



**Circle of Nations**  
**832 8<sup>th</sup> St N**  
**Wahpeton ND 58075**

Registrar / Admissions Committee  
701-672-7222 701-642-1984 (fax)  
[www.circleofnations.org](http://www.circleofnations.org)

Student Name: \_\_\_\_\_ will be attending CNS for School year 2021-22

Grade: \_\_\_\_\_

**PARENTAL CONSENT: (please check all that apply)**

Permission to utilize the above-named student's photographs, writings or illustrations for information/educational purposes  
Yes No

Permission is granted for the above-named student to participate in organized school related / sponsored activities and field trips as approved by CNS. It is understood that these trips may be overnight and may cross state lines. Yes No  
Exception(s): \_\_\_\_\_

Permission is granted for the above-named student to participate in organized competitive sports. A physical examination for the student is required before the student can fully participate in any competitive sports offered by CNS. Yes No

Permission is granted for the above-named student for the following choices:

*Haircuts* Yes No      *Coloring* Yes No      *Highlighting* Yes No

Additional comments / instructions: \_\_\_\_\_

Permission to participate in Sweat Ceremonies and/or church activities.

Sweat ceremonies	Yes	No
Church activities	Yes	No

Additional comments / instructions: \_\_\_\_\_

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date

Coronavirus: For students 12 years and older – Has student received the Covid-19 vaccine? Yes No  
If so, please provide date received: \_\_\_\_\_

Student Name: \_\_\_\_\_

**FAMILY AND BACKGROUND INFORMATION**

**Mother:** \_\_\_\_\_

**Father:** \_\_\_\_\_

Legal Guardian:

Legal Guardian:

Address: \_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Tribal Affiliation: \_\_\_\_\_

Tribal Affiliation: \_\_\_\_\_

Telephone numbers:

Telephone numbers:

Home: \_\_\_\_\_

Home: \_\_\_\_\_

Cell: \_\_\_\_\_

Cell: \_\_\_\_\_

Other: \_\_\_\_\_

Other: \_\_\_\_\_

Please circle:    Living       Deceased

Please circle:    Living       Deceased

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Emergency contact: \_\_\_\_\_

Emergency contact: \_\_\_\_\_

Emergency number: \_\_\_\_\_

Emergency number: \_\_\_\_\_

E-mail: \_\_\_\_\_

E-mail: \_\_\_\_\_

**This section must be accompanied by a copy of the Custody Order if Legal Guardian is not a Parent**

**Legal Guardian -** \_\_\_\_\_

Relationship to student: \_\_\_\_\_

*(if not parent)* Tribal or County Program: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Tribal Affiliation: \_\_\_\_\_

Employer: \_\_\_\_\_

Telephone numbers:

Home: \_\_\_\_\_

Cell: \_\_\_\_\_

Other: \_\_\_\_\_

Emergency contact: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Emergency number: \_\_\_\_\_

**I am legally responsible for this student and hereby apply for his/her admission to the Circle of Nations School. I understand that CNS may request additional information before the student is accepted and/or enrolled.**

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date

# VERIFICATION OF CHILD CUSTODY

Name of Child: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Name of Custodial Parent / Legal Guardian: \_\_\_\_\_

Name of Non-Custodial Parent: \_\_\_\_\_

Custody set forth by (please circle): Birth Divorce Decree Court Order Other: \_\_\_\_\_

Type of custody (please circle): Sole custody Joint custody Other: \_\_\_\_\_

**Please provide Circle of Nations School with a copy of the judgment issued regarding the custody.**

Please answer the following questions:

- May the non-custodial parent have access to your child's school records (report card, progress report, class work, IEP, etc.)? YES NO
- May the non-custodial parent discuss your child's progress with CNS staff members? YES NO
- May the non-custodial parent visit your child at CNS? YES NO
- May the non-custodial parent telephone your child at CNS? YES NO
- May the non-custodial parent sign your child out from CNS? YES NO
- Do you wish to be advised of any contact from the non-custodial parent? YES NO
- Is there a restraining order in place? YES NO  
If yes, please provide the name(s) of person(s) and a copy of the order:

\_\_\_\_\_

Additional comments / restrictions regarding your child's non-custodial parent that CNS should be aware of:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date

**GIFTED AND TALENTED PROGRAM**  
**CIRCLE OF NATIONS-WAHPETON INDIAN SCHOOL**

The CNS Gifted and Talented Program offers many opportunities in a variety of areas to the students of the school. In order for your child to participate, CNS and the Gifted and Talented Coordinator need your permission for your child to be evaluated to determine whether or not they are eligible for the special services provided by this program. We also need your permission to place your child in the program, if they qualify. The areas that the Gifted and Talented Program services are listed below. **Check any of the areas that you feel apply to your child and explain why in the spaces provided.**

\_\_\_\_\_ Intellectual Ability: \_\_\_\_\_

\_\_\_\_\_ Creativity / Divergent Thinking: \_\_\_\_\_

\_\_\_\_\_ Academic Aptitude / Achievement: \_\_\_\_\_

\_\_\_\_\_ Leadership: \_\_\_\_\_

\_\_\_\_\_ Aptitude in Visual and Performing Arts: \_\_\_\_\_

List something that the student is exceptionally good at doing or enjoys doing: \_\_\_\_\_

\_\_\_\_\_

Additional comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\*\*\*\*\*

I GIVE PERMISSION FOR MY CHILD, \_\_\_\_\_,

TO BE EVALUATED AND PLACED IN THE GIFTED AND TALENTED PROGRAM AT THE CIRCLE OF NATIONS SCHOOL AND SAMPLES PLACED IN THE STUDENT'S FILE AS EVIDENCE OF THEIR ABILITIES.

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date

# STUDENT INFORMATION SUMMARY

Name of Student: \_\_\_\_\_

## Student & family language survey

What is the student's first language? \_\_\_\_\_ Is a language other than English used in the home? Y or N  
If yes, what is the language? \_\_\_\_\_

Describe any traumatic event the student has experienced (ex: death of close relative, abuse, divorce/separation of parents, etc.):  
\_\_\_\_\_  
\_\_\_\_\_

What is the most important information to know about the student? \_\_\_\_\_  
\_\_\_\_\_

Has the student ever been involved in gang activity? Yes No

If yes, please explain: \_\_\_\_\_

Has the student ever been arrested? Yes No

If yes, give reason(s): \_\_\_\_\_

How many times? \_\_\_\_\_

Has the student ever been in detention or jail? Yes No

If yes, give reason(s): \_\_\_\_\_

How many times? \_\_\_\_\_

Is the student currently on probation or ever been on probation? Yes No

If yes, give reason(s): \_\_\_\_\_

Duration of probation or sentence: \_\_\_\_\_

***If applicable, please provide the name(s) and contact information of the judge, probation officer, D.O.C. Worker, or Court Services Worker that is currently working with the student and/or the family:***

\_\_\_\_\_  
Name of service provider

\_\_\_\_\_  
Telephone Number(s) / Contract Information

***If applicable, please provide the name(s) and contact information of the social worker or caseworker or school counselor that has worked with the student and/or the family:***

\_\_\_\_\_  
Name of social worker, caseworker, or school counselor

\_\_\_\_\_  
Telephone Number(s) / Contact Information

**CIRCLE OF NATIONS SCHOOL**  
**BIE McKinney-Vento Enrollment/Referral**

This questionnaire is intended to address a child's eligibility for services provided and required by the McKinney-Vento Act of No Child Left Behind Act. Your answers will help the administration determine residency documents necessary for enrollment of the student. Please check any statement that applies to your child's residency. It will be school staff and partnering agencies to ensure all providers have the necessary information to support the child and his/her family.

1. Is the student's current address a temporary living arrangement?                      Yes      No  
2. Is the student's temporary address due to loss of housing OR economic hardship?      Yes      No

**Student Information**

Student Name: \_\_\_\_\_ Grade Level: \_\_\_\_\_ Age: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Parent / Guardian phone number: \_\_\_\_\_

- Cellular phone               Work Phone               Shelter Phone               Family / Friend's Residence

**Residency Information**

***Where does the student stay at night?***

- Doubled up (more than one family in a house, apartment, or mobile home)  
 Hotels/ motels, temporary housing, campsite  
 Shelter/transitional housing / awaiting foster care  
 Unsheltered (cars, parks, etc.)

Address/Directions: \_\_\_\_\_

Shelter Contact Person: \_\_\_\_\_

- Choices listed above do not apply

**What supplemental services would you like the student to receive?**

**Educational Services**

Description: \_\_\_\_\_

**After-school Services**

Description: \_\_\_\_\_

**Health Services**

Immunizations \_\_\_\_\_

Dental \_\_\_\_\_

Food/Clothing \_\_\_\_\_

Free Lunch \_\_\_\_\_

Counseling \_\_\_\_\_

Optometry \_\_\_\_\_

*The parent/guardian understands the above services are supplemental to the regular instructional day and will be re-evaluated to determine which need to be continued. In the event that the family/youth residency changes, it is your responsibility to notify the Circle of Nations School Registrar.*

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

## STUDENT HEALTH INFORMATION SUMMARY

Student Name: \_\_\_\_\_

Medical Assistance Number: \_\_\_\_\_ Insurance Policy Number: \_\_\_\_\_

Coronavirus: Have you been exposed? \_\_\_\_\_ Have you been tested? \_\_\_\_\_ Results: \_\_\_\_\_

Is the student currently receiving medical care from a physician? Yes No

If yes, please provide physician's name and contact information: \_\_\_\_\_

Has the student ever been on medication for mental health reasons? Yes No

If yes, please explain: \_\_\_\_\_

Has the student ever been pregnant or have a child? Yes No

If yes, please explain: \_\_\_\_\_

Has the student ever been hospitalized or treated for any of the following medical conditions? (Circle all that apply)

Seizures / Convulsions	Headaches	Head injury	Epilepsy	Ulcers	Surgery
Suicide attempt/ Overdose	Depression	Eating disorder	Allergies	Diabetes	Coronavirus
Serious accident	Kidney problems	Alcohol/drug issues	Coronavirus	Other: _____	

Briefly describe any of the problems circled above: \_\_\_\_\_

Does the student wear eyeglasses / contacts or both? Yes No

If yes, please furnish provider's name and contact information: \_\_\_\_\_

Does the student have ear problems/infections, hearing problems, or wear a hearing aid? Yes No

If yes, please explain: \_\_\_\_\_

Does the student have speech problems? Yes No

If yes, please explain: \_\_\_\_\_

Has the student had any trouble associated with dental treatment? Yes No

If yes, please explain: \_\_\_\_\_

Is the student currently receiving dental care or orthodontic care? Yes No

If yes, please furnish provider's name and contact information: \_\_\_\_\_

Does the student wet the bed? Yes No

Describe the student's sleeping patterns: \_\_\_\_\_

Is the student on a special diet? Yes No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date

## Patient Registration / Update Indian Health Service

Patient's Name: \_\_\_\_\_  
Other Names Used: \_\_\_\_\_ Sex: M \_\_\_\_\_ / F \_\_\_\_\_  
Chart Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Religion: \_\_\_\_\_  
Tribe of Enrollment: \_\_\_\_\_ Enrollment Number: \_\_\_\_\_  
Indian Blood Quantum: 4/4 \_\_\_\_\_ 3/4 \_\_\_\_\_ 1/2 \_\_\_\_\_ 1/4 \_\_\_\_\_ 1/8 \_\_\_\_\_ Other: \_\_\_\_\_  
Present Community (where you live): \_\_\_\_\_ Number of years: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Birthplace (Town/State): \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Do you have any of the following insurances?

Medicare: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, give number: \_\_\_\_\_ Eff. Date: \_\_\_\_\_  
Medicaid: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, give number: \_\_\_\_\_ Eff. Date: \_\_\_\_\_  
Private Health Insurance: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, give number: \_\_\_\_\_  
Eff. Date of Insurance: \_\_\_\_\_ Policy Holder & Name: \_\_\_\_\_  
Name & Address of Insurance Company: \_\_\_\_\_  
Place of Employment: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
Mother's Name (maiden): \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
Parents' Place of Employment, if minor: Mother: \_\_\_\_\_ Father: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship to You: \_\_\_\_\_  
Address: \_\_\_\_\_ Town \_\_\_\_\_ State/zip \_\_\_\_\_ Telephone # \_\_\_\_\_

Next of Kin (If same as above, write SAME):

Name: \_\_\_\_\_ Relationship to You: \_\_\_\_\_  
Address: \_\_\_\_\_ Town \_\_\_\_\_ State/zip \_\_\_\_\_ Telephone #: \_\_\_\_\_

Optional: Do you have internet access? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, where: \_\_\_\_\_

**\*\*Please provide a copy of your SS#, enrollment papers, birth certificate, and any insurance you may have: Medicare, Medicaid, Private Health Insurance, for your records here that we can keep on file. This info is useful to reach you and your family for future appointments, Contract Health Care, and mostly for upkeep of your medical records.**



WOODROW WILSON KEEBLE MEMORIAL HEALTH CARE CENTER  
PO BOX 189  
100 LAKE TRAVERSE DRIVE  
SISSETON, SD 57262

1. Ethnicity: \_\_\_\_\_  
Hispanic or Latino
2. Primary language: \_\_\_\_\_
3. Other languages spoken: \_\_\_\_\_
4. Preferred language: \_\_\_\_\_
5. Are you a migrant worker? Yes or No  
Please pick one if yes:  
Migrant agricultural worker  
Seasonal agricultural worker
6. Are you homeless? Yes or No  
Please pick one if yes:  
Homeless shelter  
Transitional  
Doubling up  
Street  
Other  
Unknown
7. Advance directives? Yes or No  
Do you have a Power of Attorney or Living Will?
8. Internet access? Yes or No  
If yes, where: \_\_\_\_\_
9. Email address: \_\_\_\_\_
10. Generic Health Permission: Yes or No  
Do we have permission to send Generic Health Information to your email address?
11. Preferred method: \_\_\_\_\_  
What is your preferred method to receive reminders?  
Phone  
Email  
Mail

WOODROW WILSON KEEBLE MEMORIAL HEALTH CARE CENTER  
PO BOX 189  
100 LAKE TRAVERSE DRIVE  
SISSETON, SD 57262

NOTICE TO PATIENTS ON ELIGIBILITY & REFERRALS

It is the policy of Sisseton Indian Health Service to provide health care to people who are regarded within the scope of the Indian Health program as specified in the INDIAN HEALTH MANUAL, Part 2, Chapter 2 – Persons to whom services may be provided.

A person may be referred by a Physician or delegated personnel of the Indian Health Service: when the medical care required cannot be provided by the Indian Health facility. INDIAN HEALTH SERVICE WILL NOT AUTHORIZE PAYMENT for this care until the eligibility requirements are met:

1. You must be eligible for Direct Care: To be eligible for DIRECT CARE, you must be an Indian from a Federally Recognized Tribe of the United States and you may reside anywhere within the United States. You are allowed up to 30 days to show proof of being Indian from a Federally Recognized Tribe of the U.S. Proof shall be in the form of a letter or statement from his/her Tribe which contains their enrollment number and degree of Indian blood if not enrolled. It is the responsibility of the patient, parent, or guardian to obtain this proof. If proof is not shown within that frame of time, services will not be allowed at the Indian Health Service facility.
2. You must be eligible for Contract Health Care: This is care provided away from Indian Health Service facility. YOU MUST MEET THE DIRECT CARE REQUIREMENTS AND YOU MUST RESIDE WITHIN A DELIVERY AREA called the "On or Near Regulation," "ON" refers to an Indian eligible for DIRECT CARE AND LIVES within the boundaries of the reservation where the Indian Health Service facility is located. The "NEAR" refers to the MEMBERS OF THE TRIBE who live ON or NEAR (the counties are defined in the Federal Regulations) the reservation where the Indian Health Service facility is located.

If a patient does not meet BOTH eligibility requirements for DIRECT CARE AND CONTRACT HEALTH CARE, Indian Health Service will not pay for care provided at a non-IHS (private sector) health care facility.

INDIAN OR CANADIAN OR MEXICAN ORIGIN

Any Indian or Canadian or Mexican origin is not eligible for care with IHS.

NON-INDIAN BENEFICIARIES

Any non-Indian woman pregnant with an eligible Indian's child will be required to show proof that she is eligible for prenatal and postnatal services either through marriage to an eligible Indian male or by statement from the eligible Indian that she is carrying his child.

\*Any questions concerning the above policy should be directed to the Service Unit Director.

I have read and received a copy of the above information, all my questions have been answered, and I understand the information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## ADMISSION INFORMATION FOR EMERGENCY MEDICAL CARE

**Please submit a copy of medical assistance card and/or any vision, dental, and health insurance card(s). In addition, please include signed, notarized parental consent for health services form and release of information forms.**

### 1. Patient/Student Information

Full legal name: \_\_\_\_\_

Current address: *Circle of Nations School, 832 8th Street North, Wahpeton, ND 58075*

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Medical facility: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Telephone number: \_\_\_\_\_

Address: \_\_\_\_\_

### 2. Legal Guardian Information

Guardian's Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Guardian's Address: \_\_\_\_\_ DOB: \_\_\_\_\_

Telephone number(s): \_\_\_\_\_

Emergency contact (in addition to Legal Guardian): *Circle of Nations School*

Emergency contact telephone number: *(701) 642-3796, ext. 256*

### **MANDATORY - Please complete the sections below (all that apply):**

3a. Medical Assistance State and Number: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Telephone Number(s): \_\_\_\_\_

3b. Insurance Company: \_\_\_\_\_

Telephone Number(s): \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

3c. Indian Health Service Unit: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number(s): \_\_\_\_\_ Fax number: \_\_\_\_\_

### 4. Medical Information for Student

Food allergies: \_\_\_\_\_

Medication allergies: \_\_\_\_\_

Current medications / prescriptions: \_\_\_\_\_

Medical conditions: \_\_\_\_\_

Additional information: \_\_\_\_\_

\_\_\_\_\_

**CONSENT OF PARENT OR LEGAL GUARDIAN OR OTHER PERSON \*  
WHO HAS PRIMARY RESPONSIBILITY FOR THE CARE OF THE CHILD**

Name of Student: \_\_\_\_\_

Birth date: \_\_\_\_\_

I (We) \_\_\_\_\_

am (are) the parent(s) / legal guardian(s) of the above named student. I (We) have read and understand the consent and give the Circle of Nations School in Wahpeton, ND permission to arrange for and/or to provide the following health services for my (our) child:

1. Health care including medical examinations, routine laboratory studies, x-ray procedures, skin tests, immunizations - including flu vaccine and HPV, and administration of medication.
2. Routine dental care including dental examinations, preventative use of fluorides, and necessary emergency dental care.
3. Optometry care including optometry examinations.
4. Mental health services including evaluation, treatment, and medication, as necessary.
5. Emergency health care for accidents or illness.
6. Transportation of child to and/or from health facilities for these services.
7. Health education and instruction including, but not limited to, the following subjects: diabetes, nutrition, exercise, AIDS, STD's, age and gender appropriate sex education, and routine health maintenance.

( ) Exceptions or special instructions: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient/Student: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Disclosure of information from the above named patient/student record is hereby requested.

The information is to be released from:

Name of facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip Code: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

and is to be provided to:

School Clinic – Circle of Nations School  
832 8<sup>th</sup> Street North  
Wahpeton, ND 58075  
701-642-3796, ext. 256

The purpose or need for this disclosure is for the student's school medical file while enrolled and in attendance at the Circle of Nations School.

The information to be released is from my:

\_\_\_\_\_ Medical Record  
\_\_\_\_\_ Dental Record  
\_\_\_\_\_ Other (specify) \_\_\_\_\_

and includes:

\_\_\_\_\_ Only information related to (specify): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Only the period or events from: \_\_\_\_\_ to \_\_\_\_\_

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of signature.

\_\_\_\_\_  
Signature of Patient/Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Guardian or Authorized Representative (if necessary)

\_\_\_\_\_  
Date

This information is to be released for the purpose(s) 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 U.S.C. 552a(i)(3)). In the case of alcohol and drug patient records, a falsified authorization of disclosure is also prohibited under 42 CFR 2.31(d).

# HIPAA Privacy Authorization Form

## \*\* Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)\*\*

### \*\*1. Authorization\*\*

I authorize \_\_\_\_\_ (*healthcare provider*) to use and disclose the protected health information regarding \_\_\_\_\_ (*student*) described below to \_\_\_\_\_ (*individual seeking the information*).

### \*\*2. Effective Period\*\*

This authorization for release of information covers the period of healthcare from:

a.  \_\_\_\_\_ to \_\_\_\_\_.

\*\* OR \*\*

b.  all past, present, and future periods.

### \*\*3. Extent of Authorization\*\*

a.  I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

\*\* OR \*\*

b.  I authorize the release of my complete health record with the exception of the following information:

Mental health records

Communicable diseases (including HIV and AIDS)

Alcohol / drug abuse treatment

Other (please specify): \_\_\_\_\_

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes I may direct.

5. This authorization shall be in force and effect until \_\_\_\_\_ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient or personal representative and his or her relationship to patient