SOUTHERN UTE INDIAN TRIBE

SOUTHERN UTE HEALTH CENTER
Behavioral Health Division

Authorization to Release Protected Health Information

This form authorizes the Southern Ute Health Center (SUHC), including satellite buildings, to release your Protected Health Information (PHI). You only need to complete this form if you want SUHC to give your PHI to another department, organization or person, such as your family members. PHI is information that may identify you and relates to your past, present, or future physical health, mental health, substance use and related health services. Please print clearly in blue or black ink.

Section A: Individual authorizing release of PHI

Name: ___________________________________ Date of Birth: __________________________
Address: ____
Telephone Number: ____

Section B: Description of Authorization

I Hereby authorize SUHC to release my PHI as described in this authorization. I understand that my PHI may include, but is not limited to the following: medical records, emergency care records, laboratory reports, mental health and substance abuse diagnoses and treatment records, and any personal or medical information related to the purpose of this authorization.

I further understand that my PHI may include information related to any of the following: mental health (excluding psychotherapy notes) HIV/AIDS, prescription medication, pregnancy/ maternity, and chemical dependency (including alcohol and drug diagnosis and treatment).

Section C: Persons/ Organizations authorized to receive my PHI

Please tell us who you are authorizing to receive your PHI by completing the table below.

- For “Relationship to you”, Please give a general description such as “Husband” or “Attorney”
- The “Start Date”, is the date this authorization will begin
- The “End Date”, is the date this authorization will end.

If you do not want this Authorization to end on a specific date, you may leave this box blank. In that case, this authorization will remain valid for one year.

Individuals Authorized to Receive your PHI

Name of person/ Organization	Relationship to you	Address	Telephone Number	Start Date	End Date

Section D: Purpose of Release:

___ Continuity of Care with other treatment professional
___ Legal Investigation
___ Personal Use
___ Family/Significant Other Involvement in treatment
___ Disability Determination
___ Other (Please Specify): ____

Section E: Specific Information to be Disclosed from My Health Record

___ Only information related to (Specify) __Behavioral Health ____________________
___ Only the period of events from __________________ to _____________________
___ Other (Specify) ____
___ Entire Record

Section F: If you would like any of the following sensitive information disclosed, please specify:

___ Alcohol/Drug Abuse Diagnosis and Treatment
___ Sexually Transmitted Disease
___ Mental Health Records (not including psychotherapy notes)
___ HIV/Aids – Related treatment

Section G: Terms and Conditions of this authorization

I understand that I may refuse to sign this authorization. I understand that if the person(s)/ organization(s) authorized to receive my PHI is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I further understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will end on the date specified above, in one year if no date specified, or upon departure from the Health Center.

Section H: Your Signature

Signature: _____________________________________ Date: ________________________

If this authorization is signed by a personal representative on behalf of the individual, please complete the following:

Personal Representative's Name: ____

Relationship to the individual:

___ Parent of a minor child
___ Legal Guardian, Conservator, or Executor – Please attach legal documentation
___ Durable Power of Attorney – Please attach legal documentation