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 Hitéemenwees**
Medical Records	**Head Start/Early Head Start**
PO Drawer 367	**PO Box 365 / 117 Lo Lo Street**
Lapwai, Idaho 83540	**Lapwai, Idaho 83540**

THE PURPOSE OF TIUS 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

Other: _____

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

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

I understand that I have the right to revoke this authorization in writing at any time, 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 If this authorization has not been revoked, it will expire in six (6) months from the date of my signature.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 of 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