

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Complete all sections, date, and sign

I. I, _____, hereby voluntarily authorize the disclosure of information from my record. (Name of Patient)

II. The information is to be disclosed by:

Name of Facility: _____

Address: _____

City/State: _____

And is to be provided to:

Name of Person/Organization/Facility: _____

Address: _____

City/State: _____

III. The purpose or need for this disclosure is:

IV. The information to be disclosed from my health record: (check appropriate box(es))

Entire Record

Only information related to (specify): _____

Only the period of events from: _____ to _____

Other (specify): _____

Psychotherapy Notes ONLY (by checking this box, I waive my psychotherapist-patient privilege to the notes)

If you would like any of the following sensitive information disclosed, check the applicable box(es) below.

Alcohol/Drug Abuse Treatment/Referral HIV/AIDS-related Treatment

Sexually Transmitted Diseases Mental Health (Other than Psychotherapy Notes)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event _____

(if different from one year after date below)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

Signature of Patient: _____

_____ Date

Signature of Authorized Representative (state relationship to patient)
or Witness (if signature is by thumb print or mark)

_____ Date

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION	NAME (Last, First MI)	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH
IHS-810 (10/02)		

(on back of IHS form 810)

INSTRUCTIONS TO COMPLETE FORM IHS-810, "AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION"

1. Print legibly in all fields using black ink.
2. Section I, print your name or the name of the patient whose information is to be released..
3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility and address that will receive the information.
4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, etc.
5. Section IV, check the appropriate box as applicable.
 - a. **Entire Record** – the complete record except for the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS related treatment, and mental health other than psychotherapy notes)
 - b. **Only information related to** – specify diagnosis, injury, operations, special therapies, etc.
 - c. **Only the period of events from** -- specify date range, e.g., Jan 1, 2002 to Feb 1, 2002.
 - d. **Other (specify)** – e.g., CHS, billing, employee health
 - e. **Psychotherapy Notes ONLY – IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.
 - f. **IN ORDER TO RELEASE SENSITIVE INFORMATION, ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), YOU MUST CHECK THE APPROPRIATE BOX!**
6. Section V, sign and date. If a different expiration date is desired, specify a new date
7. Section V, Authorized Representative, e.g., legal guardian, power of attorney, etc.
8. A copy of the completed Form IHS-810 will be provided to the patient.