

**Little Shell Healthcare Program**  
**A "NEW" PATIENT APPOINTMENT**

**GENERAL ELIGIBILITY REQUIREMENTS: MUST BE an enrolled member or Descendent of an enrolled member of a Federally Recognized Tribe.**

**INFORM PATIENT TO CHECK IN AT LEAST 1 HOUR PRIOR TO APPOINTMENT IN ORDER TO ESTABLISH CHART WITH ALL DOCUMENTS**

- a. **PROOF** of being a member or descendent of Tribal member. **MUST BRING YOUR TRIBAL ID/CIB to your 1<sup>st</sup> appointment to establish eligibility.**
- b. **IF DESCENDENT** of parent, grandparent, we will need their TRIBAL ID & STATE BIRTH CERTIFICATES for ALL FAMILY MEMBERS WHICH links the patient to the Tribal Member to show proof of Dependency.
  - **Example:** Patient is descendant of Grandmother; we will need Grandmothers Tribal ID, Parent State Birth Certificate and Patient's State BC; all birth certificates showing names or lineage "link" back to Grandmother.
- c. **ADDITIONAL DOCUMENTS** we will also need:
  - **Social Security Card** - our system is linked to Social Security Administration and once we put in the RPMS/GUI system it takes time for SSA to verify. That is why you see on page 2 in RPMS (Verified by SSA OR Not Verified by SSA).
  - **State ID Card or Driver's License** (picture ID)
  - **Insurance Cards.** (So proper ID/Group Name/Group # is entered for billing purposes).
  - **Military DD-214** for those that served in the U.S. Military. Veterans maybe eligible for Veterans Medical Beneficiary.
- d. **CUSTODY/GUARDIAN PAPERWORK** for Minors.
- e. **PARENTAL PRE-AUTHORIZATIONS** signed by parent/legal guardian if you want another person to bring your child or children to a doctor's appointment. You can fill out the proper I.H.S. forms at patient registration.
- f. **NEWBORN:** We will need Mothers Tribal ID along with the Hospital Record and/or CRIB Card at first visit; mothers name will be on the Hospital Record of Birth/CRIB Card. **WE WILL NEED STATE BIRTH CERTIFICATE ONCE PARENT RECEIVES IT WITH IN 60 DAYS OR patient will be considered ineligible.**

**Eligibility will be extended to NON-INDIAN in only three (3) situations:**

- a. Non-Indian woman pregnant with eligible Indian's child for duration of pregnancy through six (6) weeks post-partum for pregnancy related care only. **WE WILL NEED PROOF OF PREGNANCY FROM OUTSIDE FACILITY BEFORE APPOINTMENT.**
- b. Non-Indian member of eligible Indian's household-public health hazard only.
- c. Non-Indian: adopted, foster, step-child/children of eligible Indian until age of 19 years of age. (PL100-713). **NOTE:** Non-Indian patients who do not meet the above eligibility **but present at I.H.S. Emergency Room** for emergency care (prevent immediate death, serious impairment to life, limb, senses) can be treated, stabilized and outed to a NON-I.H.S. facility with patient responsible for costs; they will need to follow up with their own provider.





DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service  
Indian Health Services Hospital  
Little Shell Service Unit  
Great Falls, Mt 59404

PATIENT: \_\_\_\_\_ CHART: \_\_\_\_\_

BASIS FOR ENTITLEMENT TO MEDICARE: \_\_\_ AGE \_\_\_ DISABILITY  
\_\_\_ END STAGE RENAL DISEASE

ARE YOU CURRENTLY EMPLOYED? \_\_\_ YES \_\_\_ NO

IS THIS ILLNESS/INJURY DUE TO AN ACCIDENT (AUTO)? \_\_\_ YES \_\_\_ NO

IS THE VISIT PAYABLE TO WORKERS COMPENSATION INSURANCE? \_\_\_ YES \_\_\_ NO

DO YOU HAVE A VA FEE SERVICE CARD? \_\_\_ YES \_\_\_ NO

DO YOU HAVE BLACK LUNG DISEASE? \_\_\_ YES \_\_\_ NO

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT UNABLE TO SIGN (REASON): \_\_\_\_\_

(EXAMPLES: NURSING HOME PATIENT, MEDICAL CONDITION, OR INJURY)

EMPLOYEES SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



## Summary Notice of Privacy Practices

425 Smelter Ave NE, Great Falls, MT 59404 • P: 406.760.2055 • F: 406.403.0276

### Little Shell Commitment to Health Information Privacy

Little Shell Health provides care that preserves customer-owner dignity, privacy, safety, and security. Care provided honors cultural, spiritual, and personal beliefs, values, and preferences. We are committed to protecting customer-owner privacy. *This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.***

### Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You can choose to how we use and share information as we tell family and friends about your condition and provide mental health care.

### Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our Clinic
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

If you believe that your privacy rights have not been maintained, you can file a complaint with the Director of Operations, Skye McGinty, at [s.mcginty@lstclinic.org](mailto:s.mcginty@lstclinic.org) or 406.760.2055.

## **Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

### **Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request.

### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

### **Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

### **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

### **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

We never share your information unless you give us written permission for most psychotherapy notes.

## Our Uses and Disclosures

### How do we typically use or share your health information?

We typically use or share your health information in the following ways.

#### Treat you

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

#### Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

#### Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

### How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

#### Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

#### Do research

We can use or share your information for health research.

### **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

### **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

### **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

### **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

## **Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.



## Summary Notice of Privacy Practices

425 Smelter Ave NE, Great Falls, MT 59404 • P: 406.760.2055 • F: 406.403.0276

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

Please list any person(s) you would like involved in your care or payment for your care.

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Customer-Owner  
(Printed Name): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Customer-Owner Declines to Sign

LST Staff: \_\_\_\_\_

Date: \_\_\_\_\_

**PURCHASED / REFERRED CARE  
PROOF OF RESIDENCY**

The Indian Health Service (IHS) provides services through Purchased/Referred Care (PRC) to American Indian/Alaska Native people who live within the designated geographic area known as a PRC delivery area. The PRC program is authorized to pay for medical care provided to IHS beneficiaries by non-IHS or Tribal, public or private health care providers, depending on the availability of funds.

Federal law generally requires residency within the PRC delivery area in order to receive services through PRC. If you are requesting PRC authorization of payment by the IHS for medical services/treatment from a non-IHS provider, you must prove that you reside within the PRC delivery area.

Please print when completing this form. If you need help in completing the sections, you may ask for assistance and instructions from the IHS PRC Office.

Section A: Your Information (Required)			
Last Name	First Name	Middle Initial	Date of Birth
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		
Home street address:	Post Office Box:	Home phone number:	
City:	State:	Zip Code:	Cell phone number:
Physical location: <i>(For Post Office Box addresses, provide house location with street or road and the nearest intersection.)</i>			
Have you lived at this location for more than six months? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, provide your old address.		
Are you homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact phone number:		
<b>Verification Statement</b>			
By signing this form, under perjury of law, I verify that the information provided is true and factual to the best of my knowledge. I know that if I knowingly and willfully give any false information, that a false statement on any part of this declaration or attached documents may be grounds for punishment by a fine or imprisonment. (18 U.S.C. § 1001)			
I know that IHS PRC will check this information and I agree to cooperate with their information requests. I understand that the IHS PRC is only available to beneficiaries of the IHS who live in the PRC delivery area.			
_____			_____
Applicant Signature			Date

Provide one of the following to show that you live within the PRC delivery area.

Valid State driver's license or State Issued ID card	Employment check stub received within the past thirty (30) days showing address and withholding taxes.	Utility Bill: electric, gas, water, cable, cell phone, or telephone issued within the last sixty (60) days.
Tribal ID card with a photo	Homeowner's or renter's insurance policy	Rental or lease agreement
U.S. Passport	Mortgage Statement	Rental payment receipt
Voter's registration card	Property Tax Bill	Settlement Papers
Valid college ID with a photo	Property Deed	Marriage License
Other Tribal government issued documents		

If you do not have any of these documents, you can prove that you live in the PRC delivery area by completing Section B or Section C.

Another resident of the PRC delivery area, who knows where you live, can verify your residency by filling out Section B. If you do not know anyone who is willing or able to verify where you live, a local non-profit social services provider can verify your residency by completing Section C.

<b>Section B: Individual Verifier's Information</b>			
This section must be filled out by a resident who knows where you, the applicant, live – someone you live with is best. If you do not know anyone who is willing or able to verify where you live, a local non-profit organization that provides you with services may complete Section C for you. <i>(You do not need to fill in Section C if this section is completed.)</i>			
Last Name:	First Name:	Middle Initial	
Home address:	Post Office Box:	Home phone number:	
City:	State:	Zip Code:	Cell phone number:
Physical location: <i>(For Post Office Box addresses, provide house location with street or road and the nearest intersection.)</i>			
How do you know the applicant?			
<b><u>Verification Statement</u></b>			
By signing this form, under perjury of law, I verify that the information provided is true and factual to the best of my knowledge. I know that if I knowingly and willfully give any false information, that a false statement on any part of this declaration or attached documents may be grounds for punishment by a fine or imprisonment. (18 U.S.C. § 1001)			
I know that IHS PRC will check this information and I agree to cooperate with their information requests. I understand that the IHS PRC is only available to people who live in the PRC delivery area.			
By signing below, I verify that, to the best of my knowledge, the applicant listed in Section A on page 1 lives at the location stated in Section A.			
_____		_____	
Verifier's Signature		Date	

The individual verifier must sign Section B and provide a copy of at least one (1) of the following documents showing the **verifier's** name and address.

Valid State driver's license or State Issued ID card	Employment check stub received within the past thirty (30) days showing name and address.	Utility Bill: electric, gas, water, cable, cell phone, or telephone issued within the last sixty (60) days.
Tribal ID card with a photo	Homeowner's or renter's insurance policy	Rental or lease agreement
Valid U.S. Passport	Mortgage Statement	Rental payment receipt
Voter's registration card	Property Tax Bill	Settlement Papers
	Property Deed	

Name (Last, First, M.I.): \_\_\_\_\_  M  F DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

## HEALTH HISTORY QUESTIONNAIRE



LITTLE SHELL  
TRIBAL HEALTH

Please complete this entire questionnaire. It will provide your care team with important information about your health. All answers contained in this questionnaire are strictly confidential and will become part of your medical record.

**Marital status:** Circle the answer. Single Partnered Married Separated Divorced Widowed

**Number of children:** \_\_\_\_\_ **How many live with you?** \_\_\_\_\_ **Occupation is/was:** \_\_\_\_\_

**Previous or referring doctor:** \_\_\_\_\_ **Date of last physical exam:** \_\_\_\_\_

### HEALTH HISTORY

**Tests/Screenings and Dates:**  Eye Exam \_\_\_\_\_  Colonoscopy \_\_\_\_\_  Dexa Scan \_\_\_\_\_

#### Hospitalizations /or Surgeries

Year \_\_\_\_\_ Reason \_\_\_\_\_ Hospital \_\_\_\_\_

Year \_\_\_\_\_ Reason \_\_\_\_\_ Hospital \_\_\_\_\_

Year \_\_\_\_\_ Reason \_\_\_\_\_ Hospital \_\_\_\_\_

Year \_\_\_\_\_ Reason \_\_\_\_\_ Hospital \_\_\_\_\_

I have had no surgeries  I have never been hospitalized

Have you ever had a blood transfusion?  Y  N

Please list other physicians you have seen in the last 12 months, and for what reason.



LITTLE SHELL  
TRIBAL HEALTH

Name (Last, First, M.I.): \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

### FAMILY MEDICAL HISTORY

Please indicate if **YOUR FAMILY** has a history of the following: (ONLY include parents, grandparents, siblings, and children)

I am adopted and do not know biological family history  Family History Unknown

Mother, Grandmother, or Sister developed heart disease before the age of 65

Father, Grandfather, or Brother developed heart disease before the age of 55

<u>Disease/Conditions</u>	<u>Relationship to you</u> (mom, grandparents, siblings, and children)
<input type="checkbox"/> Seizures/Convulsions	_____
<input type="checkbox"/> Colon Cancer	_____
<input type="checkbox"/> Migraines	_____
<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Alcohol Abuse	_____
<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Lung/Respiratory Disease	_____
<input type="checkbox"/> Anemia	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Breast Cancer	_____
<input type="checkbox"/> Anesthetic Complication	_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Rectal Cancer	_____
<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> High Cholesterol	_____
<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Other Cancer -- Specify _____	_____
<input type="checkbox"/> Bladder Cancer	_____
<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Stroke/CVA of the Brain	_____
<input type="checkbox"/> Bleeding Disease	_____
<input type="checkbox"/> Leukemia	_____
<input type="checkbox"/> Thyroid Disorder	_____
<input type="checkbox"/> Other -- Specify _____	_____

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_





**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**COMPLETE ALL SECTIONS, DATA, AND SIGN**

I, \_\_\_\_\_, hereby voluntarily authorize the disclosure of information from my health record.

The information is to be disclosed by: NAME OF PERSON/ORGANIZATION/FACILITY	And is to be provided to NAME OF PERSON/ORGANIZATION/FACILITY <b>Little Shell Health Clinic</b>
ADDRESS	ADDRESS <b>**FAX TO +1-406-403-0276**</b>
CITY/STATE	CITY/STATE <b>425 Smelter Ave NE, Great Falls, MT 59404</b>

- II. The purpose or need for this disclosure is: (check all that apply)
  - Treatment, Payment, or other Healthcare Operations
  - Research
  - Insurance
  - School
  - Attorney
  - Disability
  - Personal Use
  - Other (specify) \_\_\_\_\_
- III. The information to be disclosed from my health record (check all that apply)
  - Entire Record
  - Lab Results
  - Immunization Records
  - Billing/Insurance Records
  - Other (specify) \_\_\_\_\_
- IV. If you would like any of the following sensitive information disclosed, check the applicable box(es) below:
  - Substance Use Disorder 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 any psychotherapist-patient privilege)
- V. I understand that I may revoke this authorization in writing submitted at any time to the Director of Operations, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

\_\_\_\_\_  
(Specify new date or expiration event)

I understand that Little Shell Health Clinic (LSHC) will not condition treatment or eligibility for care on my providing this authorization.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2 (see below), may be subject to redisclosure by the recipient and may no longer be protected Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

**SPECIFIC PROVISIONS REGARDING THE USE OR DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS:** I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] and the Privacy Act of 1974 [5 USC 552a], and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if I am authorizing the disclosure of my substance use disorder records to a Health Information Exchange pursuant to a general designation, I have the right to receive a list of all such disclosures made from the Health Information Exchange.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (State relationship to patient)	DATE
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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 willfully requests or obtains any record concerning any individual under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

**Patient Identification**



AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATA, AND SIGN

I, \_\_\_\_\_, hereby voluntarily authorize the disclosure of information from my health record.

Table with 2 columns: 'The information is to be disclosed by:' and 'And is to be provided to'. Rows include Name of Person/Organization/Facility (Little Shell Health Clinic), Address (\*\*FAX TO +1-406-403-0333\*\*), and City/State (425 Smelter Ave NE, Great Falls, MT 59404).

- II. The purpose or need for this disclosure is: (check all that apply)
III. The information to be disclosed from my health record (check all that apply)
IV. If you would like any of the following sensitive information disclosed, check the applicable box(es) below:
V. I understand that I may revoke this authorization in writing submitted at any time to the Director of Operations, except to the extent that action has been taken in reliance on this authorization.

(Specify new date or expiration event)

I understand that Little Shell Health Clinic (LSHC) will not condition treatment or eligibility for care on my providing this authorization.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2 (see below), may be subject to redisclosure by the recipient and may no longer be protected Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

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Signature and Date fields: SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (State relationship to patient) and 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 willfully requests or obtains any record concerning any individual under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

Patient Identification



## Patient Rights and Responsibilities

As a patient at **Little Shell Health Clinic**, you have a right to:

- Considerate and respectful care.
- Know the name of your health care provider(s).
- Appropriate assessment, education and management of pain.
- All information about your health status and treatment.
- Participate in all decisions about your care.
- Informed consent. You must give permission for tests, treatment and medicines.
- Refuse treatment. You may choose not to be treated. The provider will tell you how it might affect your health.
- A safe environment.
- Acceptance for treatment. If you want treatment at this clinic, you should not be refused care or sent to another facility without good reason.
- Give permission if LSHC is producing the recordings, films, or other images of you.
- Give permission to students to be involved in your care.
- Privacy. You must give permission before anyone not directly involved in your care is given information about you.
- Confidentiality. Messages between you and your provider, health charts, test results and medications must be kept private.
- Choose to participate in research projects.
- Know about clinic rules and regulations.
- Information about continuing care.
- Voice complaints regarding your care and have them addressed without fear of it affecting your care.
- Practice your religious, cultural, and spiritual beliefs.