

HIPAA Release Information

Thank you for filling out these medical information sheets. They will assist us in caring for your child's medical needs while he is at school. You will notice that there are two HIPAA release forms included in the packet. If your child only sees one primary physician, please disregard the second form. However, if your child sees two or more physicians for differing conditions, i.e. psychologist or psychiatrist, please fill out a release of information form for each physician. You may copy the form if your child sees more than 2 doctors. Thank you again for all your assistance with gathering this information.

Flandreau Santee Sioux Tribal Clinic

Chart No: _____
Tribal Code: _____

Flandreau Santee Sioux Tribal Health Clinic Patient Data Sheet

Full Name: _____ Male _____ Female _____

Other Names: _____ Social Security Number: _____

Street Address: _____ How Long? _____

City/ State/ Zip Code: _____

Home Phone Number: (____) _____ Work Phone : (____) _____

Date of Birth: _____ City & State of Birth: _____

List Others Living in Household: _____

Membership in What Tribe? _____

Tribal Blood Quantum: _____ Total Indian Blood Quantum: _____

Enrollment Number: _____ Religion: _____

Place of Employment: _____

Address of Employment: _____

City/ State/ Zip Code: _____

Spouse's Place of Employment: _____

Emergency Contact: _____ Relationship: _____

Address/ Phone Number: _____

City/ State/ Zip Code: _____

Father's Name: _____ Birthplace (city/ state): _____

Mother's Maiden Name: _____ Birthplace: _____

Veteran? Yes _____ No _____ Branch of Service: _____

Dates of Service: _____

Next of Kin (if same as Emergency Contact, please write SAME): _____

**I understand that I am required to provide proof of Indian eligibility.
I understand that I am required to provide proof of Social Security Number and Birth Certificate.
I understand that I may be required to provide proof of residence in Moody County for CHS eligibility.
I understand that falsifying any information may be reason for denial of services or eligibility.**

Patient Signature / Parent Signature _____
Date
Patient must be 18 years of age or older to be seen for dental or medical appointments or be accompanied by a parent or an adult. Flandreau Indian School Students are exempt of this policy.

MEDICAL HISTORY

PROVIDER REVIEW	
Date	Initials

NAME _____ AGE _____ DATE OF BIRTH _____
 SOCIAL SECURITY NUMBER _____ INDIAN OR NON-INDIAN _____
 TRIBE _____ AGENCY WHERE ENROLLED _____
 ADDRESS _____
(Street or P. O. Box) City State Zip

PLACE OF EMPLOYMENT _____
 PHONE: Home _____ Work _____ How long at current address? _____

CIRCLE: Y-YES N-NO

DO YOU HAVE OR HAVE YOU HAD?

- | | |
|--|--|
| <ol style="list-style-type: none"> 1. Do you have a toothache now? Y / N 2. Have you received medical care in the past two years? Y / N 3. Have you ever been hospitalized? Y / N
What for? _____
When? _____ 4. List any medication you have taken in the past two months. _____
_____ 5. Are you allergic to or made sick by any medicine? Y / N
Which medicine(s) _____ 6. Have you ever had a bleeding problem that that needed medical treatment? Y / N 7. Do you ever have chest pains? Y / N 8. Have you had a weight gain or loss of 10% or more in the past year? Y / N 9. Do you use alcohol or other drugs? Y / N 10. Do you use tobacco products? Y / N
Do you use? Cigarettes / Smokeless / Both
Would you like to quit smoking? Y / N 11. Do you have reason to believe you have been exposed to AIDS? Y / N 11a. Do you have AIDS or are you HIV positive? Y / N 12. Have you ever had radiation treatment for any reason? Y / N 13. WOMEN: Are you pregnant? Y / N
Not sure, possible? Y / N
Are you taking birth control pills? Y / N | <ol style="list-style-type: none"> 14. High Blood Pressure? Y / N 15. Heart Murmur? Y / N 16. Heart Attack? Y / N 17. Heart valve or pacemaker? Y / N 18. Rheumatic fever? Y / N 19. Congenital Heart Defect? Y / N 20. Heart Surgery? Y / N 21. Artificial Joint? Y / N 22. Surgical implants? Y / N 23. Stroke? Y / N 24. Hepatitis? Y / N 25. Liver Disease? Y / N 26. Kidney Disease? Y / N 27. Diabetes? Y / N 28. Asthma? Y / N 29. Tuberculosis (TB)? Y / N 30. Sinus Trouble? Y / N 31. Arthritis / Rheumatism? Y / N 32. Cancer or tumors? Y / N 33. Blood transfusions? Y / N 34. Venereal Disease? Y / N 35. Anemia? Y / N 36. Ulcers? Y / N 37. Thyroid? Y / N 38. Nervousness? Y / N 39. Have you ever had any other illness or condition not stated above Y / N
If so, please list any _____
_____ |
|--|--|

EMERGENCY CONTACT: _____ RELATIONSHIP _____

EMERGENCY CONTACT PHONE NUMBER _____ ADDRESS _____

What is the purpose of your visit to the dental clinic? _____

DO HAVE INSURANCE? _____ If yes, company name _____

MEDICAL DENTAL PHARMACY? (circle please) GROUP NUMBER _____

MEDICAID? _____ MEDICARE? _____ Effective date _____

These answers are true to the best of my knowledge. I hereby give my informed consent for myself / my child (17 years of age or below) to receive treatment necessary, including extractions, x-rays, fillings, or local anesthesia.

PATIENT / PARENT SIGNATURE _____

TODAY'S DATE _____

Medication Assistance Information

Occasionally our students at the Flandreau Indian School require medication that is not covered by a third party. In these circumstances we will attempt to obtain financial assistance from pharmaceutical companies. We are asking for the following information to assist us in this process.

Name _____ Soc. Sec. No. _____

Home Address: _____

Phone: _____

Date of Birth: _____

Number of People in Household: _____ Is the student a US resident? Yes No

Total Monthly Household Income: _____ (Please attach Federal Income Tax Form)

Is student receiving support from Social Security, SS Disability Insurance, SSI, Pension, Alimony, Child Support or IRA? If so, amount:

Is the student covered by Medicaid? Yes No

If yes, Medicaid number: _____

Is your Medicaid a Managed Care Program? Yes No

If yes, who is the student's primary provider? _____

Does the student have prescription coverage through a private insurance? Yes No

If yes, name of insurance company: _____

Policy Holder: _____ Relationship: _____

Policy Number: _____ Group Number: _____

Please make a copy of your insurance card and attach it to this form. Thank you!

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I, _____, hereby voluntarily authorize the disclosure of information from my record. (Name of Patient)

II. The information is to be disclosed by:	And is to be provided to:
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE

III. The purpose or need for this disclosure is:

- Further Medical Care Attorney School Research
 Personal Use Insurance Disability Other (Specify) _____

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

- Entire Record
 Only information related to *(specify)* _____
 Only the period of events from _____ to _____
 Other *(specify)* _____
 Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- Alcohol/Drug Abuse Treatment/Referral HIV/AIDS-related Treatment
 Sexually Transmitted Diseases Mental Health *(Other than Psychotherapy Notes)*

V. 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.

(Enter if different from one year after date below)

I understand that IHS 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 disclosure to a third party.

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

SIGNATURE OF PATIENT	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE <i>(State relationship to patient) or Witness (if signature is thumbprint or mark)</i>	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 552a(i)(3)).

PATIENT IDENTIFICATION	NAME <i>(Last, First, MI)</i>	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I, _____, hereby voluntarily authorize the disclosure of information from my record. (Name of Patient)

II. The information is to be disclosed by:	And is to be provided to:
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE

III. The purpose or need for this disclosure is:

- Further Medical Care
 Attorney
 School
 Research
 Personal Use
 Insurance
 Disability
 Other (Specify) _____

IV. The information to be disclosed from my health record: (check appropriate box(es))

- Entire Record
 Only information related to (specify) _____
 Only the period of events from _____ to _____
 Other (specify) _____
 Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- Alcohol/Drug Abuse Treatment/Referral
 HIV/AIDS-related Treatment
 Sexually Transmitted Diseases
 Mental Health (Other than Psychotherapy Notes)

V. 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.

(Enter if different from one year after date below)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is:
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SIGNATURE OF PATIENT	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE (State relationship to patient) or Witness (if signature is thumbprint or mark)	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 552a(i)(3)).

PATIENT IDENTIFICATION	NAME (Last, First, MI)	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH

**Instructions for Completing IHS Form 810 --
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

1. Print legibly in all fields using black ink.
2. Section I, print name of patient whose information is to be released.
3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility and address that will receive the information.
4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research related projects, etc.
5. Section IV, check the appropriate box as applicable.
 - a. **Entire Record** -- the complete record except for the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS related treatment, and mental health other than psychotherapy notes)
 - b. **Only information related to** -- specify diagnosis, injury, operations, special therapies, etc.
 - c. **Only the period of events from** -- specify date range, e.g., Jan. 1, 2002 to Feb. 1, 2002.
 - d. **Other (specify)** -- e.g., CHS, billing, employee health
 - e. **Psychotherapy Notes ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.
 - f. **IN ORDER TO RELEASE SENSITIVE INFORMATION, ALCOHOL/DRUG ABUSE TREATMENT/ REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), YOU MUST CHECK THE APPROPRIATE BOX!**
6. Section V, sign and date. If a different *expiration* date is desired, specify a new date.
7. Section V, Authorized Representative, e.g., legal guardian, power of attorney, etc.
8. A copy of the completed Form IHS-810 will be given to the patient.

OMB STATEMENT

Public reporting burden for this collection of information is estimated to average 20 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Indian Health Service, PH, 801 Thompson Ave., Suite 126, Rockville, MD 20852, RE: PRA 0917-0030. Please DO NOT SEND this form to this address.
