Prairie Band Potawatomi Nation – Tribal Victim Services Program
P.O. Box 174 • 11400 158th Road • Mayetta, KS 66509-0174
(P) 785-966-8330 (F) 785-966-8388
Toll Free (888) 966-2932

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:

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

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.