Dear applicant:

This letter is in regard to your request for an application (PAO-21) for tribal health care services. We are currently a Tribal Health Facility, but utilize Indian Health Service rules and regulations.

Each question should be answered as completely as possible. It is most important that any alternate resources available be listed such as private insurance, Medicare, Medicaid (Oregon Health Plan, HMO) or workers compensation. **A copy of your card is requested.** If you do not have any health insurance, we are required by Federal Regulation to request that you apply for the Oregon Health Plan (If you are an Oregon state resident). Yellowhawk will be happy to assist you in this process or you can call (800) 359-9517 to request a packet and bring this to Yellowhawk for assistance if needed.

The application (PAO-21) has information on the reverse side regarding the Privacy Act of 1974 and Statement for Maintenance of Health records. **Your signature is required on both sides of the application form.**

You will need to submit the following with the completed application:

- Proof of Native American descent. (Certificate of Indian Blood or a Tribal I.D card).
- Copy of State Issued Birth Certificate.
- Copy of Social Security Card.
- Proof of Residency – Need both mailing and physical address listed on application.
- Veteran Status

Your eligibility for benefits through Yellowhawk Tribal Health Center is determined by the information entered on the application. If you have any questions, please call (541) 966-9830.

—PLEASE PRINT LEGIBLY—

DEPARTMENT OF HEALTH AND HUMAN SERVIES
U.S. PUBLIC HEALTH— INDIAN HEALTH SERVICE

INDIVIDUAL APPLICATION FOR HEALTH CARE SERVICES

PAO-21 REV. 5-84

I.H.S. OFFICE USE ONLY

ELIGIBILITY STATUS	2	3	4
	CHART #	TRIBE	RESERVATION
DIRECT ☐	5	6	7
	COMMUNITY	COUNTY	STATE
CONTRACT ☐	8	9	10
DENIED ☐	ROLL NUMBER	TRIBAL QUANTUM	TOTAL QUANTUM

11			12	13	14
NAME– LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER	BIRTHDATE	SEX (M OR F)

15	16	17	18	19	20
MAILING ADDRESS-STREET	CITY	STATE	ZIP CODE	AREA PHONE	COUNTY

21	22
IF RESIDING ON A RESERVATION PLEASE GIVE NAME AND STATE	RESIDING ON TRUST LAND? (YES OR NO)

23	24	25	26	27	28
PREVIOUS ADDRESS-STREET	CITY	STATE	ZIP CODE	COUNTY	DATE LEFT

29	30	31	32 YES NO	33
TRIBE	HOME RESERVATION	BIRTHPLACE	ENROLLED	ROLL # IF KNOWN

34	35	36	37
TRIBAL BLOOD QUANTUM	TOTAL BLOOD QUANTUM	LIST MAIDEN NAME OR OTHER NAMES YOU HAVE USED	GIVE NAME OF HEAD OF HOUSEHOLD

38	39	40
FATHER'S NAME	TRIBE	BIRTHPLACE
41	42	43
MOTHER'S MAIDEN NAME	TRIBE	BIRTHPLACE
44		45
IF FULL TIME STUDENT GIVE SCHOOL NAME AND CITY		DATE CLASSES BEGAN

OTHER MEMBERS OF YOUR HOUSEHOLD	SEX M or F	RELATIONSHIP	BLOOD QUANTUM	TRIBE ENROLLED	BITH-PLACE	SOCIAL SECURITY NUMBER	IHS USE
46a	46b	46c	46d	46e	46f	46g	46h
47a	47b	47c	47d	47e	47f	47g	47h
48a	48b	48v	48d	48e	48f	48g	48h
49a	49b	49c	49d	49e	49f	49g	49h
50a	50b	50c	50d	50e	50f	50g	50h
51a	51b	51c	51d	51e	51f	51g	51h

IMPORTANT! PLEASE COMPLETE THIS SECTION IN FULL

ARE YOU EMPLOYED? 52 _____ IF SO, EMPLOYER NAME? 53 _____

SPOUSE EMPLOYED? 54 _____ IF SO, EMPLOYER NAME? 55 _____

IF ARE YOU COVERED BY MEDICAL OR DENTAL INSURANCE? 56 _____ IS SPOUSE? 57 _____

LIST PERSONS COVERED BY YOU OR YOUR SPOUSE'S INSURANCE 52 _____

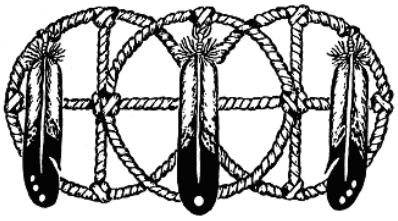
IF YOU HAVE HEALTH RECORDS AT OTHER IHS LOCATIONS, PLEASE LIST 58 _____

INSURANCE AND OTHER COVERAGE		
TYPE OF COVERAGE	POLICY/ELIGIBILITY NUMBER	DATE ELIGIBILITY BEGAN
60 1 MEDICARE A OR AB (PLEASE CIRCLE)	60a	60b
60 2 MEDICAID	61a	61b
60 3 VETERANS ADMINISTRATION	62a	62b
60 4 PRIVATE COVERAGE PLEASE LIST	63a	63b

I CERTIFY THE ABOVE INFORMATION TO BE ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE IHS TO VERIFY THE ACCURACY OF THIS APPLICATION.

APPLICANT'S SIGNATURE _____ DATE _____

YELLOWHAWK
TRIBAL HEALTH CENTER



P.O. Box 160
73265 Confederated Way
Pendleton, OR 97801
Phone: (541) 966-9830 Fax: (541) 278-7579
Website: www.yellowhawk.org

OMNIBUS Rule

HIPAA 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 under the HIPAA Omnibus Rule of 2013.

PLEASE REVIEW IT CAREFULLY

For purposes of this Notice "us" "we" and "our" refers to Yellowhawk Tribal Health Center (YTHC): "you" or "your" refers to our patients (or their legal representatives as determined by us in accordance with state informed consent law). When you receive healthcare services from us, we will obtain access to your medical information (i.e. your health history). We are committed to maintaining the privacy of your health information and we have implemented numerous procedures to ensure that we do so.

The Federal Health Insurance Portability & Accountability Act of 2013, HIPAA Omnibus Rule, (formally HIPAA 1996 & HI TECH of 2004) require us to maintain the confidentiality of all your healthcare records and other identifiable patient health information (PHI) used by or disclosed to us in any form, whether electronic, on paper, or spoken. HIPAA is a Federal Law that gives you significant new rights to understand and control how your health information is used. Federal HIPAA Omnibus Rule and state law provide penalties for covered entities, business associates, and their subcontractors and records owners, respectively that misuse or improperly disclose PHI.

Starting April 14, 2003, HIPAA requires us to provide you with the Notice of our legal duties and the privacy practices we are required to follow when you first come into our office for health-care services. If you have any questions about this Notice, please ask to speak to our HIPAA Privacy Officer.

Our doctors, clinical staff, employees, Business Associates (outside contractors we hire), their subcontractors and other involved parties follow the policies and procedures set forth in this Notice. If at this facility, your primary caretaker / doctor is unavailable to assist you (i.e. illness, on-call coverage, vacation, etc.), we may provide you with the name of another healthcare provider inside our clinic or outside our practice for you to consult with. If we do so, that provider will follow the policies and procedures set forth in this Notice or those established for his or her practice, so long as they substantially conform to those for our practice.

OUR RULES ON HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Under the law, we must have your signature on a written, dated Consent Form and/or an Authorization Form of Acknowledgement of this Notice, before we will use or disclose your PHI for certain purposes as detailed in the rules below.

Documentation – You will be asked to sign an Authorization / Acknowledgement form when you receive this Notice of Privacy Practices. If you did not sign such a form or need a copy of the one you signed, please contact a Privacy Officer. You may take back or revoke your consent or authorization at any time (unless we already have acted based on it) by submitting our Revocation Form in writing to us at our address listed above. Your revocation will take effect when we actually receive it. We cannot give it retroactive effect, so it will not affect any use or disclosure that occurred in our reliance on your Consent or Authorization prior to revocation (i.e. if after we provide services to you, you revoke your authorization / acknowledgement in order to prevent us billing or collecting for

those services, your revocation will have no effect because we relied on your authorization/ acknowledgement to provide services before you revoked it).

General Rule – If you do not sign our authorization/ acknowledgement form or if you revoke it, as a general rule (subject to exceptions described below under "Healthcare Treatment, Payment and Operations Rule" and "Special Rules"), we cannot in any manner use or disclose to anyone (excluding you, but including payers and Business Associates) your PHI or any other information in your medical record. By law, we are unable to submit claims to payers under assignment of benefits without your signature on our authorization/ acknowledgement form. You will however be able to restrict disclosures to your insurance carrier for services for which you wish to pay "out of pocket" under the new Omnibus Rule. We will not condition treatment on you signing an authorization / acknowledgement, but we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the authorization/ acknowledgement or revoke it.

Healthcare Treatment, Payment and Operations Rule

With your signed consent, we may use or disclose your PHI in order:

- To provide you with or coordinate healthcare treatment and services. For example, we may review your health history form to form a diagnosis and treatment plan, consult with other doctors about your care, delegate tasks to ancillary staff, call in prescriptions to your pharmacy if outside of the YTHC Pharmacy, disclose needed information to your family or others so they may assist you with home care, arrange appointments with other healthcare providers, schedule lab work for you if outside of the YTHC Lab, etc.
- To bill or collect payment from you, an insurance company, a managed-care organization, a health benefits plan or another third party. For example, we may need to verify your insurance coverage, submit your PHI on claim forms in order to get reimbursed for our services, obtain pre-treatment estimates or prior authorizations from your health plan or provide your x-rays because your health plan requires them for payment; Remember, you will be able to restrict disclosures to your insurance carrier for services for which you wish to pay "out of pocket" under this new Omnibus Rule.
- To run our office, assess the quality of care our patients receive and provide you with customer service. For example, to improve efficiency and reduce costs associated with missed appointments, we may contact you by telephone, mail or otherwise remind you of scheduled appointments, we may leave messages with whomever answers your telephone or email to contact us (but we will not give out detailed PHI), we may call you by name from the waiting room, we may ask you to put your name on a sign-in sheet, (we will cover your name just after checking you in), we may tell you about or recommend health-related products and complementary or alternative treatments that may interest you, we may review your PHI to evaluate our staff's performance, or a Privacy Officer may review your records to assist you with complaints. If you prefer that we not contact you with appointment reminders or information about treatment alternatives or health-related products and services, please notify us in writing at our address listed above and we will not use or disclose your PHI for these purposes.
- New HIPAA Omnibus Rule does not require that we provide the above notice regarding Appointment Reminders, Treatment Information or Health Benefits, but we are including these as a courtesy so you understand our business practices with regards to your (PHI) protected health information.

Additionally you should be made aware of these protection laws on your behalf, under the new HIPAA Omnibus Rule:

- That **Health Insurance plans** that underwrite cannot use or disclose genetic information for underwriting purposes (this excludes certain long-term care plans). Health plans that post their NOPPs on their web sites must post these Omnibus Rule changes on their sites by the effective date of the Omnibus Rule, as well as notify you by US Mail by the Omnibus Rules effective date. Plans that do not post their NOPPs on their Web sites must provide you information about Omnibus Rule changes within 60 days of these federal revisions.
- **Psychotherapy Notes** maintained by a healthcare provider, must state in their NOPPs that they can allow "use and disclosure" of such notes only with your written authorization.

Special Rules

Notwithstanding anything else contained in this Notice, only in accordance with applicable HIPAA Omnibus Rule, and under strictly limited circumstances, we may use or disclose your PHI without your permission, consent or authorization for the following purposes:

- When required under federal, state or Tribal law
- When necessary in emergencies to prevent a serious threat to your health and safety or the health and safety of other persons
- When necessary for public health reasons (i.e. prevention or control of disease, injury or disability, reporting information such as adverse reactions to anesthesia, ineffective or dangerous medications or products, suspected abuse, neglect or exploitation of children, disabled adults or the elderly, or domestic violence)
- For federal or state government health-care oversight activities (i.e. civil rights laws, fraud and abuse investigations, audits, investigations, inspections, licensure or permitting, government programs, etc.)
- For judicial and administrative proceedings and law enforcement purposes (i.e. in response to a warrant, subpoena or court order, by providing PHI to coroners, medical examiners and funeral directors to locate missing persons, identify deceased persons or determine cause of death)
- For Worker's Compensation purposes (i.e. we may disclose your PHI if you have claimed health benefits for a work-related injury or illness)
- For intelligence, counterintelligence or other national security purposes (i.e. Veterans Affairs, U.S. military command, other government authorities or foreign military authorities may require us to release PHI about you)
- For organ and tissue donation (i.e. if you are an organ donor, we may release your PHI to organizations that handle organ, eye or tissue procurement, donation and transplantation)
- For research projects approved by an Institutional Review Board or a privacy board to ensure confidentiality (i.e. if the researcher will have access to your PHI because involved in your clinical care, we will ask you to sign an authorization)
- To create a collection of information that is "de-identified" (i.e. it does not personally identify you by name, distinguishing marks or otherwise and no longer can be connected to you)
- To family members, friends and others, but only if you are present and verbally give permission. We give you an opportunity to object and if you do not, we reasonably assume, based on our professional judgment and the surrounding circumstances, that you do not object (i.e. you bring someone with you into the operatory or exam room during treatment or into the conference area when we are discussing your PHI); we reasonably infer that it is in your best interest (i.e. to allow someone to pick up your records because they knew you were our patient and you asked them in writing with your signature to do so); or it is an emergency situation involving you or another person (i.e. your minor child or ward) and, respectively, you cannot consent to your care because you are incapable of doing so or you cannot consent to the other person's care because, after a reasonable attempt, we have been unable to locate you. In these emergency situations we may, based on our professional judgment and the surrounding circumstances, determine that disclosure is in the best interests of you or the other person, in which case we will disclose PHI, but only as it pertains to the care being provided and we will notify you of the disclosure as soon as possible after the care is completed. **As per HIPAA law 164.512(j) (i)… (A) Is necessary to prevent or lessen a serious or imminent threat to the health and safety of a person or the public and (B) Is to person or persons reasonably able to prevent or lessen that threat.**

Minimum Necessary Rule

Our staff will not use or access your PHI unless it is necessary to do their jobs (i.e. doctors uninvolved in your care will not access your PHI; ancillary clinical staff caring for you will not access your billing information; billing staff will not access your PHI except as needed to complete the claim form for the latest visit; janitorial staff will not access your PHI). All of our team members are trained in HIPAA Privacy rules and sign strict Confidentiality Contracts with regards to protecting and keeping private your PHI. So do our Business Associates and their Subcontractors. Know that your PHI is protected several layers deep with regards to our business relations. Also, we disclose to others outside our staff, only as much of your PHI as is necessary to accomplish the recipient's lawful purposes. Still in certain cases, we may use and disclose the entire contents of your medical record:

- To you (and your legal representatives as stated above) and anyone else you list on a Consent or

Authorization to receive a copy of your records

- To healthcare providers for treatment purposes (i.e. making diagnosis and treatment decisions or agreeing with prior recommendations in the medical record)
- To the U.S. Department of Health and Human Services (i.e. in connection with a HIPAA complaint)
- To others as required under federal or state law
- To a Privacy Officer and others as necessary to resolve your complaint or accomplish your request under HIPAA (i.e. clerks who copy records need access to your entire medical record)

In accordance with HIPAA law, we presume that requests for disclosure of PHI from another Covered Entity (as defined in HIPAA) are for the minimum necessary amount of PHI to accomplish the requestor's purpose. A Privacy Officer will individually review unusual or non-recurring requests for PHI to determine the minimum necessary amount of PHI and disclose only that. For non-routine requests or disclosures, a Privacy Officer will make a minimum necessary determination based on, but not limited to, the following factors:

- The amount of information being disclosed
- The number of individuals or entities to whom the information is being disclosed
- The importance of the use or disclosure
- The likelihood of further disclosure
- Whether the same result could be achieved with de-identified information
- The technology available to protect confidentiality of the information
- The cost to implement administrative, technical and security procedures to protect confidentiality

If we believe that a request from others for disclosure of your entire medical record is unnecessary, we will ask the requestor to document why this is needed, retain that documentation and make it available to you upon request.

Incidental Disclosure Rule

We will take reasonable administrative, technical and security safeguards to ensure the privacy of your PHI when we use or disclose it (i.e. we shred all paper containing PHI, require employees to speak with privacy precautions when discussing PHI with you, we use computer passwords and change them periodically (i.e. when an employee leaves us), we use firewall and router protection to the federal standard, we back up our PHI data off-site and encrypted to federal standard, we do not allow unauthorized access to areas where PHI is stored or filed and/or we have any unsupervised business associates sign Business Associate Confidentiality Agreements).

However, in the event that there is a breach in protecting your PHI, we will follow Federal Guide Lines to HIPAA Omnibus Rule Standard to first evaluate the breach situation using the Omnibus Rule, 4-Factor Formula for Breach Assessment. Then we will document the situation, retain copies of the situation on file, and report all breaches (other than low probability as prescribed by the Omnibus Rule) to the US Department of Health and Human Services at:
http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html

We will also make proper notification to you and any other parties of significance as required by HIPAA Law.

Business Associate Rule

Business Associates are defined as: an entity, (non-employee) that in the course of their work will directly / indirectly use, transmit, view, transport, hear, interpret, process or offer PHI for this Facility.

Business Associates and other third parties (if any) that receive your PHI from us will be prohibited from re-disclosing it unless required to do so by law or you give prior express written consent to the re-disclosure. Nothing in our Business Associate agreement will allow our Business Associate to violate this re-disclosure prohibition. Under Omnibus Rule, Business Associates will sign a strict confidentiality agreement binding them to keep your PHI protected and report any compromise of such information to us, you and the United States Department of Health and Human Services, as well as other required entities. Our Business Associates will also follow Omnibus Rule and have any of their Subcontractors that may directly or indirectly have contact with your PHI, sign Confidentiality Agreements to Federal Omnibus Standard.

Super-confidential Information Rule

If we have PHI about you regarding communicable diseases, disease testing, alcohol or substance abuse diagnosis and treatment, or psychotherapy and mental health records (super-confidential information under the law), we will not disclose it under the General or Healthcare Treatment, Payment and Operations Rules (see above) without your first signing and properly completing our Consent form (i.e. you specifically must initial the type of super-confidential information we are allowed to disclose). If you do not specifically authorize disclosure by initialing the super-confidential information, we will not disclose it unless authorized under the Special Rules (see above) (i.e. we are required by law to disclose it). If we disclose super-confidential information (either because you have initialed the consent form or the Special Rules authorizing us to do so), we will comply with state and federal law that requires us to warn the recipient in writing that re-disclosure is prohibited.

Changes to Privacy Policies Rule

We reserve the right to change our privacy practices (by changing the terms of this Notice) at any time as authorized by law. The changes will be effective immediately upon us making them. They will apply to all PHI we create or receive in the future, as well as to all PHI created or received by us in the past (i.e. to PHI about you that we had before the changes took effect). If we make changes, we will post the changed Notice, along with its effective date, in our office and on our website. Also, upon request, you will be given a copy of our current Notice.

Authorization Rule

We will not use or disclose your PHI for any purpose or to any person other than as stated in the rules above without your signature on our specifically worded, written Authorization / Acknowledgement Form (not a Consent or an Acknowledgement). If we need your Authorization, we must obtain it via a specific Authorization Form, which may be separate from any Authorization / Acknowledgement we may have obtained from you. We will not condition your treatment here on whether you sign the Authorization (or not).

Marketing and Fund Raising Rules

Limitations on the disclosure of PHI regarding Remuneration

The disclosure or sale of your PHI without authorization is prohibited. Under the new HIPAA Omnibus Rule, this would exclude disclosures for public health purposes, for treatment / payment for healthcare, for the sale, transfer, merger, or consolidation of all or part of YTHC and for related due diligence, to any of our Business Associates, in connection with the business associate's performance of activities for YTHC, to a patient or beneficiary upon request, and as required by law. In addition, the disclosure of your PHI for research purposes or for any other purpose permitted by HIPAA will not be considered a prohibited disclosure if the only reimbursement received is "a reasonable, cost-based fee" to cover the cost to prepare and transmit your PHI which would be expressly permitted by law. Notably, under the Omnibus Rule, an authorization to disclose PHI must state that the disclosure will result in remuneration to the Covered Entity. Notwithstanding the changes in the Omnibus Rule, the disclosure of limited data sets (a form of PHI with a number of identifiers removed in accordance with specific HIPAA requirements) for remuneration pursuant to existing agreements is permissible until September 22, 2014, so long as the agreement is not modified within one year before that date.

Limitation on the Use of PHI for Paid Marketing

We will, in accordance with Federal and State Laws, obtain your written authorization to use or disclose your PHI for marketing purposes, (i.e.: to use your photo in ads) but not for activities that constitute treatment or healthcare operations. To clarify, ***Marketing*** is defined by HIPAA's Omnibus Rule, as "a communication about a product or service that encourages recipients . . . to purchase or use the product or service." Under the Omnibus Rule, we will obtain a written authorization from you prior to recommending you to an alternative therapist, or non-associated Healthcare Covered Entity.

Under Omnibus Rule we will obtain your written authorization prior to using your PHI or making any treatment or healthcare recommendations, should financial payment for making the communication be involved from a third

party whose product or service we might promote (i.e.: businesses offering YTHC incentives to promote their products or services to you). This will also apply to our Business Associate who may receive such payment for making a treatment or healthcare recommendations to you. All such recommendations will be limited without your expressed written permission.

We must clarify to you that financial compensation does not include "as in-kind payments" and payments for a purpose to implement a disease management program. Any promotional gifts of nominal value are not subject to the authorization requirement, and we will abide by the set terms of the law to accept or reject these.

The only exclusion to this would include: "refill reminders", so long as the payment for making such a communication is "reasonably related to our cost" for making such a communication. In accordance with law, YTHC and our Business Associates will only ever seek reimbursement from you for permissible costs that include: labor, supplies, and postage. Please note that "generic equivalents" , "adherence to take medication as directed" and "self-administered drug or delivery system communications" are all considered to be "refill reminders."

Face-to-face marketing communications, such as sharing with you, a written product brochure or pamphlet, is permissible under current HIPAA Law.

Flexibility on the Use of PHI for Fundraising

Under the HIPAA Omnibus Rule use of PHI is more flexible and does not require your authorization should we choose to include you in any fund raising efforts attempted at YTHC? However, we will offer the opportunity for you to "opt out" of receiving future fundraising communications. Simply let us know that you want to "opt out" of such situations. There will be a statement on your ***HIPAA Patient Acknowledgement Form*** where you can choose to "opt out". Our commitment to care and treat you will in no way effect your decision to participate or not participate in our fund raising efforts.

Improvements to Requirements for Authorizations Related to Research

Under HIPAA Omnibus Rule, we may seek authorizations from you for the use of your PHI for future research. However, we would have to make clear what those uses are in detail.

Also, if we request of you a compound authorization with regards to research, YTHC would clarify that when a compound authorization is used, and research-related treatment is conditioned upon your authorization, the compound authorization will differentiate between the conditioned and unconditioned components.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

If you got this Notice via email or website, you have the right to get, at any time, a paper copy by asking a Privacy Officer. Also, you have the following additional rights regarding PHI we maintain about you:

To Inspect and Copy

You have the right to see and get a copy of your PHI including, but not limited to, medical and billing records by submitting a written request to a Privacy Officer. Original records will not leave the premises, will be available for inspection only during our regular business hours, and only if a Privacy Officer is present at all times. You may ask us to give you the copies in a format other than photocopies (and we will do so unless we determine that it is impractical) or ask us to prepare a summary in lieu of the copies. We may charge you a fee not to exceed state law to recover our costs (including postage, supplies, and staff time as applicable, but excluding staff time for search and retrieval) to duplicate or summarize your PHI. We will not condition release of the copies on summary of payment of your outstanding balance for professional services if you have one). We will comply with Federal Law to provide your PHI in an electronic format within the 30 days, to Federal specification, when you provide us with proper written request. Paper copy will also be made available. We will respond to requests in a timely manner, without delay for legal review, or, in less than thirty days if submitted in writing, and in ten business days or less if malpractice litigation or pre-suit production is involved. We may deny your request in certain limited circumstances (i.e. we do not have the PHI, it came from a confidential source, etc.). If we deny your request, you may ask for a review of that decision. If required by law, we will select a licensed health-care professional (other than the person

who denied your request initially) to review the denial and we will follow his or her decision. If we select a licensed healthcare professional who is not affiliated with us, we will ensure a Business Associate Agreement is executed that prevents re-disclosure of your PHI without your consent by that outside professional.

To Request Amendment / Correction

If another doctor involved in your care tells us in writing to change your PHI, we will do so as expeditiously as possible upon receipt of the changes and will send you written confirmation that we have made the changes. If you think PHI we have about you is incorrect, or that something important is missing from your records, you may ask us to amend or correct it (so long as we have it) by submitting a "**Request for Amendment / Correction"** form to a Privacy Officer. We will act on your request within 30 days from receipt but we may extend our response time (within the 30-day period) no more than once and by no more than 30 days, or as per Federal Law allowances, in which case we will notify you in writing why and when we will be able to respond. If we grant your request, we will let you know within five business days, make the changes by noting (not deleting) what is incorrect or incomplete and adding to it the changed language, and send the changes within 5 business days to persons you ask us to and persons we know may rely on incorrect or incomplete PHI to your detriment (or already have). We may deny your request under certain circumstances (i.e. it is not in writing, it does not give a reason why you want the change, we did not create the PHI you want changed (and the entity that did can be contacted), it was compiled for use in litigation, or we determine it is accurate and complete). If we deny your request, we will (in writing within 5 business days) tell you why and how to file a complaint with us if you disagree, that you may submit a written disagreement with our denial (and we may submit a written rebuttal and give you a copy of it), that you may ask us to disclose your initial request and our denial when we make future disclosure of PHI pertaining to your request, and that you may complain to us and the U.S. Department of Health and Human Services.

To an Accounting of Disclosures

You may ask us for a list of those who got your PHI from us by submitting a "**Request for Accounting of Disclosures**" form to us. The list will not cover some disclosures (i.e. PHI given to you, given to your legal representative, given to others for treatment, payment or health-care-operations purposes). Your request must state in what form you want the list (i.e. paper or electronically) and the time period you want us to cover, which may be up to but not more than the last six years (excluding dates before April 14, 2003). If you ask us for this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee to respond, in which case we will tell you the cost before we incur it and let you choose if you want to withdraw or modify your request to avoid the cost.

To Request Restrictions

You may ask us to limit how your PHI is used and disclosed (i.e. in addition to our rules as set forth in this Notice) by submitting a written "**Request for Restrictions on Use, Disclosure**" form to us (i.e. you may not want us to disclose your surgery to family members or friends involved in paying for our services or providing your home care). If we agree to these additional limitations, we will follow them except in an emergency where we will not have time to check for limitations. Also, in some circumstances we may be unable to grant your request (i.e. we are required by law to use or disclose your PHI in a manner that you want restricted, you signed an Authorization Form, which you may revoke, that allows us to use or disclose your PHI in the manner you want restricted; in an emergency).

To Request Alternative Communications

You may ask us to communicate with you in a different way or at a different place by submitting a written "**Request for Alternative Communication**" Form to us. We will not ask you why and we will accommodate all reasonable requests (which may include: to send appointment reminders in closed envelopes rather than by postcards, to send your PHI to a post office box instead of your home address, to communicate with you at a telephone number other than your home number). You must tell us the alternative means or location you want us to use and explain to our satisfaction how payment to us will be made if we communicate with you as you request.

To Complain or Get More Information

We will follow our rules as set forth in this Notice. If you want more information or if you believe your privacy rights have been violated (i.e. you disagree with a decision of ours about inspection / copying, amendment / correction, accounting of disclosures, restrictions or alternative communications), we want to make it right. We never will penalize you for filing a complaint. To do so, please file a formal, written complaint within 180 days with:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201
877.696.6775

Or, submit a written Complaint form to us at the following address:

A Privacy Officer:	*Eric Gabriel*
Office Name:	*Risk Management/Quality Improvement*
Office Address:	*PO Box 160*
	Pendleton, OR 97801
Office Phone:	*541.278.7545*
Office Fax:	*541.278.7575*
Email Address:	*ericgabriel@yellowhawk.org*

You may get your "**HIPAA Complaint"** form by calling our A Privacy Officer.

These privacy practices are in accordance with the original HIPAA enforcement effective April 14, 2003, and undated to Omnibus Rule effective March 26, 2013 and will remain in effect until we replace them as specified by Federal and/or State Law.

OPTIONAL RULES FOR NOPP

Faxing and Emailing Rule

When you request us to fax or email your PHI as an alternative communication, we may agree to do so, but only after having a Privacy Officer or treating doctor review that request. For this communication, a Privacy Officer will confirm that the fax number or email address is correct before sending the message and ensure that the intended recipient has sole access to the fax machine or computer before sending the message; confirm receipt, locate our fax machine or computer in a secure location so unauthorized access and viewing is prevented; use a fax cover sheet so the PHI is not the first page to print out (because unauthorized persons may view the top page); and attach an appropriate notice to the message. Our emails are all encrypted per Federal Standard for your protection.

Practice Transition Rule

If we sell our practice, our patient records (including but not limited to your PHI) may be disclosed and physical custody may be transferred to the purchasing healthcare provider, but only in accordance with the law. The healthcare provider who is the new records owner will be solely responsible for ensuring privacy of your PHI after the transfer and you agree that we will have no responsibility for (or duty associated with) transferred records. If all the owners of our practice die, our patient records (including but not limited to your PHI) must be transferred to another healthcare provider within 90 days to comply with State & Federal Laws. Before we transfer records in either of these two situations, a Privacy Officer will obtain a Business Associate Agreement from the purchaser and review your PHI for super-confidential information (i.e. communicable disease records), which will not be transferred without your express written authorization (indicated by your initials on our Consent form).

Inactive Patient Records

We will retain your records for seven years from your last treatment or examination, at which point you will become an inactive patient in our practice and we may destroy your records at that time (but records of inactive minor patients will not be destroyed before the child's eighteenth birthday). We will do so only in accordance with the law (i.e. in a confidential manner, with a Business Associate Agreement prohibiting re-disclosure if necessary).

Collections

If we use or disclose your PHI for collections purposes, we will do so only in accordance with the law.

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Yellowhawk Tribal Health Center (YTHC). A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient | Patient Signature / Guardian of Patient

_____ _____

Legal Representative / Guardian | Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO THE FOLLOWING INFORMATION: (Please Check Those That Apply)

☐ Medical ☐ Dental ☐ Behavioral Health ☐ Patient Account ☐ All Health Information

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone (when available)
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone (when available)
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

□ Phone Message
□ Text Message (when available)
□ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that YTHC may recommend products or services to promote your improved health. YTHC may or may not receive third party payment from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As a YTHC Representative, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____ _____

Signature of YTHC Representative

CONSENT FOR RELEASE OF MEDICAL RECORDS USE
PLUS DISCLOSURE OF PROTECTED HEALTH INFORMATION to a THIRD PARTY

I, _____, (Name of Patient making Request), hereby authorize Yellowhawk Tribal Health Center (YTHC) to use and disclose:

☐ **Date specific Portions of my Medical or Dental Record, From Date:_____ To Date: _____**
☐ Test Results only
☐ Portions of my Medical or Dental Record, specifically: _____
☐ Other (specify) _____

I acknowledge that YTHC, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical or dental records to the party listed below. I have reviewed YTHC's NOPP and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify YTHC, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize YTHC to use and disclose verbally, by mail, fax or unencrypted email, the following types of ***super-confidential information*** as stated in the NOPP **(initial where appropriate)**:

_____HIV records (including HIV test results) and sexually transmissible diseases
_____Alcohol and substance abuse diagnosis and treatment records
_____Psychotherapy records
_____Not Applicable

REQUIRED TO COMPLETE:
In accordance with HIPAA Omnibus Rule of 2013, I understand that I need to provide the specifics of this release request:

1. Date of this Request: _____

2. Please Release my records to: _____ (Name of Third Party)
   ☐ Send Third Party a copy of my records to this address: _____
   _____
   _____

3. The Records will be obtained by:
   Please allow _____ to pick up a copy of my records (including

   ☐ Third Party will pick up a copy of my records on or after this date: _____

By Patient:

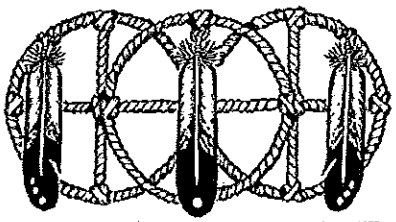
_____ _____ Date: _____
(Print name) (Sign name)
Patient Date of Birth _____
or

By Patient's Representative

_____ _____ Date: _____
(Print name, sign, and describe authority)

Yellowhawk Information: Attn: Medical Records PO Box 160 Pendleton, OR 97801
Phn: 541-278-7501 Fx: 541-278-7570

YELLOWHAWK
TRIBAL HEALTH CENTER



P.O. Box 160
73265 Confederated Way
Pendleton, OR 97801
Phone: (541) 966-9830 Fax: (541) 278-7579
Website: www.yellowhawk.org

Contract Health Services
Proof of Residency Requirements

In the past, Yellowhawk Tribal Health Center has accepted a valid Oregon Driver's License as proof of residency to receive Contract Health Services (CHS). However, the State of Oregon has transitioned to drivers licenses with 8-year expiration dates making them inadequate as the sole proof of residency. To ensure that our limited CHS funds are being used for eligible beneficiaries we are changing the proof of residency requirement.

Proof of residency for CHS Federal Funding:

As of January 1, 2014 all persons seeking eligibility approval for CHS referrals (per 42CFR §36.12) will be in one of the following categories:

a. *CTUIR member or immediate child of a CTUIR member (until they attain 19 yrs old)*: Must show proof of residing in Umatilla or Union County within the last 30 days from the date requesting services. (must submit at least one of the following)
   - ***Exemption of waiting period if the tribal member has a verified alternate resource.***

b. *Non-CTUIR member American Indian*: Must show they have resided on the Umatilla Indian Reservation for twelve (12) months from the date requesting services. **(must submit at least two of the following)**

Acceptable Proof of Residency Documents:

1. Oregon Driver's License
2. A rental or lease agreement[a] on an official pre-printed application form (purchased receipts are not acceptable) dated within one year of the application which contains:
   - The name of the tenant;
   - The address of the rental unit; and
   - The name and signature of the rental owner or manager.

   [a]Photocopies of rental or lease agreement are acceptable with manager/landlord original signature or statement that photocopy is a true copy of the original signed by the manager/landlord.

3. A utility hook up or work order dated within 60 days of the application.
4. Mail from the following sources within the required time listed above (depending on enrolled CTUIR or other American Indian/Alaska Native):
   a. U.S. Treasury.
   b. Current Oregon Health Plan coupon or green card showing current address.

c. Utility companies.

5. Educational institute transcript forms for the current school year.
6. Current year income tax return.
7. CTUIR enrollment office verification with current local address.
8. CTUIR documentation from Social Services or employer showing local address.

During patient registration, should a Patient Care Coordinator (PCC) feel additional or more definitive documentation for proof of residency is needed, additional information will be requested. Such requests will be reviewed by the PCC Manager or Business Office Manager. If the request is a justified request, the additional information to show proof of residency will need to be submitted before authorizing CHS eligibility.

Full-Time Student Status and CHS Eligibility:

Yellowhawk Tribal Health Center requires all full-time students that show documentation of their full-time status at least once a year to ensure their CHS eligibility is maintained.

Required documentation: a copy of the student's current transcript showing name of college/university, and number of credits being taken (13 or more credits is considered full-time student status).

Revision: 02-04-14

Tim Gilbert
Chief Executive Officer

Shawna M. Shillal-Gavin, Chair
CTUIR Tribal Health Commission