Tuolumne Me-Wuk
Indian Health Center

Tuolumne Me-Wuk Indian Health Center (TMWIHC) HIPAA authorization to use and disclose protected health information (PHI)

Please note that there may be a charge for providing copies of your medical records as allowed by federal and state law.

TMWIHC cannot disclose PHI without a valid authorization from the patient (or patient's representative) that the information is about. We use this form to obtain your written authorization to disclose your PHI to someone designated by you. This request does not allow your designated person to make any of your treatment decisions or direct care decisions. Use this form to authorize the release of **verbal or written** PHI, named in **Section 2** below. When filling out this form provide your most current information. Failure to fill out this form completely may cause delay in acting on your authorization.

Section 1. Patient information: Please provide current information:			
Last name:	First name:	Middle initial:	Date of birth:
Mailing street address:			Apt.#:
City:	State:	Zip code:	Medical record #:
Phone # with area code:	Email address:		

Section 2. Designated person/organization: Who is receiving your records?

I authorize (TMWIHC clinic name)____to disclose my PHI to the person(s) or organization(s) designated below. I understand that there are certain parties that must protect the privacy of my PHI. These are health care providers and other parties who are required to do so under federal or related state laws. If my designated person is not a health care provider or another party required to protect my PHI, my PHI will no longer be protected by HIPAA, and it could be discussed and/or released by them without my permission. Send my medical records to:

Name:		Relationship to patient:
Mailing street address:		Apt.#:
City:	State:	Zip code:
Phone # with area code:		Fax # with area code:
Email address:		

Section 3. Description of PHI: What types of information do you want TMWIHC to release?

At my request, I authorize the use and/or release of my records as indicated below to the person or entity listed in **Section 2** above. **Check the boxes below to indicate date(s) of service and types of records to be released.**

☐ Release my records from these date(s) of service: From:____________________to ____________				
☐ Release my records from the last_________years			☐Specialty diagnostic test results	
☐ Physician notes	☐ Physician's order	☐ Consultation reports	☐Lab reports	☐X-ray reports
☐ Immunization records		☐ Billing records	☐All medical records	
☐ Other (Be specific)				

The following items require special authorization by law. Check the boxes below to indicate your intent to include:

☐ Alcohol, drug or substance abuse	☐ Genetic information	☐ Reproductive health	☐ HIV/AIDS
☐ Mental or behavioral health	☐ Other		

Section 4. Purpose of disclosure: Check all that apply			
☐ Continuing care	☐ Referral to a specialist		☐ Change of doctor/provider
☐ Insurance	☐ Personal	☐ Workers compensation	☐ Disability determination
□ "At my request"	☐ Legal	□ Other	

Section 5. Format & delivery method: Send my records to the individual/entity listed in Section 2 above. Check one option			
☐ Send paper copies by mail		☐ Fax	☐ Secure email (provide email)
☐ Pick up in person	☐ Other (Specify other format and delivery method)		

Section 6. Expiration and revocation:

I understand that this authorization will expire twelve (12) months from the date of my signature as noted below unless I either:

1. Revoke the authorization in writing. To revoke this authorization, I must do so in writing and present my written revocation to my TMWIHC provider or by mailing to the address listed in Section 7 of this form. I understand that the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed by my TMWIHC provider.
2. Request a different date as noted below. I wish to request my authorization to expire on the date noted here________________

Section 7. Signature:

A. Authorized person designated by client or patient:

I have read and understand the above information. I acknowledge that my decision of whether or not to sign this form will not affect my eligibility for treatment or payment. I acknowledge that by my signature I am voluntarily authorizing TMWIHC and its affiliates to use and/or disclose my PHI to the person(s) or organization(s) designated in Section 2 above.

Patient signature: Date:

B. Personal representatives who are legally appointed:

I have read and understand the request and acknowledge that by signing this form I have the legal authority to act on behalf of the patient and am attaching the appropriate legal documentation to this request.

Signature of personal representative: Date:

Section 8. Return the completed form to:

Mailing address:
Tuolumne Me-Wuk Indian Health Center- Medical Records
905 Mono Way
Sonora, CA 95370
[Phone Number]: 209-928-5400 [Fax Number]: 209-928-5411

Please keep a copy of this form for your records.

Office use only

Date received: / / Received by (Print name/initial):

□ Faxed □ Mailed □

Date completed: / / □ Picked up □ Other (e.g., Patient portal)