NIMIIPUU HEALTH

Authorization to Disclose Healthcare Information

PATIENT IDENTIFICATION:

Chart Number: ____________________

Name of Patient: ____________________

Date of Birth: ____________________

I AUTHORIZE MEDICAL INFORMATION TO BE RELEASED:

FROM:	TO:
NiMiiPuu Health Clinic	Mamáy'asnim Hit'eemenwees
Medical Records	Head Start/Early Head start
PO Drawer 367	PO Box 365/117 Lolo St.
Lapwai, ID 83540	Lapwai, ID 83540

THE PURPOSE OF THIS REQUEST IS:

____ Attorney	____ History & Physical	____ Medical Health Summary	____ Lab Test Reports
____ Continued Care	____ Immunization Record	____ Medical Progress Notes	____ Social Security Disability
____ Dental Notes	____ EKG's	____ Radiology Reports	____ Personal Use.
____ Insurance Purposes			

Other: ____________________

Please specify below, the time period for information you are requesting above.

Only information from: ____________________ to ____________________
(Month/Year) (Month/Year)

I understand that I have the right to revoke this authorization in writing at anytime, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire in six (6) months from the date of my signature. I understand that once the above information has been disclosed, it may be re-disclosed by the recipient and the information may be protected by federal privacy laws or regulations. I further understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this for to ensure healthcare treatment.

____________________ ____________________

Signature of Patient, Guardian or Legal Representative Date