FALLON PAIUTE-SHOSHONE TRIBE
FALLON TRIBAL HEALTH CENTER
1001 Rio Vista Drive • Fallon, Nevada 89406-5463
Tel 775-423-3634 • Fax 775-423-2287 • www.fthcnv.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Registration Form 300-9 (Rev. Apr 2023)

COMPLETE ALL SECTIONS, DATE AND SIGN

I, _____, hereby voluntarily authorize the disclosure of information from my health record.
(NAME OF PATIENT)

I. The information is to be disclosed by:

Name of Facility	Fallon Tribal Health Center
Address	1001 Rio Vista Drive
City/State/Zip	Fallon, NV 89406
Telephone	775-423-3634

And is to be provided to:

Name of Person/ Organization/Facility	
Address	
City/State/Zip	
Telephone	

II. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Personal Use ☐ Other: specify _____

III. The information to be disclosed from my health record: Check all appropriate box(es)

☐ Entire Record
☐ Only information related to: specify _____
☐ Only for the period of events **from:** _____ **to:** _____
☐ Other: be specific _____

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

☐ Alcohol/Drug Abuse Treatment/Referral
☐ HIV/AIDS-Related Treatment
☐ Sexually Transmitted Diseases
☐ Mental Health (other than Psychotherapy Notes)
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

IV. I understand that I may revoke this authorization in writing submitted at any time to the FTHC, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law(s) may provide 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 If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. (Specify different date: _____)

I understand that the FTHC will not condition treatment or eligibility of care on my providing this authorization except if such care is (1) research related and/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, except for Alcohol and Drug Abuse is defined in 42 CFR Part 2, 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 V Part 164}, and the Privacy Act of 1974 [5 USC 552a].

_____ _____
SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN (state relationship to patient) DATE

_____ _____
SIGNATURE OF WITNESS (if signature of patient is a thumbprint 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)