Please use black ink

Urban Inter-Tribal Center of Texas
PATIENT REGISTRATION FORM

RPMS #

Patient's Legal Name _____
Last *First* *Full middle name*

Sex _____ Social Security Number _____ Marital Status _____

Address _____ _____ _____ _____
City *State* *Zip*

Birth date _____ City & State of birth _____ When did you move here? _____

Phone ( ) _____ ( ) _____ ( ) _____
Home *Work* *Cell/Message*

Employer _____ Employer Address _____

Fathers Name _____ Mother's Maiden Name _____
Last *First* *Last* *First*

Father's Birthplace _____ Mother's Birthplace _____

IF PATIENT IS UNDER AGE 18

Guardian: _____ *Relationship to Patient:* _____

Address if different _____
City *State* *Zip*

Telephone: ( ) _____ ( ) _____ ( ) _____
Home *Work* *Cell/Message*

Father's Employer _____ *Mother's Employer* _____

E-MAIL Address _____ @ _____
We may use your Email address to send you announcements of events you may have an interest in or when attempts to reach you by phone or postal mail have failed.

If you are a member of a Native American or Alaska Native Tribe, please provide the name of the tribe and a copy of your membership documentation. **Tribe** _____

Emergency Contact
Name _____ Phone _____
Complete
Address _____ Relationship to patient _____

Next of Kin
Name _____ Phone _____
Complete
Address _____ Relationship to patient _____

RPMS #

Urban Inter-Tribal Center of Texas
PATIENT REGISTRATION FORM

As a Federally Qualified Health Center and to keep our services affordable, UITCT receives grant funding. To qualify for these resources we must collect the following information on all our clients. Please support UITCT by answering all these questions.

Financial Responsibility
Do you have Medical **Y / N** Dental **Y / N** insurance or Medicare **Y / N** Medicaid **Y / N**

If you are a dependent on someone else's insurance we will need the following to verify eligibility and to bill the insurance

Full Name _____ Date of Birth _____ Sex _____

Be sure to provide the card(s) so we may make a photocopy.

Are you a US Veteran? **Y / N** Do you have VA benefits? **Y / N** Branch _____ Entered Date _____

Discharged date _____

Indicate your race(s)
[ ] American Indian/Alaska Native [ ] Asian [ ] Black or African American
[ ] Unknown [ ] Native Hawaiian or Pacific Islander
[ ] White [ ] Declined to answer

Indicate your ethnicity
[ ] Not Hispanic or Latino [ ] Hispanic or Latino [ ] Declined to answer
[ ] Unknown

What is your primary language (the language you speak at home)? _____

What other languages do you speak? _____

What is your preferred language? _____ Do you need an interpreter? **Y / N**

What is your religious preference? _____

Are you a migrant agricultural worker? **Y / N** Are you a seasonal agricultural worker? **Y / N**

Are you current homeless? **Y / N**
If yes, please indicate if you are Staying in a shelter? **Y / N** In a transitional living arrangement? **Y / N**
Doubling Up? **Y / N** Living on the street? **Y / N**

Do you have access to the Internet? YES / NO *Where:* Home / Work / School / Clinic / Library / Community Center

Income Information

Number in Family _____ Monthly Income $_____ or Annual Income $_____

Present: Photo identification, Native Verification, & Insurance Card(s)

Initials of Screener _____

Revised: 06/12-JC

New Patient Questionnaire

NAME_____ **AGE**_____ **DATE** _____

WHAT BRINGS YOU TO CLINIC TODAY?

LIST ANY CHRONIC MEDICAL ISSUES YOU HAVE: (Diabetes, High blood pressure, Asthma, etc.)

Do you have a primary care physician or specialist you see regularly? If so list here: _____

MEDICATIONS: List OR Show Provider Medications brought with you.

Drug name	Dosage	Frequency	How Long Taken?

SURGICAL HISTORY

Year: _____ Procedure: _____ Year: _____ Procedure: _____

Year: _____ Procedure: _____ Year: _____ Procedure: _____

HOSPITALIZATIONS

Year: _____ Reason: _____ Year: _____ Reason: _____

Year: _____ Reason: _____ Year: _____ Reason: _____

FAMILY HISTORY of: DIABETES, HIGH BLOOD PRESSURE, HEART PROBLEMS, CANCER, BLOOD CLOTS for the following:

Mother _____ Maternal Grandmother _____

Father _____ Maternal Grandfather _____

Brother _____ Paternal Grandmother _____

Sister _____ Paternal Grandfather _____

Others_____

HEALTH MAINTENANCE: Please indicate if you have received the following tests, with most recent date and result:

COLONOSCOPY: _____ LABS/BLOODWORK: _____

MAMMOGRAM: _____ EYE EXAM: _____ DENTAL VISIT: _____

PAP SMEAR: _____ Smoking/Drugs/ETOH/Dep/ Dom Vio: _____

BONE DENSITY: _____ HPV Vaccine/Multi Partners(Risk)/Abs/Prot. _____

Urban Inter-Tribal Center of Texas

1283 Record Crossing Dallas, TX. 75235 Mailing Address
1261 Record Crossing Dallas, TX. 75235 Physical Address
Phone: (214) 941-1050 Fax: (214) 946-4738

MEDICAL CONSENT FORM

Date: _____

I, the undersigned, hereby give consent to the Urban Inter-Tribal Center of Texas and its medical staff, physician assistant, employees, and agents to examine, administer tests, prescribe therapy, administer treatments, or perform other procedures that are deemed necessary and advisable for:

_____
Patient (Please print)

In connection with any illness, defect, or complaint for which the above named patient has been brought or may hereafter come to Urban Inter-Tribal Center of Texas, it is my request that one or more members of the professional medical staff examine me as necessary and to diagnose and treat the illness, defect, or complaint for which I seek treatment for Urban Inter-Tribal Center of Texas.

I realize that upon signing this consent for treatment, I may present myself for diagnose and treatment of illness, defects or complaints. I do hereby give my unqualified consent for treatments, as necessary, at anytime I come to the clinic. I also give my consent to be seen by the physician assistant. I know the physician assistant is not a physician and that I may insist on seeing the physician at any time.

I CERTIFY THAT I HAVE READ THE ABOVE AND THAT I UNDERSTAND ITS CONTENTS.

_____
Patient or Parent/Guardian Signature

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

Name: _____

Relationship: _____

Address: _____

_____

Phone: _____

Urban Inter-Tribal Center of Texas

1261 Record Crossing Rd., Dallas, TX 75235
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HEALTH SERVICES

NO SHOW POLICY

To better serve all community members, the Health Services Department has the following policy concerning appointments:

1. Any patient who fails to come in for an appointment, arrives more than 15 minutes late for an appointment, or cancels an appointment with less than 24 hours notice will be documented in the patient record as a **No Show.**

2. If a **No Show** for medical and dental appointments occurs 3 times in one year for a patient, that patient will be seen only on a same day appointment basis for medical and walk-in time for dental for a period of six months. At the end of this probationary period, the patient may be reinstated to receive designated appointments for medical and dental care.

3. In the event that this patient has an occurrence of a **No Show** again after the probationary period, the patient will be placed on six months probationary period once again.

Please call no later than 12:00 noon the day before your appointment is scheduled (or on Friday if your appointment is on Monday) to cancel or reschedule your appointment if you will not be able to keep your appointment.

I understand my responsibility to keep my appointments and agree to comply with Health Services Department No Show Policy.

_____ _____

Patient or Parent/Guardian Signature Date

JF 08/05/14

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HEALTH SERVICES

CLINIC MEDICATION POLICY

To better serve all community members, the Health Services Department has the following policy concerning medications:

1. Please keep all appointments to ensure that you do not run out of medication. We are set up so that when you have your appointment you also receive medications. (Usually every two months)

2. If you are unable to keep your regular scheduled appointment and need medication, please request in advance no later than 7-10 days before your medications are out. Allow a 48 hour processing time and possibly more time depending on patient status and situation.

3. Refill of medication does not qualify as grounds for a walk-in visit.

4. The Urban Inter-Tribal Center of Texas pharmacy does not by any means fill outside prescriptions.

Note: Requests called in on Friday will have a 48 hour processing time that begins on Monday or following business day.

I understand my responsibility to agree to comply with Health Services Department Clinic Medication Policy.

_____ _____

Patient or Parent/Guardian Signature Date

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ELIGIBILITY

In order to receive Clinical Services at this facility, proper documentation is required. No one will be permitted to utilize our services, otherwise.

We will accept as official documentation:

1. **C.D.I.B** card with **driver's license** or **official state I.D. card** for those over 18 years old.

   C.D.I.B. with **copy of birth certificate, social security card and shot record** for those under 18 years old with parents ID.

2. **Tribal/B.I.A. verification on official letterhead with appropriate signature with driver's license and birth certificate:**

   Infants from 1 day - 6 months will be seen if either parent has proper documentation. After 6 months, child will be required to also have birth certificate along with parent(s) proper documentation. **Due to our contracting guidelines we are only able to provide direct care to Native Americans. Those seeking services are strongly encouraged to obtain proper documentation.**

I have been informed and am aware of documentation required to be able to use this facility.

_____ _____

Patient or Parent/Guardian Signature Date

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CONTRACT CARE FUNDS

If one of our doctors, physician's assistant, nurses, or dentists refer you to another health facility, hospital, or clinic to obtain health care services that we cannot or do not provide here:

PLEASE BE ADVISED, YOU ARE RESPONSIBLE TO PAY FOR THE COST OF THIS CARE.

You will be billed by the referral health facility. If you have private or public health insurance coverage you may use this to pay the bill, if appropriate. You may of course, refuse to go to the referral facility, but please remember the purpose of the referral is to provide you with the opportunity to receive the appropriate health care needed for your well being. If you go to the referral facility, please make the necessary arrangements to pay the bill.

WE CANNOT PAY THE BILL FOR YOU.

1. I have read the above and understand my financial responsibilities should I be referred to another health facility.

2. Because our funding does not cover any tests which are done by outside labs, we ask all patients receiving laboratory tests to pay for them prior to the specimens being sent out.

_____ _____

Patient or Parent/Guardian Signature Date

CONSENT TO TREAT

I hereby give consent to the attending physician, physician's assistant, dentist or nurse of the Urban Inter-Tribal Center of Texas to examine and treat my child and/or myself.

I hereby authorize payment under the medical insurance program to be made to the Urban Inter-Tribal Center of Texas for services furnished to me. I authorize the provider to release to the authorized insurance company. I authorize that my signature be kept on file at the Urban Inter-Tribal Center of Texas. I HAVE READ AND UNDERSTAND THE ABOVE AND GIVE MY CONSENT.

_____ _____

Patient or Parent/Guardian Signature Date

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Medication Release

I _____
(Patient name print.)

(Circle one)
a.) Give permission to:

b.) Do not give permission to anyone.

1._____
(Name and Relation.)

2._____
(Name and Relation.)

3._____
(Name and Relation.)

4._____
(Name and Relation.)

5._____
(Name and Relation.)

The persons named above have my permission to pick up my medications and supplies until further notice is given. This form is not a release of information form.

_____ _____
(Patient Signature) (Date)

Urban Inter-Tribal Center of Texas

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Release of Information / Assignment of Benefits

Urban Inter-Tribal Center of Texas has my permission to release information as needed for insurance processing and for my insurance to release payment to UITCT.

I HEARBY AUTHORIZE TREATMENT

*Signature of Patient or guardian*_____

*Printed Name*_____ *Date*_____

JC 05/2012

Initials of Screener _____

Urban Inter-Tribal Center of Texas

1261 Record Crossing Rd., Dallas, TX 75235
Phone: 214/941-1050 Fax: 214/946-4738

Acknowledgement of Receipt of
Urban Inter-Tribal Center of Texas
Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

UITCT is furnishing you with the attached notice, which provides information about how UITCT and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have a copy of UITCT's *Notice of Privacy Practices.***

_____ _____

Signature of Patient or Legal Representative Date

JF 08/04/14

Initials of Screener _____

Urban Inter-Tribal Center of Texas

Patient Rights and Responsibilities

As a patient, you have a right to:

- Respectful and Considerate care in a safe environment that supports your personal dignity
- Receive, upon registration, information about the UITCT's Patient Rights
- Be involved in decisions about your care, treatment, and services
- Give Informed Consent or to refuse care, treatment and services as allowed by law and regulations
- Be informed about outcomes of care, treatment, and services
- Effective communication and to receive information and all communications in a manner you understand
- Make a complaint or file a grievance concerning the quality of your care, or any other issue
- Confidentiality, privacy, and security
- Be free from mental, physical, sexual and verbal abuse, neglect and exploitation
- Participate in the consideration of ethical issues that arise during your care
- Access the information contained in your medical record
- Have these rights extended to your guardian, next of kin or legally authorized responsible person if you are unable to speak for yourself
- Be free from discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, gender, sexual orientation, and gender identity or expression

As a patient, you have a responsibility to:

- Provide accurate and complete information about your medical history and current condition
- Participate in and follow your treatment plan, and accept the consequences of refusing treatment or not following your treatment plan
- Ask questions if you don't understand something that you have been told regarding you care
- Respect and show consideration for the rights of others by complying with UITCT's policies regarding noise, smoking, and conduct of visitors

Complaint & Grievance Policy Statement

- Urban Inter-Tribal Center of Texas provides for and welcomes the expression of complaints/grievances and suggestions at any time by the patient, patient's family and/or designated representatives. This feedback allows us to understand and improve the environment of care.

- Every patient has the right to file a complaint/grievance with any staff member or the facility's Administrative Director. In absence of the Administrative Director, an Executive Assistant will address the complaint/grievance. The grievance process begins with the facility's Administrative Director. If the patient is still not satisfied, the process is given to the CEO. In the event the problem is still not resolved, a complaint can be registered by phone or in writing to :

Texas Department of State Health and Services
Health Facility Licensing and Compliance Division
1100 West 49th St., Austin, TX 78756
Or call 1-888-973-0022

- A complainant may also contact the state directly, bypassing any internal process.

- A complainant may provide his/her name, address, and phone number or may register an anonymous complaint. All complaints are confidential.

INDIAN HEALTH SERVICE
Notice of Privacy Practices

"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."

SUMMARY OF YOUR PRIVACY RIGHTS

A. Understand Your Medical Record/Information. Each time you visit an Indian Health Service (IHS) facility for services, a record of your visit is made. If you are referred by the IHS through the Purchased/Referred Care (PRC) program, the IHS also keeps a record of your PRC visit. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your medical record, serves as a:
1) Plan for your care and treatment.
2) Communication source between health care professionals.
3) Tool with which we can check results and continually work to improve the care we provide.
4) Means by which Medicare, Medicaid, or private insurance payers can verify the services billed.
5) Tool for education of health care professionals.
6) Source of information for public health authorities charged with improving the health of the people.
7) Source of data for medical research, facility planning, and marketing.
8) Legal document that describes the care you receive.

B. Understanding what is in your medical record and how the information is used helps you to:
1) Ensure its accuracy.
2) Better understand why others may review your health information.
3) Make an informed decision when authorizing disclosures.

C. Your Medical Record/Information Rights. Your medical record is the physical property of the IHS, but the information belongs to you. You have the right to:
1) Inspect and receive a paper or electronic copy of your health information.
2) Receive notification of a breach of your unsecured protected health information.
3) Request a restriction on certain uses and disclosures of your health information to include certain disclosures of protected health information to your health plan. The IHS is not required to agree to the requested restriction except when the disclosure would be for the purpose of carrying out payment or health care operations and is not otherwise required by law and the PHI relates solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.
4) Request a correction or amendment to your health information. The IHS may amend your record or include your Statement of Disagreement.
5) Request confidential communications about your health information.
6) Request and obtain a listing of certain disclosures the IHS has made of your health information.
7) Revoke your written authorization to use or disclose health information.
8) Request and obtain a paper or electronic copy of the IHS Notice of Privacy Practices
9) Request and obtain a paper or electronic copy of the patient's medical record from the IHS Medical, Health and Billing Records, System Notice Number 09-17-0001.

D. Indian Health Service Responsibilities. The IHS understands that health information about you is personal and is committed to protecting your health information. The IHS is required by law to:
1) Maintain the privacy of your health information.
2) Inform you about our privacy practices regarding health information we collect and maintain about you.
3) Notify you if we do not agree to a requested restriction.
4) Notify you of our decision regarding a request for correction or amendment.
5) Accommodate reasonable requests you may have to communicate health information by alternate means or to an alternate location.
6) Promptly notify you of a breach of unsecured protected health information (PHI).
7) Honor the terms of this Notice or any subsequent revisions of this Notice.

REVISED NOTICE OF PRIVACY PRACTICES

The Indian Health Service (IHS) reserves the right to change its privacy practices and to make the new provisions effective for all PHI it maintains. The IHS will post any revised Notice of Privacy Practices at public places within its facilities and on the IHS web site at:: http://www.ihs.gov/AdminMgrResources/HIPAA/index.cfm

1) How the IHS may use and disclose health information about you. The IHS will not use or disclose your health information without your permission, except as described in this Notice and as permitted by the HHS Privacy Act regulations, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, Genetic Information Nondiscrimination Act (GINA) of 2008, and the IHS Medical, Health, and Billing Records, System Notice 09 17 0001. The following categories describe how we may use and/or disclose your health information.

A. Treatment. We will use and/or disclose your health information to provide your treatment. For example:
1) Your personal information will be recorded in your medical record and used to determine the course of treatment for you. Your health care provider will document in your medical record their instructions to members of your healthcare team. The actions taken and the observations made by the members of your healthcare team will be recorded in your medical record so your health care provider will know how you are responding to treatment.
2) If you are referred or transferred to another facility or provider for further care and treatment, the IHS may disclose information to that facility or provider to enable them to know the extent of treatment you have received and other information about your condition.
3) Your health care provider(s) may give copies of your health information to others, including health care professionals or personal representatives, to assist in your treatment.

B. Payment Purposes. We will use and disclose your health information for payment purposes. For example:
1) If you have private insurance, Medicare, or Medicaid, a bill will be sent to your health plan for payment. The information on or accompanying the bill will include information that identifies you, as well as your diagnosis, procedures, and supplies used for your treatment.
2) If you are referred to another health care provider under the Purchased/Referred Care (PRC) program, the IHS may disclose your health information to that provider for health care payment purposes.

C. Health Care Operations. We will use and disclose your health information for health care operations. For example:
1) We may use your health information to evaluate your care and treatment outcomes with our quality improvement team. This information will be used to continually improve the quality and effectiveness of the services we provide.

D. Health Information Exchange (HIE). The IHS HIE may make your health information available electronically through an information exchange network to other providers involved in your care who request your electronic health information. Participation in the national eHealth Exchange network is voluntary. If you want your health information to be accessible to authorized health care providers through the IHS HIE to the national eHealth Exchange, you must authorize this use and disclosure. More information is available at http://www.ihs.gov/hie/

E. Personal Health Record. The Personal Health Record (PHR) is a secure web based application that provides patient access to their health care information. The PHR is accessible to any patient who receives care at an IHS facility and requests a PHR account.

F. Direct. The IHS may share your health information between providers and between healthcare providers, patients and/or patients' authorized representatives, using the DIRECT secure, web-based messaging service.

G. Business Associates. The IHS provides some healthcare services and related functions through the use of contracts with business associates. For example, the IHS may have contracts for medical transcription. When these services are contracted, the IHS may disclose your health information to business associates so that they can perform their jobs. The IHS requires our business associates to protect and safeguard your health information in accordance with applicable Federal laws.

H. Directory. If you are admitted to an IHS inpatient facility, the IHS may use your name, general condition, and location within our facility, for facility directory purposes, unless you notify us that you object to this information being listed. If an individual asks for you by name, the IHS may disclose your name, general condition, and location within our facility, unless you notify us that you object to this information being listed. The IHS may provide your religious affiliation only to members of the clergy.

I. Notification. The IHS may use or disclose your health information to notify or assist in the notification of a family member, personal representative, or other authorized person(s) responsible for your care, unless you notify us that you object.

J. Communication with Family. All IHS health providers may use or disclose your health information to others involved with and/or responsible for your care unless you object. For example, the IHS may provide your family members, other relatives, close personal friends, or any other person you identify, with health information that is relevant to that person's involvement with your care or payment for such care.

K. Adults and Emancipated Minors with Personal Representatives. The IHS may disclose health information to a personal representative of an individual who has been declared incompetent due to physical or mental incapacity by a court of competent jurisdiction.

HIPAA
Health Insurance Portability and Accountability Act
PRIVACY RULE

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.

INDIAN HEALTH SERVICE

DIVISION OF REGULATORY AFFAIRS

NOTICE OF PRIVACY PRACTICES

SUMMARY OF YOUR PRIVACY RIGHTS

L. Interpreters. In order to provide you proper care and services, the IHS may use the services of an interpreter. This may require the disclosure of your health information to the interpreter.

M. Research. The IHS may use or disclose your health information for research purposes when approved by an IHS Institutional Review Board (IRB) that has reviewed the research proposal and established protocols to ensure the privacy of your health information. The IHS may also use or disclose your health information for non-IRB approved research purposes based on your written authorization.

N. Organ Procurement Organizations. The IHS may use or disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of facilitating organ, eye, or tissue donation and transplant.

O. Uses and Disclosures about Decedents. The IHS may use or disclose health information about decedents to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. The IHS also may disclose health information to funeral directors consistent with applicable law as necessary to carry out their duties. In addition, the IHS may disclose health information about decedents where required under the Freedom of Information Act or otherwise required by law.

P. Treatment Alternatives and Other Health Related Benefits and Services. The IHS may contact you to provide information about treatment alternatives or other types of health related benefits and services that may be of interest to you. For example, we may contact you about the availability of new treatment or services for diabetes.

Q. Food and Drug Administration. The IHS may disclose your health information to the Food and Drug Administration (FDA) in connection with a FDA regulated product or activity. For example, we may disclose to the FDA information concerning adverse events involving food, dietary supplements, product defects or problems, and information needed to track FDA regulated products or to conduct product recalls, repairs, replacements, or look-backs (including locating people who have received products that have been recalled or withdrawn), or post-marketing surveillance.

R. Appointment Reminders. The IHS may contact you with a reminder that you have an appointment for medical care at an IHS facility or to advise you of a missed appointment.

S. Workers Compensation. The IHS may disclose your health information for workers compensation purposes as authorized or required by law.

T. Public Health. The IHS may use or disclose your health information to public health or other appropriate government authorities (Federal, State, local or Tribal) as follows:

1) To government authorities that are authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or conducting public health surveillance, investigations, and interventions;

2) To government authorities that are authorized by law to receive reports of child abuse or neglect, and

3) To government authorities that are authorized by law to receive reports of other abuse, neglect, or domestic violence, or as authorized by law if the IHS believes it is necessary to prevent serious harm. Where authorized by law, the IHS may disclose your health information to an individual who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition. In some situations or if necessary to prevent or lessen a serious and imminent threat to the health and safety of an individual or the public), the IHS may disclose to your employer health information concerning a work related illness or injury or a workplace related medical surveillance. (for example, if you are employed by IHS or another component of the Department of Health and Human Services (HHS))

U. Correctional Institution. If you are an inmate of a correctional institution, the IHS may disclose to the institution, health information necessary for your health and the health and safety of other individuals such as officers, employees, or other inmates.

V. Law Enforcement. The IHS may disclose your health information for law enforcement activities as authorized by law or in response to an order of a court of competent jurisdiction.

W. Health Oversight Authorities. The IHS may disclose your health information to health oversight agencies for activities authorized by law. These oversight activities may include: investigations, audits, inspections, and other actions. These are necessary for the government to monitor the health care system, government benefit programs, and entities subject to government regulatory programs and/or civil rights laws for which health information is necessary to determine compliance. The IHS is required by law to disclose health information to the Secretary, HHS to investigate or determine compliance with the HIPAA privacy standards.

X. Members of the Military. If you are a member of the military services, the IHS may disclose your health information if necessary to the appropriate military command authorities as authorized by law.

Y. Compelling Circumstances. The IHS may disclose your health information in certain other situations involving compelling circumstances affecting the health or safety of an individual. For example, in certain circumstances:

1) The IHS may disclose limited health information where requested by a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person;

2) If you are believed to be a victim of a crime and a law enforcement official requests information about you and we are unable to obtain your agreement because of incapacity or other emergency circumstances, we may disclose the requested information if we determine that such disclosure would be in your best interests;

3) The IHS may use or disclose health information that we believe is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person;

4) The IHS may disclose health information in the course of judiciary and administrative proceedings if required or authorized by law;

5) The IHS may disclose health information to report a crime committed on IHS health facility premises or when the IHS is providing emergency health care; and

6) The IHS may use or disclose health information during a disaster and for disaster relief purposes.

Z. Required by Law. The IHS may use or disclose health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

AA. Non-Violation of this Notice. The IHS is not in violation of this Notice or the HIPAA Privacy Rule if any of its employees or its contractors (business associates) discloses health information under the following circumstances:

1) Disclosures by Whistleblowers. If an IHS employee or business associate in good faith believes that the IHS has engaged in conduct that is unlawful or otherwise violates clinical and professional standards or that the care or services provided by the IHS has the potential of endangering one or more patients, members of the workplace, or the public and discloses such information to:

a. A Public Health Authority or Health Oversight Authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions, or the suspected violation, or an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by the IHS; or

b. An attorney on behalf of the workforce member, or contractor (business associate) or hired by the workforce member or contractor (business associate) for the purpose of determining their legal options regarding the suspected violation.

2) Disclosures by Workforce Member Crime Victims. Under certain circumstances, an IHS workforce member (either an employee or contractor) who is a victim of a crime on or off the IHS facility premises may disclose information about the suspect to law enforcement officials provided that:

a. The information disclosed is about the suspect who committed the criminal act.

b. The information disclosed is limited to identifying and locating the suspect.

BB. Any Other Uses and Disclosures. Most uses and disclosures of psychotherapy notes (where appropriate) require authorization. Other uses and disclosures of PHI not listed in this Notice will be made only with your written authorization, which you may later revoke in writing at any time. Such revocation would not apply where the health information already has been disclosed or used or in circumstances where the IHS has taken action in reliance on your authorization or the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy or the policy itself.

Rights under this Notice or to Request Information or Report a Problem

To exercise your rights under this Notice, to ask for more information, or to report a problem contact the Service Unit Chief Executive Officer or the appropriate Privacy official at:

_____

Facility name

_____

Address

_____

Phone number

_____

If you believe your privacy rights have been violated, you may file a written complaint with the above individual or the Secretary, Department of Health and Human Services, Washington, D.C. 20201.
There will be no retaliation for filing a complaint.

Effective Date: **April 09, 2014**