NAVAJO NATION MEDICAL RECORDS DISCLOSURE AUTHORIZATION FORM

Authorization form Disclosure of Information: I voluntarily consent to authorize my health care provider: _____ (Insert Name), disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: _____

Address: _____

Purpose: I authorize the release of my health information for the following purpose:

_____

(Note: "at the request of the patient" is sufficient of the patient is initiating the Authorization.)

Information to be disclosed: I authorize the release of the only the following records or types of health records pertaining to:

_____

Term: I understand that this Authorization will remain in effect:

- ☐ From the date of this Authorization until: _____
- ☐ Until the provider fulfills this request.
- ☐ Until the following event occurs: _____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The Third Party may not be:

_____

Employee Name (print): _____

Signature/Date: _____