



SEMINOLE TRIBE OF FLORIDA MULTIPARTY CONSENT FORM

Consent for exchange of confidential information between Seminole Tribe of Florida tribal departments

I, _____, authorize the following information to be disclosed and re-disclosed as necessary to evaluate my need for services and to coordinate those services being provided to me.

The purpose or need for the exchange and disclosure of this information is to enable the Seminole Tribe of Florida and its various programs and service providers to evaluate my need for services from the Tribe, and for them to provide and coordinate those Services to me.

Information to be released: (Check and Initial)

- My Name and Other Identifying Information_____ My Status as a Patient/Client_____
- Initial and Subsequent Evaluations of my Service Needs_____ Summary of Assessment_____
- Dates of Discharge and Discharge Status_____ Attendance_____
- Discharge Plans for Drug and Alcohol and Mental Health Treatment Services _____
- Summary of Service Plan Progress and Compliance_____ Medical Diagnosis _____
- Other; Please Explain_____

I authorize that information is to be disclosed between and among the following individuals and programs: (check and initial) Program Representatives:

- Family Services_____
- Education_____
- Health/Clinic_____
- Legal_____
- Dispute Resolution_____
- Housing_____
- Seminole Police_____
- Pemayetv Emahakav_____
- Ahfachkee School_____
- Elder Services_____
- CC Elderly-Handicapped_____
- Council Representative's Office_____
- Chairman's Office_____
- Tribal Secretary_____
- Treasurer's Office_____
- Other_____

I understand that my alcohol and/or drug treatment records are protected under federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R., Part 2. My records are also protected under the Seminole Tribe of Florida's Health Information Privacy Policies and Procedures which mirror the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. parts 160 and 164 and apply to any protected information collected by the STOF Health Administration after May 1, 2005. I understand that none of my records can be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one month following the date I stop receiving services from the Core Group or any of its members, whichever is later.

Signature of Patient Date

Signature of Parent, Guardian Date
Or Authorized Representative

Witness Signature Date