



Claremore Indian Hospital
101 South Moore Ave
Claremore, OK 74017
(918) 342-6200

Department of Health and Human Services

Consent to the Use and Disclosure of Health information for Treatment

1. **Medical Care:** During Hospitalization or treatment at IHS, the patient must at all times be under the care of a medical professional is called the attending provider. The attending providers is usually selected by the Patient or the Patient's representative but may, under unusual or emergency circumstances, be otherwise selected. The undersigned understands that no guarantees have been made as a result of examination or treatment of the Patient in IHS.
2. **Nursing Care:** IHS provides professional nursing care for every Patient in each Patient care unit and provides nursing care to Patients seeking treatment at the Claremore Indian Hospital. Constant observations and specialized care are provided in all units.
3. **Consent for Treatment:** The undersigned requests and voluntarily consents to the Patient's receipt of the usual Claremore Service Unit services, as well as diagnostic, laboratory (such as testing of the blood or other bodily fluids) and imaging services including IV contrast media. The Claremore Indian Hospital is authorized to retain, preserve, and use for scientific or teaching purposes, or disposed of at its convenience any specimens or tissue removed from the Patient's body during hospitalization or treatment.
4. **Personal Valuables:** For the convenience of the patient, a safety box for safekeeping of patient's valuables is available without charge in the Security Office. CIHS will not be liable for the loss or damage to any personal property of the patient brought to CIHS except that which is properly deposited in the Security office.
5. **Compliance with Rules and Regulations:** In consideration of admission and/or treatment, the Patient agrees to abide by the rules of the Claremore Indian Hospital.
6. **Release of Information:** The undersigned agrees that he or she has received a copy of the IHS Notice of Privacy Practices, which describe when and how CIHS will use and disclose health information, including medical records.
7. **Release from Responsibility:** The undersigned hereby agrees, acknowledges and understands that the Claremore Indian Hospital is not responsible for injuries sustained by use of a Patient's own personal equipment; electrical, mechanical, or otherwise. It is further understood that, should the Patient leave the Claremore Indian Hospital without the consent or against the medical advice of the Patients attending physician, the under signed hereby relieves said providers and he Claremore Indian Hospital of all responsibility for such action
8. **Agreement:** By signing this form I understand the contents of the service agreement and have received a copy. I have also received the Health Insurance Portability and Accountability Act (HIPAA) fact sheet.

Information may be discussed with the following Organization:

Insurance Company: _____

Family Member: _____

Other: _____

CLA-158 Chart #: _____

Name: _____

Request the following restrictions to the use and/or disclosure of my health information:

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, BEING THE PATIENT OR ANOTHER PERSON LEGALLY AUTHORIZED TO ACT FOR THE PATIENT, HAVE READ PARAGRAPHS 1-8 OF THIS DOCUMENT, UNDERSTAND ITS CONTENTS, AND ACCEPT ITS TERMS. I ALSO UNDERSTAND AND HAVE RECEIVED A COPY OF THE PATIENTS RIGHTS AND RESPONSIBILITIES.

Signature of Patient

Date: _____ Time: _____

Hospital Witness to Signature

WHEN PATIENT IS A MINOR OR INCOMPETENT TO GIVE CONSENT: I HEREBY CONSENT FOR THE PATIENT:

Signature of Person Authorized to consent for Patient

Date: _____ Time: _____

Relationship to Patient

You may _____ may not _____ leave medical information on my message service or answering machine.

Home _____ Work _____ Mobile _____

Note to Patient: Photocopy of this consent may be provided upon request.