DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

INDIAN HEALTH SERVICES
Great Plains Area Youth Residential Treatment Center
P.O. Box 680
12451 Highway 1806
Mobridge, SD 57601-0680

To: Referring Agencies

From: GPAYRTC

Subject: Information Required for Admission

1. Let us take this opportunity to thank you for referring your client to our residential treatment program.

2. The Great Plains Area Youth Regional Treatment Center (GPAYRTC) provides drug and alcohol treatment for adolescents ages 13 - 17 years of age who are enrolled in a federally recognized American Indian tribe. Utilizing the South Dakota Division of Alcohol and Drug Abuse criteria, we are recognized as ASAM Level III Medically Monitored Intensive Inpatient Treatment for Adolescents.

3. We are dedicated to promoting a healthy lifestyle restoring balance and harmony in mind, body and spirit to our American Indian youth and their families. We provide a safe, compassionate, healing environment where our American Indian Youth can be strengthened socially, spiritually, emotionally and physically utilizing a holistic, multi-disciplinary approach.

4. As an Indian Health Service funded and operated Youth Regional Treatment Center, there are specific requirements for admission. Attached are all requirements needed to assist you in the admission referral process. Please complete and send to us all required forms. Our admission staff will enthusiastically assist and guide you throughout the process.

5. Mail or Fax all completed attached forms to:

   The Great Plains Area Youth Regional Treatment Center (GPAYRTC)
   ATTN: Admissions
   P.O. Box 680
   Mobridge, SD 57601-0680

   Admissions Clerk: Delaine Keller

   Fax: (605) 845-5072
   Phone: (605) 845-7181

6. We appreciate the confidence and trust that you have placed in us and look forward continuing to serve you and your clients.

ADMISSION CHECKLIST

Great Plains Area Youth Regional Treatment Center (GPAYRTC)

1. The Chief Gall Great Plains Area Youth Residential Treatment Center is funded and operated by the Department of Health and Human Services, Indian Health Services. For admission to the GPAYRTC an applicant/referral ***MUST*** provide the following required documents:

Items a thru d are needed to begin the Admission's Review	Completed	Date Completed
a. ☐ Copy of Tribal enrollment letter	☐ Yes ☐ No	
b. ☐ Completed Residential Application Form. Form TC-AD-2	☐ Yes ☐ No	
c. ☐ A Bio-psycho-social Assessment, completed by a duly State licensed professional within the last six months. It must contain a primary diagnosis of Substance Abuse/Dependence.	☐ Yes ☐ No	
d. ☐ Releases of Information, IHS-810 form. A total of eight IHS-810 forms are enclosed. All need to be signed as indicated in item II (Legal Guardian, Client, referent, school and medical facility). Please complete the form by checking the box that pertains to each form.	☐ Yes ☐ No	
e. ☐ Copy of Birth Certificate.	☐ Yes ☐ No	
f. Physical History and Examination by a Physician, NP, or PA to include: ☐ History of allergies ☐ Dental exam ☐ All Labs Completed ☐ Physical limitations ☐ Medication orders ☐ Eye Exam	☐ Yes ☐ No	
g. ☐ Proof of TB test results with in the last year.	☐ Yes ☐ No	
h. ☐ Immunization Record	☐ Yes ☐ No	
i. ☐ Copy of Social Security Card.	☐ Yes ☐ No	
j. ☐ Copy of Medicaid or Private Insurance coverage (If applicable)	☐ Yes ☐ No	
k. ☐ Legal Custody Order (if applicable)	☐ Yes ☐ No	
l. ☐ Court Order (if applicable)	☐ Yes ☐ No	

2. After all required items have been received; the Admissions committee will make a final decision. Please contact Delaine Keller at 605.845.7181 ext. 112 with any questions or if you need assistance.

3. Once a final decision for admission is made, an admission acceptance letter will be submitted (faxed or mailed) to the referring agency.

4. The GPAYRTC is prohibited from accepting any clients without the explicit written approval (an admission acceptance letter) of the admission committee and with concurrence by the Clinical Director.

Residential Admission Form
Great Plains Area Youth Regional Treatment Center (GPAYRTC)

Client Demographic Information (To be completed by counselor)

Client Information

Name:			Date:
Address:		City, State & Zip Code:	
Date of Birth:	Age:	Sex: ☐ Female ☐ Male	Social Security #: — —
Home Phone #:		Religion:	
Tribal Affiliation:			

Emergency Contact

Name:	Relationship to Client:
Address:	City, State & Zip Code:
Phone #:	Work Phone #:

Referral Source

Name:	Program Name:
Address:	City, State & Zip Code:
Phone #:	Fax #:

Parent/Guardian Information

Mother's Name:	
Address:	City, State & Zip Code:
Home Phone #:	Work Phone #:
Date of Birth:	Tribal Affiliation:
Father's Name:	
Address:	City, State & Zip Code:
Home Phone #:	Work Phone #:
Date of Birth:	Tribal Affiliation:

Residential Admission Form
Great Plains Area Youth Regional Treatment Center (GPAYRTC)
Client Demographic Information (To be completed by counselor)

Health Care Coverage

IHS Service Unit:		Phone #:	
Eligible for Contract Health Services? ☐ Yes ☐ No	Name & Phone # of IHS/ CHS Authorizing Official:		
Medicaid(welfare)? ☐ Yes ☐ No	Medicaid #:	State Medicaid filed in:	Eligibility Date:
Private Insurance? ☐ Yes ☐ No	Insurance #:	Name of Insured:	
Relationship to Client:		Name of Insurance Company:	
Address:		City, State & Zip Code:	
Phone:		Fax:	

Why does the client need residential treatment?

Residential Admission Form
Great Plains Area Youth Regional Treatment Center (GPAYRTC)
Substance Use History

Biomedical Conditions (Medical Problems and Physical Challenges)

Allergies: ☐ Medications ☐ Foods ☐ Insect Stings ☐ Plants	NOTE: For any item checked, a Doctor statement required and reasons for medications. Any Other Allergies?
Does the client have a history of: ☐ Asthma ☐ Seizure Disorder ☐ Heart Problems ☐ Diabetes ☐ Tuberculosis	Other medical problems:
What medications are currently prescribed for the client?	List medications:
Is the client physically challenged? Does the client use a wheelchair, crutches, cane? Does the client have vision or hearing difficulties? ☐ Yes ☐ No	If "YES" please explain:

Emotional/Behavioral Conditions and Complications

Has the client seen a psychiatrist, psychologist, or counselor for emotional or mental problems? ☐ Yes ☐ No	If "YES" please explain: Therapist's Name / Phone # / Dates of Treatment / Reason for Therapy
Is the client currently in outpatient treatment? ☐ Yes ☐ No	If "YES" describe frequency and regularity of visits:
Does the client have a history of suicide thoughts or attempts? ☐ Yes ☐ No	If "YES" please describe the situation(s) to include how and with what they tried to harm themselves:
Was the client Hospitalized? ☐ Yes ☐ No	Date / Methods / Name of Hospital / # Days in Hosp. / Substance Abuse Involved?
Does the potential resident currently have any suicidal thoughts ☐ Yes ☐ No	If "YES" please describe:
Does the potential resident currently have any homicidal thoughts? ☐ Yes ☐ No	If "YES" please describe:
Does the client have past or current legal problems? ☐ Yes ☐ No	If "YES" please describe:
Does the client have a history of violent or assaultive behavior? ☐ Yes ☐ No	If "YES" please describe:
Has the client been involved with a gang? ☐ Yes ☐ No	If "YES" which gang and what are their colors? / Describe the client's involvement with the gang:

Residential Admission Form
Great Plains Area Youth Regional Treatment Center (GPAYRTC)
Substance Use History

Is the client court ordered to treatment? ☐Yes ☐No	If "YES" please enclose a copy of the court order.
Does the client have any symptoms of an eating disorder? These may be restricted food intake, excessive exercise, use of laxatives, binge eating or vomiting. ☐Yes ☐No	If "YES" please explain:
Client's height (without shoes):	Client's weight (without shoes):
Does the client have a history of fire setting? ☐Yes ☐No	If "YES" please describe:
Does the client have a history of problematic sexual behavior? ☐Yes ☐No	If "YES" please describe:
Does the client have a history of learning problems learning disability, special education, resource rooms, and mental retardation? ☐Yes ☐No	If "YES" please describe:

Is the client pregnant? ☐Yes ☐No	If "YES" how many weeks pregnant?	Prenatal care provider name, location and phone #:	When was the last prenatal appointment?

Treatment Acceptance/Resistance

Does the adolescent recognize their use of drugs and/or alcohol is a problem? ☐Yes ☐No	Please describe:
How does the adolescent describe his/her use of drugs and/or alcohol?	Please describe:

Residential Admission Form
Great Plains Area Youth Regional Treatment Center (GPAYRTC)
Substance Use History

Relapse/Continued Use potential

Is the client having any drug cravings or demonstrating any drug-seeking behavior? ☐Yes ☐No	Has their drug and/or alcohol use increased recently? ☐Yes ☐No	If "YES" please describe:
Has the client made attempts to control or cut down on their substance use? ☐Yes ☐No	If "YES" please describe:	
If the client is abstinent, are they in a personal crisis and at risk of relapse? ☐Yes ☐No	If "YES" please describe:	

Recovery Environment

The following questions deal with whether the client's current environment is not supportive of recovery, is hazardous, or there are difficulties in the home that make it difficult to participate in treatment on an outpatient level.

	Family Member's Name	Age	Relationship
Please list the members of the client's family.			

	Name	Age	Relationship
Who currently lives in the home with the client, other than family members? Please list their names, ages, and relationship to the client.			

Is there any history of violence or domestic abuse in the home? ☐Yes ☐No	If "YES" please describe:
Is there anyone currently living in the client's home that is an active substance abuser? ☐Yes ☐No	If "YES" please describe:

Residential Admission Form
Great Plains Area Youth Regional Treatment Center (GPAYRTC)
Substance Use History

Is there anyone currently living in the client's home that is active in a recovery program? ☐Yes ☐No	If "YES" please describe:
Does the client have any friends who are Non-users or are active in a recovery program? ☐Yes ☐No	If "YES" please check which program: ☐Aftercare ☐Alateen ☐AA ☐NA ☐Al-Anon ☐Other If "Other", please describe:
What types of support groups are available to the family?	☐Aftercare ☐Alateen ☐AA ☐NA ☐Al-Anon ☐Healing Through Feeling ☐Other If "Other" please describe:
What are the current discharge plans for the client after treatment?	Living Situation:
	School/Work:
	Aftercare Program:
	Frequency of aftercare visits:

Additional Information

Is the client's substance abuse at least of moderate severity?	☐Yes ☐No
Does the client need an intensive program with a 24-hour structure?	☐Yes ☐No
Is the client unable to control use despite active participation in less intensive care?	☐Yes ☐No
Is there a danger of physical, sexual, and/or severe emotion attached in the patient's current environment, which will make recovery unlikely without removing the individual from this environment?	☐Yes ☐No
Does the client experience difficulties in getting to outpatient treatment?	☐Yes ☐No
Has the client's use increased in the last 6 months?	☐Yes ☐No

Referring Counselor's Name/ Signature: _____ DATE: _____

Residential Admission Form
Great Plains Area Youth Regional Treatment Center (GPAYRTC)
Substance Use History

Substance (Check all that apply)	Age of First Use	Date of Last Use	Usual Amount Used	Frequency of Use	Months or Years of Actual Use	How Taken (See Below)	Tolerance (Yes or No)	Withdraw! (Yes or No)
Alcohol:								
Beer/Coolers ☐								
Wine ☐								
Hard liquor ☐								
Cannabis:								
Marijuana ☐								
Hashish ☐								
Hash Oil ☐								
Hallucinogens:								
LSD or "Acid" ☐								
Peyote/Mescaline ☐								
Psilocybin ☐								
PCP ☐								
Mushrooms ☐								
Datura ☐								
Other ☐								
Cocaine:								
Powder ☐								
Crack!Freebase ☐								
Opiates ☐								
Heroin ☐								
Codeine ☐								
Opium ☐								
Synthetics ☐								
Stimulants:								
Speed ☐								
Crank/Crystal ☐								
Ice ☐								
STP, MDA, etc. ☐								
Sedatives:								
Valium ☐								
Librium ☐								
Xanax ☐								
Nicotine:								
Cigarettes ☐								
Cigars ☐								
Pipes ☐								
Chew Snuff ☐								
Snort Snuff ☐								
Inhalants:								
Solvents ☐								
White-out ☐								
Spray Cans ☐								
Anesthetics ☐								

How Taken: O =Oral I= Injection X= Other

Frequency of Use: (Chose a number that best describes the frequency of use)
1 = No use in the past month. 2 = Once a month 3 = Once a week
4= 2- 3 times per week 5 = Once a day 6= 2-3timesaday 7= Continuous Use

HISTORY AND PHYSICAL EXAMINATION

Great Plains Area Youth Regional Treatment Center (GPAYRTC)

This form is to be completed by a licensed Physician, Physician's Assistance, or a Nurse Practitioner. A complete history and physical examination **needs to be completed within at least six (6) months** prior to entering our treatment facility.

Client's Name: _____ Date of Physical: _____

DOB: _____ ☐Male ☐Female (check one)

VITAL SIGNS: T_____ **P**_____ **R**_____ **B/P**_____ **HT**_____ **WT**_____ (HT/WT without shoes)

ALLERGIES: ☐Yes ☐No (Check all that apply and explain reaction)	☐Medications ☐Food ☐Bee Stings ☐Others

VISION Screening: R_____ L_____ Corrected_____ Uncorrected_____

HEARING Screening: R_____ L_____ Corrected_____ Uncorrected_____

REPRODUCTIVE FACTORS: (Check one) ☐G ☐P ☐LC ☐SA ☐TZ	LMP:	Smoking: ☐Yes ☐No PPD_____ Chewing Tobacco: ☐Yes ☐No

CURRENT MEDICAL PROBLEMS:

_____

Current Medications and Dose:

_____

DRUG/ALCOHOL Usage History: (Circle all that apply)		Alcohol	Marijuana	Inhalants	Prescriptions Drugs	Others:_____
	How Long:	_____	_____	_____	_____	_____
	Last Use:	_____	_____	_____	_____	_____
	Other Street Drugs:	_____	_____	_____	_____	_____

LABS REQUIRED: (BY GPAYRTC)

☐CBC ☐SMA-8 ☐LFT'S ☐UA ☐HCG ☐TSH

☐STD Screen: To Include: CHLYMIDIA, GONORRHEA, SYPHYLIS, & HIV

☐Hepatitis Panel (with A, B, C)

Please Attach Copies of ALL LABS

Past Medical History (**F**= Family **S**=Self)					REVIEW of Systems			Physical Examination		
Yes	**No**	**F**	**S**		**NL**	**ABN**		**NL**	**ABN**	Appearance
				Heart Disease			General			Skin
				Heart Murmur			Skin			Eyes
				Hypertension			Eyes			Ears
				Diabetes			Ears			Nose
				Tuberculosis			Nose			Mouth

HISTORY AND PHYSICAL EXAMINATION

Great Plains Area Youth Regional Treatment Center (GPAYRTC)

Past Medical History (F= Family S=Self)					REVIEW of Systems			Physical Examination		
Yes	No	F	S		NL	ABN		NL	ABN	Appearance
				Asthma			Throat			Throat
				Seizures			Mouth			Neck
				Cancer			Endo/Meta			Thorax
				Hepatitis			Neuro			Heart
				STD's			Musculoskeletal			Abdomen
				Kidney Disease			Blood/Lymph			Extremities
				Athlete's Foot			Cardio.			Neuro.
				Mental Disorders			Respiratory			Psychological
				Hospitalization			GI/Liver			Genitalia
				Surgeries			Kidney/ Urol			Spine/Scoliosis
				Any Prosthesis			Genitalia			Rectal
							Breasts			Pelvic
							Gyn			Breast
							Other			

GENERAL ASSESSMENT AND PLAN:

Medical Diagnosis:

_____

Plan: _____

_____

____

Any physical restrictions?

_____

(Note: Approximate length of stay at our treatment facility *may* be three months or longer depending on this resident's level of advancement. Please schedule any future CRITICAL appointments *before* treatment and other follow up appointments after the resident have finished treatment at our facility.)

COMMENTS: _____

_____

PLEASE ATTACH THE PPD FORM AND A COPY OF THE IMMUNIZATION RECORD

_____ _____

Signature of Medical Provider and Degree Date Completed

_____

Print Medical Provider's name and Degree

Name of Clinic/ Facility: _____

Mailing Address: _____

Street/PO Box City State Zip+4

Phone No. _____ Fax No. _____

TUBERCULIN SKIN TEST QUESTIONNAIRE

Great Plains Area Youth Regional Treatment Center (GPAYRTC)

Client's Name: _____ SSN#_____-_____-_____ DOB:_____

Please answer the following questions about your health prior to your TB skin test. "Yes" answers indicate conditions that can cause false results on the TB test.

a. Have you ever had Tuberculosis or a positive TB skin-test?..... ☐Yes ☐No

—If yes, were you treated?..... ☐Yes ☐No

—If yes, have you had a recent chest x-ray?..... ☐Yes ☐No

✓ (If you have answered yes to all of the above, then a copy of the chest x-ray report must accompany this form)

b. Are you pregnant?..... ☐Yes ☐No ☐N/A

c. Are you currently ill or running a fever?..... ☐Yes ☐No

d. Have you received a vaccine in the last two months?..... ☐Yes ☐No
(i.e. MMR, flu vaccine, etc.)

e. Have you had a viral infection within the last two months?..... ☐Yes ☐No

TUBERCULIN SKIN TEST DATA

***Please note that results for a TB skin test done within the last year are acceptable, if all the information requested below is available on that test result.

1. TB skin test given on: _____ _____ on ☐Right — ☐Left forearm
Date Time (Check one)

Given by: _____ _____
Nurse's Name and Signature Phone No.

TB Skin Test Must Be Read Within 48 - 72 Hours Of Placement On The Forearm
Tests Not Read And Recorded Within This Time Will Be Considered Invalid.

2. Skin test read on: _____ _____. Results in mm's: _____
Date Time

3. Redness?..... ☐Yes ☐No Induration?..... ☐Yes ☐No
*—If induration noted; size in mm's*_____

Read by: _____ _____
Nurse's Name and Signature Phone No.

INVENTORY CHECKLIST FOR RESIDENTS

Great Plains Area Youth Regional Treatment Center (GPAYRTC)

Name: _____ Date_____

1. **Clothing and Hygiene Items TO BRING:**

_____ 1 Hooded Sweater/Sweatshirt
_____ jacket (seasonal)
_____ 1 shirts or t-shirts
_____ 1 pairs of jeans
_____ 1 pairs of shorts (must be knee length) (seasonal)
_____ 1 - stocking cap (seasonal)
_____ 1 pair of gloves (seasonal)
_____ 1 pair of old shoes (good for messy outings)
_____ i.e. for going fishing or when raining/snowing.

_____ 4 A-Shirts or Tank-tops undershirts
_____ 5 – 7 pairs of socks
_____ 5 – 7 pairs of underwear
_____ athletic shoes (any type)
_____ shower shoes (flip flops)
_____ pajamas / slippers
_____ Swim wear (seasonal)
_____ Snow Boots (seasonal)

ALL CLOTHING SHALL NOT HAVE INAPPROPRIATE LOGOS: RELATED TO ALCOHOL, DRUGS, TOBACCO, GAMBLING, ANY SEXUAL CONNOTATIONS, AND GANG RELATED LOGOS.

2. ALL Personal Hygiene Products **must be alcohol free** (any products without content information will be put into resident's luggage and cannot be used):

_____ 1 Bath Sponge
_____ Shampoo / conditioner
_____ Comb/brush/hair ties
_____ Lotion
_____ Toothpaste/toothbrush (need toothbrush cover)
_____ Fingernail/toenail clippers
_____ Mousse/ Hair gel
_____ Dental Floss

_____ Q-tips
_____ 2 bars of soap / soap dish
_____ Non-alcohol face wash
_____ Disposable razors/shaving cream
_____ Deodorant (Non-aerosol)
_____ Chapsticks
_____ Body Wash
_____ Foot Powder

3. Please **do not bring any** of the items listed below. These are **prohibited** items. The list is not all inclusive:

☒ String/Spaghetti strap tops
☒ Cameras / radios/ tape or CD players
☒ Pillows, blankets, towels, or stuffed animals
☒ Any type of aerosols or hair sprays
☒ Food, pop, gum, or seeds
☒ Tobacco products/Lighters
☒ Makeup
☒ Bandanas
☒ Hats are not allowed
☒ Gang colored T-shirts Red, Blue,
☒ Drug paraphernalia
☒ Cologne / perfume are NOT allowed

☒ Any type of jewelry (rings,
☒ Earrings, tongue studs, etc.)
☒ Cell Phones/I-Pods
☒ Alcohol or drugs of any kind
☒ Over the counter medications
☒ Any type of glass item
☒ Mouthwash
☒ Belly tops/skimpy /tight clothing (females)
☒ Bras with under wires (the wires will be removed, if brought in.)
☒ Pens/Wire bound tablets
☒ Weapons of any kind

4. The GPAYRTC will not be held financially responsible for prohibited items that are brought in and not taken home by the family/Legal guardian.

NOTE to Referral source: This check-list sheet may be reproduced and given to the family.

IHS-810 (4/09)
FRONT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 4/30/2016
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

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

II. The information is to be disclosed by:	And is to be provided to:
NAME OF FACILITY GPAYRTC	NAME OF PERSON/ORGANIZATION/FACILITY Parents/Legal Guardians
ADDRESS PO Box 680	ADDRESS
CITY/STATE Mobridge, SD 57601	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))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____

☐ Other *(specify) (CHS, Billing, etc.)* _____

☐ Entire Record

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)*
☐ 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 Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide 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 a different expiration date or *expiration event* is stated.

_____
(Specify new date)

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 OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a 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

IHS-810 (4/09)
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ADDRESS	ADDRESS PO Box 680
CITY/STATE	CITY/STATE Mobridge, SD 57601

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- ☐ Disability
- ☐ Other *(Specify)* _____

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

- ☐ Only information related to *(specify)* _____
- ☐ Only the period of events from _____ to _____
- ☐ Other *(specify) (CHS, Billing, etc.)* _____
- ☐ Entire Record

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- ☐ HIV/AIDS-related Treatment
- ☐ Sexually Transmitted Diseases
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	ADDRESS	
	CITY/STATE	DATE OF BIRTH

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☐ 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))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____

☐ Other *(specify) (CHS, Billing, etc.)* _____

☐ Entire Record

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)*
☐ 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 Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide 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 a different expiration date or *expiration event* is stated.

_____ *(Specify new date)*

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 OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a 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

IHS-810 (4/09)
FRONT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 4/30/2016
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

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

II. The information is to be disclosed by:	And is to be provided to:
NAME OF FACILITY Referral Agency/Referent	NAME OF PERSON/ORGANIZATION/FACILITY GPAYRTC
ADDRESS	ADDRESS PO Box 680
CITY/STATE	CITY/STATE Mobridge, SD 57601

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))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____

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☐ Entire Record

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II. The information is to be disclosed by:	And is to be provided to:
NAME OF FACILITY GPAYRTC	NAME OF PERSON/ORGANIZATION/FACILITY School of Record
ADDRESS PO Box 680	ADDRESS
CITY/STATE Mobridge, SD 57601	CITY/STATE

III. The purpose or need for this disclosure is:

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

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☐ Entire Record

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II. The information is to be disclosed by:	And is to be provided to:
NAME OF FACILITY School of Record	NAME OF PERSON/ORGANIZATION/FACILITY GPAYRTC
ADDRESS	ADDRESS PO Box 680
CITY/STATE	CITY/STATE Mobridge, SD 57601

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))*

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☐ Only the period of events from _____ to _____

☐ Other *(specify) (CHS, Billing, etc.)* _____

☐ Entire Record

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COMPLETE ALL SECTIONS, DATE, AND SIGN

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

II. The information is to be disclosed by:	And is to be provided to:
NAME OF FACILITY GPAYRTC	NAME OF PERSON/ORGANIZATION/FACILITY Medical Facility
ADDRESS PO Box 680	ADDRESS
CITY/STATE Mobridge, SD 57601	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))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____

☐ Other *(specify) (CHS, Billing, etc.)* _____

☐ Entire Record

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
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(Specify new date)

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

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

II. The information is to be disclosed by:	And is to be provided to:
NAME OF FACILITY Medical Facility	NAME OF PERSON/ORGANIZATION/FACILITY GPAYRTC
ADDRESS	ADDRESS PO Box 680
CITY/STATE	CITY/STATE Mobridge, SD 57601

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))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____

☐ Other *(specify) (CHS, Billing, etc.)* _____

☐ Entire Record

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
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(Specify new date)

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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].

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SIGNATURE OF WITNESS *(If signature of patient is a 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

Criminal Justice System Release of Information

I, _____, hereby voluntarily authorize the disclosure of my substance abuse treatment records
(Name of Patient)

The substance abuse treatment information is to be disclosed by: Name of Facility/Organization	And is to be provided to: Name of Facility/Organization
Great Plains Area Youth Regional Treatment Center	_____
Address	Address
PO Box 680	
City/State	City/State
Mobridge, SD 57601	

The purpose of this disclosure is: (Initial)

_____ Further Medical Care _____ Attorney _____ After Care _____ Research

_____ Personal Use _____ Insurance _____ Disability

_____ Other: (Specify _____Verification of Presence & Progress in Treatment

The substance abuse treatment record information to be disclosed is: (Initial)

_____ Only information related to: Continued presence and progress in treatment

_____ Only the period of events from: _____

_____ Other (specify) CHS, Billing, etc.: _____

_____ Intake Assessment's: _____

_____ Discharge Summary: _____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164. I also understand that I may revoke this consent 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 as follows: (Initial)

_____ When there has been a formal and effective termination or revocation of my release from confinement, probation, parole, or other proceeding under which I was mandated into treatment or:

I understand that I might be denied services if I refuse to consent to a disclosure to the Criminal Justice System that mandated my presence in treatment. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Dated: _____ Patent Signature: _____

Signature of person signing form if not the patient: _____

_____
(Describe authority to sign on behalf of patient)

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.