PONCA TRIBE OF NEBRASKA

Authorization to Discuss Protected Health Information

Name: _____________________________ Date of Birth: _________ HRN #________

I authorize Ponca Health Services to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and / or billing information) to the following named person(s):

Parent ____

Spouse / Partner ____

Child(ren) ____

Caregiver / Friend ____

Other ____

Please be advised that any person not referred to on this authorization will not be given any information related to your care.

You are not required to list any name if you do not so choose.

This authorization may be changed, restricted or expanded at any time by completing a new authorization. I know that I may request a copy of this authorization. I agree that a photographic copy of this authorization shall be valid as the original. I agree that this authorization shall be valid until revoked.

________________________________ ________________________________
Signature Witness

____
Date