Release of Information

The HHS IHS **Authorization for Use or Disclosure of Protected Health Information** form is available with instructions at <u>https://www.hhs.gov/sites/default/files/ihs-810.pdf</u>.

See the following image for an invalid Release of Information (ROI) form.

| :0 | MPLETE ALL SECTIONS, DATE, AND SIGN | SE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION |
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| • | health record. (Name of Patient) | , hereby voluntarily authorize the disclosure of information from g |
| _ | | |
| - | The information is to be disclosed by: NAME OF FACILITY | And is to be provided to: |
| | | NAME OF PERSON/ORGANIZATION/FACILITY |
| ł | ADDRESS THS Eagle Butt | e la |
| | | ADDRESS |
| | | |
| | CITY/STATE | CITY/STATE |
| | | |
| I. | The purpose or need for this disclosure is: | |
| | | School Research Softer (Specify) |
| | Personal Use Insurance | Disability Health Information Exchange (IHS/Other |
| | The information to be disclosed from my healt | h record: (check appropriate box(es)) |
| | Only information related to (specify) | last thru visits |
| | | |
| | Only the period of events from | to |
| | Other (specify) (CHS, Billing, etc.) | |
| | Entire Record | |
| | 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) |
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