AUTHORITY TO RELEASE INFORMATION TO A DESIGNATED INDIVIDUAL

Complete this form if you authorize Eastern Shawnee Tribe of Oklahoma's Health & Social Service Program to release information to someone other than yourself. The individual you designate will be able to acquire and receive information such as the status of your claim and benefit balance. Please inform this individual to allow 30 days from your submission before calling the department inquiring as to the status.

Choose One

○ I authorize Eastern Shawnee Tribe of Oklahoma's Health & Social Service Program to release information from my Health & Social Service records to the following individual

○ I withdraw my authorization to release information from my Health & Social Service records to the following individual

YOUR DESIGNATED INDIVIDUAL'S INFORMATION

Full Name -- _____
Address -- _____
City, State, Zip -- _____
Telephone -- _____
Relationship to You -- _____

I authorize the release of this information to the person named above for the following period of time:

From: _____/_____/_____ To: _____/_____/_____

Tribal Members Name -- _____
Birth Date -- _____ Tribal ID # -- _____

If you are giving your authorization – I authorize the Eastern Shawnee Tribe of Oklahoma's Health & Social Service Program to release information from my Health & Social Service records to the individual named above. I am aware that some information may not be release if it is subject to the Privacy Act. I am aware that this form is to protect my confidentiality.
If you are withdrawing your authorization – I withdraw my authorization to release information from my Health & Social Service records to the individual named above.

_____ Signature of Tribal Member

Date _____

_____ Signature of Designated Individual

Date _____