Port Gamble S'Klallam Health Clinic Consent for Treatment

Welcome to the Port Gamble S'Klallam Tribe Health Services.

All your dealing with us including what you say and what is written in your records, will be kept confidential unless you give us written permission to release the information to a person you specify. However, laws require us to release information to the proper authorities, without your permission, under certain conditions, including:

- If our staff has reasonable cause to believe child or elder abuse or neglect has occurred
- If there is a court order to release information

In order to provide you the best care possible, your service provider may need to consult with another staff professional. The information exchanged is limited to the minimum required to serve your needs. Any information shared will be kept strictly confidential, by all staff, according to our Confidentiality Policy.

Client Name: _____ Social Security Number: _____

Address: _____City:_____Sate:_____Zip:_____

Telephone_____ Gender [ ] Male [ ] Female Birth Date: ___/___/_____

Marital Status [ ] Single [ ] Married [ ] Divorced Todays Date: _____

I, the undersigned, understand the above information and wish to receive services, I consent and authorize evaluation and treatments that may be advisable or necessary in the judgement of:

- [ ] The Clinic Practitioner
- [ ] The Mental Health Counselor
- [ ] The Dental Provider

This consent for treatment will hold valid for all future visits to the Port Gamble S'Klallam Health Clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse health care. I will ask for any information I want to have about my health care and will make my wishes known.

Client Signature: _____

-Or-

Name of person authorized to give consent: _____

Authorized representative Signature: _____ Relation to Client: _____