chart: _____

HO-CHUNK NATION
DEPARTMENT OF HEALTH
Ho-Chunk Health Care Center (HHCC)
House of Wellness (HOW)

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION (HHCN PR810)

Please complete all sections, date, and sign

I. I, _____, hereby voluntarily authorize the disclosure of
(Name of Patient)

II. The information / communication is to be disclosed by: **To be provided to/communicate with:**

Name of Facility:_____ Person/Org/Facility: _____
Address: _____ Address: _____
City/State: _____ City/State: _____

III. FOR THE PURPOSE OF PROVIDING THE FOLLOWING SERVICES FOR ME:

☐ **Changing Physicians** ☐ **Consultation** ☐ **Primary Care** ☐ **Other** _____

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

☐ All Medical Records ☐ All Dental Records ☐ Lab Reports ☐ Immunizations
☐ Clinic Visit Notes last ____yrs ☐ Radiology Reports ☐ Consultation Reports
☐ Admit H&Ps, DC Summaries, ER Reports ☐ other (specify) _____
☐ Only information related to (*specify*): _____
☐ Only the period of events from: _____ to _____

☐ **Psychotherapy Notes ONLY** ***(by checking this item, I am waiving any psychotherapist-patient privilege)***

CHECK AND INITIAL the applicable item(s) below to authorize the following sensitive information to be disclosed.

___☐ Alcohol/Drug ___☐ Abuse Treatment/Referral ___☐ HIV/AIDS Tests / Treatment
___☐ Sexually Transmitted Diseases ___☐ Mental Health (Other than Psychotherapy Notes)

IV. 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, or if this authorization was obtained as a condition of providing insurance coverage, 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 If this authorization has not been revoked, it will terminate one year from the date of my signature.

I understand that HHCC will not condition treatment or eligibility for direct care on my providing this authorization.

I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) [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) Date
or Witness (if signature is by thumb print or mark)

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)). Some organizations file information by Social Security Number. You may choose not to include SSN.

HHCC PR-5 (03/05) revised from IHS-810 (09/02)

Ho-Chunk Health Care Center
N6520 Lumber Jack Guy Road
Black River Falls, WI 54615
(715) 284-9851 Fax (715) 284-5150

Pt / Maiden Name _____

DOB / SSN _____

Chart # _____

(INSTRUCTIONS TO COMPLETE FORM HHCC PR-5, "AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION"

1. Print legibly in all fields using ink.

2. Section I, print name of 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, 2012 to Feb 1, 2012.

   d. **Other (specify)** – e.g., CHS, billing, employee health, etc.

      e. **Psychotherapy Notes ONLY – IN ORDER TO RELEASE PSYCHOTHERAPY NOTES, ONLY THIS ITEM CAN BE CHECKED ON THIS FORM. NO OTHER REQUESTS FOR INFORMATION CAN BE MADE IN CONJUNCTION WITH PSYCHOTHERAPY REQUESTS.**

      IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED. AN ADDITIONAL AUTHORIZATION MUST BE USED TO RELEASE PSYCHOTHERAPY NOTES ONLY.

      Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the 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 ITEM, AND HAVE THE PATIENT INITIAL IT.**

6. Section V, sign and date.

   1. Section V, Authorized Representative, e.g., a parent signing for minor children, legal guardians, power of attorney, etc.

7. A copy of the completed Form HCNHD-810 will be given to the patient upon request.