48-3262

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

AUTHORIZATION FOR RELEASE OF INFORMATION

Each section must be completed.

I. I, Wilma Mankiller (Name of Patient), hereby request the disclosure of information from my rec

II. The information is to be released from:

Name of Facility W.W. Hastings Indian Hospital
Address 100 South Bliss Avenue
City/State Tahlequah, Oklahoma 74464-3399

and is to be provided to:

Name of Person/Organization/Facility Anthony P. Monaco, M.D.
Address New England Deaconess Hospital, 185 Pilgrim Road
City/State Boston, MA 02215

III. The purpose or need for this disclosure is:

The information authorized for release may include information which may be considered a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

IV. The information to be released is from my: *(Check one)*

☑ Medical Record ☐ Personnel Record ☐ Other *(specify)*

and includes: *(Check as appropriate)*

☐ The entire record, including any information on alcohol or drug abuse contained therein.

☐ Only information related to *(specify)*:

☐ Only the period or events from: to

V. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature.

X Signature of Patient: Wilma Mankiller 2-19-93 (Date)

Signature of Parent, Guardian or Authorized Representative *(if necessary)*: (Date)

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 U.S.C. 552a(i)(3)). In the case of alcohol and drug abuse patient records, a falsified authorization or disclosure is also prohibited under 42 CFR 2.31(d).

PATIENT'S IDENTIFICATION

NAME (First, M.I., Last)	RECORD NUMBER
	47335
ADDRESS	
CITY/STATE	DATE OF BIRTH