescent City, CA 95531	Crescent City, CA 95531	Klamath, CA 95548	Weitchpec, CA 95546
(707) 825-5000	(707) 442-0380	(707) 487-0215	(707) 464-2750	(707) 464-2919	(707) 482-2181	(530) 625-4300
(707) 825-6815 FAX	(707) 442-0381 FAX	(707) 487-3003 FAX	(707) 464-2668 FAX	(707) 464-8218 FAX	(707) 482-3655 FAX	(530) 625-4308 FAX

NOTICE OF RIGHTS AND OTHER INFORMATION

Unless revoked earlier, this **authorization** will EXPIRE after a period of one year from the date noted on the reverse. I understand I have the right to revoke this **authorization** at any time. I understand, if I revoke this **authorization**, I must do so in writing delivered to UIHS' Client Records Coordinator, 1600 Weeot Way, Arcata, CA 95521-4734. I understand such revocation will take effect upon receipt and will not apply to information which has already been released in response to this **authorization**. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

UIHS, its employees, officers, and physicians are hereby **released** from any legal responsibility or liability for disclosure of the above information to the extent **indicated** and **authorized** herein.

I understand that any **disclosure of information** carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another **authorization** for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law. If I have questions about disclosure of my health information, I can contact UIHS Client Records.

I understand that I may request a copy of this **authorization,** and I may inspect or request copies of information disclosed by this authorization, as provided by CFR§164.508(d)(l),(e)(2). I understand that if UIHS requests copies of my records from another facility, that facility may charge a fee. I will be responsible for this fee.