

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 Full Name

Address

**City, State,
Zip**

Telephone

**Relationship
to Yourself**

Name

Birth Date

Tribal ID #

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

From: ____ / ____ / ____ To: ____ / ____ / ____

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 released 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

Signature of Designated Individual

Date _____

Date _____