



PAIUTE INDIAN TRIBE OF UTAH BEHAVIORAL CARE DEPARTMENT CONSENT FOR RELEASE OF INFORMATION

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client Name: _____ Date of Birth: _____

IHS/Client Number: _____ Phone Number: _____

AUTHORIZATION

In order to provide me with the most effective services and treatment, I authorize the PITU Behavioral Care Department to coordinate with, share with, and/or release confidential information to (check all that apply):

<input type="checkbox"/> Adult Parole and Probation	<input type="checkbox"/> Southwest Behavioral Health Center
<input type="checkbox"/> Central Utah Counseling	<input type="checkbox"/> Utah Division of Child and Family Services
<input type="checkbox"/> Indian Health Services	<input type="checkbox"/> Utah Department of Workforce Services
<input type="checkbox"/> Juvenile Court (including Probation),	<input type="checkbox"/> Social Security Administration
<input type="checkbox"/> Justice/District Court	<input type="checkbox"/> Other (complete information below)
<input type="checkbox"/> Paiute Housing Authority	Name: _____
<input type="checkbox"/> PITU Education Department	Agency: _____
<input type="checkbox"/> PITU Enrollment Department	Address: _____
<input type="checkbox"/> PITU Health Department/Medical Clinics	City: _____ State: _____ Zip: _____
<input type="checkbox"/> School or School District (Specify: _____)	

TO RELEASE THE FOLLOWING INFORMATION

- All information to assist with delivery of service, evaluation and/or treatment
- Information relating to the following treatment, condition, or dates: _____
- Other (specify): _____

NOTE: ANY REDISCLOSURE OF RECORD INFORMATION IS PROHIBITED BY FEDERAL REGULATION (42 CFR PART 2). I understand that my records are protected under the federal regulations governing Confidentiality of Client Information Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically thirty (30) days following case closure or as follows: _____

DATE

SIGNATURE OF CLIENT

DATE

SIGNATURE OF PARENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE

DATE

WITNESS SIGNATURE