AUTHORIZATION TO RELEASE INFORMATION FORM

THIS FORM MUST BE COMPLETED AND ON FILE BEFORE ANY SERVICES WILL BE CONSIDERED

Please list all individuals living in the household ---- Date _____

Family Member	Relationship	Social Security #	Sex	Date of Birth	Roll #

I hereby give permission for the Eastern Shawnee Tribe, teacher or school, physician, dentist, optometrist, energy company, hospital or any other organization, healthcare provider or persons providing service to me and maintaining information about me to release information to the Health and Social Service Department. This information shall include verification that the patient was seen on a certain day, whether a healthcare insurance company or other party was billed for the service rendered and documentation of any payments received, the dates that said patient received medical treatment or otherwise from the healthcare provider and an original bill and/or original itemized statement for services rendered to the patient. The Health and Social Service Department requests such information for the purpose of determining eligibility for social services and legitimacy of claims.
I understand that I have the right to revoke this authorization at any time by written notice to the Eastern Shawnee Health and Social Service Department at 10100 S. Bluejacket Rd., Ste. 1, Wyandotte OK 74370. I am aware that my revocation of this authorization will not be effective to the extent the persons and/or organizations identified above have already acted in reliance upon this authorization. I understand that my revocation of this authorization may prevent or delay me from receiving services from the Eastern Shawnee Health and Social Service Department.
I have read, understand and agree to comply with the requirements of eligibility for the Health and Social Service Department of the Eastern Shawnee Tribe of Oklahoma. I also understand that the guidelines are set forth for the fair and equal treatment of each enrolled tribal member of the Eastern Shawnee Tribe of Oklahoma. If any of the above information changes, it is my responsibility to notify the Eastern Shawnee Health and Social Service Department in writing.

Head of Household _____
Address _____
_____
City/State/Zip _____
Daytime Phone _____

SUBMITTING FRAUDULENT CLAIMS IS A FEDERAL CRIME UNDER 18 CFR PART 1 CHAPTER 53 §1163. PRIVACY AND CONFIDENTIALITY IS PROTECTED UNDER 42 CFR.