Blackfeet Tribal Behavioral Health

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Authorization to Release, Use, or Disclose Protected Health Information (PHI)

Name: _____ D.O.B. _____

Other Names: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____

Name of Facility or Individual to Whom PHI will released to

Facility or Person Name: _____ Phone #: _____

Address: _____ City: _____ State: _____

Zip: _____ Job Title or Relationship: _____

Fax #: _____ Email: _____

Type of Information to be Released ***(Please check all that apply)***

☐ Continued Care Plan/Transition/Discharge Summary ☐ Treatment Plan ☐ Biopsychosocial

☐ Admit/Discharge dates ☐ Mental Health Assessment ☐ SUD Assessment Recommendations

☐ Progress Report ☐ Medication Records ☐ Treatment Progress Reports

☐ TB Skin Test Results ☐ Continued Stay Reviews ☐ Medical/Health Correspondence

☐ Scheduled Appts. ☐ Entire Health Record ☐ Emergency Records

☐ History and Physical ☐ Pathology Report ☐ Laboratory Reports ☐ Biopsychosocial

☐ Other *(Please be specific)* _____

Release Instructions ***(How and When do you want the information)***

Date Information is needed by: _____ Date Information was released: _____

Disclosure Method: ☐ Pickup ☐ First Class Mail ☐ Digital Copy ☐ Direct Fax

Client Signature Section

Client Signature: _____

Parent/Legal Guardian (*If a minor*) _____ Date: _____

Print Name:

Office Use Only			
Signature ID Verified: YES / NO		# of Pages Released	
Request completed by:		Date:	
Revocation Authorization			
I now revoke (cancel) this Authorization to Use or Disclose my Protected Health Information.			
Signature		Date:	

Revised: 10/1/2024