Dear Parent/Guardian,

The Gila River Indian Community Schools require a copy of your child's COVID19 test result and COVID19 vaccination record before they can attend in-person school. By signing the Gila River Healthcare Release of Information (ROI) Form, GRHC School Health Services can send your child's COVID19 information to the school.

You have the option of submitting your child's records to the school, instead of signing this release of information. You may obtain a copy of your child's COVID19 test result and vaccine record from either of the Medical Record departments listed below.

Health Information Management (Medical Records) Department
Hu Hu Kam Memorial Hospital
483 West Seed Farm Road, Sacaton, AZ 85147
(520) 562-3321 Ext. 1399 or (602) 528-1399
(602) 528-1255 - Fax
Hours of Operation: Monday and Friday 8:00 am to 6:00 pm

Komatke Health Center
17487 South Health Care Drive, Laveen, AZ 85339
(520) 550-6003
(520) 550-6034 - Fax
Hours of Operation: Monday – Friday 8:00 am to 5:00 pm

Thank you,
School Health Services
Gila River Healthcare

Gila River Health Care (GRHC)

Hu Hu Kam Memorial Hospital, PO Box 38, Sacaton, AZ 85147 PH: 602-528-1399 Fax: 602-528-1255
Komatke Health Center, 17487 S Health Care Dr, Laveen, AZ 85339 PH: 520-550-6003 Fax: 520-550-6034
Ak-Chin Clinic, 48203 West Farrell Rd, Maricopa, AZ 85239 PH: 520-568-3881 Fax: 520-568-3884
Hau'pal Health Center 3042 W Queen Creek Road, Chandler, AZ 85286 PH: 520-796-2756 Fax: 520-796-2757
The Caring House P.O. Box 2187, Sacaton, AZ 85147 PH: 520-562-7400 Fax: 520-562-7453

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

1.

Name of Patient:	Chart #:
Address:	Date of Birth:

2. Information Released

FROM (✓ box)	**TO:** (✓ box)
☐ Hu Hu Kam Memorial Hospital ☐ Komatke Health Center ☐ Ak-Chin Clinic ☐ Hau'pal Health Center ☐ The Caring House ☑ Other as identified below:	☐ Hu Hu Kam Memorial Hospital ☐ Komatke Health Center ☐ Ak-Chin Clinic ☐ Hau'pal Health Center ☐ The Caring House ☑ Other as identified below:
Name of Person/Organization/Facility GRHC School Health Services	Name of Person/Organization/Facility GRIC Tribal School: Blackwater Community School
Address PO Box 38	Address 3652 E. Blackwater School Rd
City/State Sacaton, Arizona 85147	City/State Coolidge, Arizona 85128

3. The purpose or need for this release is: (✓ box)

☐ Medical Care ☑ School ☐ Attorney ☐ Disability ☐ Patient Portal
☐ Insurance ☐ Transfer to new PCP ☐ Personal Use ☐ Other:________________

4. The information to be released from my health record: ***(✓ appropriate box(es))***

☐ Clinic Visits ☐ Physical Exam ☐ X-Ray CD (images) ☐ Lab Reports
☑ Immunization Record ☐ Billing ☐ Face Sheet ☐ X-Ray Reports
☑ Only information related to (Specify) COVID-19 Testing Results and COVID-19 Vaccination Record
☑ **Only the period of events from:** 11/01/2021 **to:** 6/30/2022 (end of School Year 2021-2022)
☐ PHI to be used in a verbal discussion per HIPAA (only used for Healthcare Operations)

➔ **If you would like any of the following sensitive information released, ✓ the applicable boxes**

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related treatment
☐ Sexually Transmitted Diseases ☐ Mental Health (Other than Psychotherapy Notes)
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving my psychotherapist-patient privilege)

5. I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event as identified here: ________________________________. Specify New Date Refer to GRHC's Notice of Privacy Practices for information concerning the right to revoke this authorization.

I hereby voluntarily authorize this release of information and understand that GRHCC will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for release to a third party.

I understand that information released by this authorization may be subject to re-release by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule of 1996 and the Privacy Act of 1974.

Signature of Patient, Guardian, or Legal Representative ***(State relationship to patient if applicable)***	**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 USC 552(a)(i)(3))

Tribal/State ID/Wrist Band/Other:__________ID VERIFIED Employee Initials: _____ Pages Given:____