

**AUTHORIZATION TO RELEASE INFORMATION  
TO THE EASTERN SHAWNEE TRIBE OF OKLAHOMA  
HEALTH AND SOCIAL SERVICE DEPARTMENT**

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

Please list all individuals living in the household

FAMILY MEMBER	RELATIONSHIP	SOC SEC #	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 person(s) 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 services 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(s) and/or organization(s) 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 Services 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.

This authorization must be signed by each tribal member (or the tribal member's parent or legal guardian if the tribal member is a minor) identified in the above table.

TRIBAL MEMBERS SIGNATURE	PRINT NAME OF TRIBAL MEMBER	DATE

I am the parent and/or legal guardian of the minors identified below and executes this authorization on their behalf.

(Please print names of minor children)

_____	_____
_____	_____
_____	_____

Head of Household \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_