

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

INSTRUCTIONS: Make sure *all* blanks on this form are filled in • Sign only if you believe the release of this information is in your best interest • Failure to sign this consent will not jeopardize your right to receive services that are not applicable to this release • Failure to sign this consent may result in our ability to determine eligibility for services or compliance with federal and/or state participation requirements.

MEMBERS LAST NAME	FIRST NAME	MI	DATE OF BIRTH
ADDRESS	CITY	STATE	TEL NUMBER

LIMITATIONS:

I hereby authorize the Mille Lacs Band of Ojibwe Circle of Health to
 disclose to obtain from exchange with: MEDICAL PROVIDERS; DENTAL PROVIDERS
INSURANCE COMPANIES

the following information:

For the time period beginning _____ through _____

The purpose for this disclosure is:

MEDICAL CLAIMS; DENTAL CLAIMS; REIMBURSEMENTS; INSURANCE

REVOCAION AND CONSENT:

Upon fulfillment of the above stated purpose(s) this consent will automatically expire without express revocation, unless otherwise specified as follows: _____

Valid for a maximum of one (1) year

I understand that I may revoke this consent to release information at any time by written notice, except when legal action prevents revocation (probation, court confinement, court ordered). However, any release made in good faith prior to receipt of revocation, shall be deemed valid. I also understand that information disclosed by this consent cannot be released to anyone else unless I give written permission.

Member signature

Signature of Parent/Guardian (if under 18)

Date

Relationship to member

Witness

Relationship to member