



Prairie Band Potawatomi Nation – Tribal Victim Services Program

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AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED INFORMATION

Client Name: _____

DOB: _____

Parent/Guardian/Authorized Representative: _____

Authorization: I authorize the Prairie Band Potawatomi Nation Social Services Department to release / obtain the following information:

- | | |
|---|--|
| <input type="checkbox"/> Account/Billing Information | <input type="checkbox"/> Court Records/Legal Information |
| <input type="checkbox"/> Admission Intake | <input type="checkbox"/> Police, Parole, Probation, Pre-Sentencing Reports |
| <input type="checkbox"/> Evaluation or Screening | <input type="checkbox"/> Medical Records, Medication & Medication Consults |
| <input type="checkbox"/> Alcohol & Drug treatment records/Referral Packet | <input type="checkbox"/> Progress or other Notes pertaining to case |
| <input type="checkbox"/> Appointments | <input type="checkbox"/> Plans – Treatment/Case/Service/Employment |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diagnosis Documentation | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Discharge Documentation | |

Information Provided To/Received From:

Name/Agency: _____ Relationship: _____

Address (city, state, zip): _____

Phone: _____ Fax: _____

Restrictions: The information indicated will be disclosed unless there are specific restrictions noted here:

Purpose: The purpose of this disclosure is to facilitate and ensure appropriate assessment, evaluation, planning, treatment, referrals, supervision, and coordination of services.

Withdrawing Authorization: This authorization will be honored upon receipt unless revoked verbally or in writing. Revocation may be made at any time, except to the extent that the action has already been taken.

Time Limited: If no date or event is selected below, this authorization expires 90-days after discharge or one (1) year from the date signed.

Expires on this date: _____ or Upon the following event: _____

This authorization is voluntary, and I have had the opportunity to ask and receive answers to questions pertaining to it.

Client Signature or Parent/Guardian/Authorized Representative

Date

Staff Signature

Date

This document may pertain to information covered under the Privacy Act, 5 USC 552(a), the Violence Against Women Act confidentiality requirements, and/or the Health Insurance Portability and Accountability Act (PL 104-191) and its various implementing regulations and must be protected in accordance with those provisions. This information is personal and sensitive and must be treated accordingly. If this correspondence contains protected information it is being provided/sought after appropriate authorization **Notice of alcohol/drug confidentiality:** This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.