CAMP AT SOLOMON! LEARN THE HISTORY OF CAPE NOME, PILGRIM HOTSPRINGS, AND SALMON LAKE THROUGH ARCHAEOLOGY, ORAL HISTORY, AND ETHNOBOTANY.

BERING STRAIT ARCHAEOLOGY CAMP

We're now accepting applicants for summer 2019!

July 7-14, 2019, Ages 14-18 eligible to apply

Submit applications to Lisa Ellanna at llellanna@kawerak.org by May 24th
Archaeology Camp 2019

*Important Camp Information*

Application Deadline is May 24

Archaeology Camp is an opportunity for youth ages 14-18 to gather in an outdoor setting to learn about the fields of archaeology, anthropology, and history, participate in cultural activities, and learn about the cultures of the Bering Strait Region. Archaeology Camp will take place outside of Nome, from July 7-14, 2018.

* All application materials must be returned to Kativik Cultural Center by May 24. Fax: 443-4452 or E-mail: lellanna@kawerak.org
* Participants will be selected based on a variety of factors; not first come first serve. However, you are encouraged to get your application in ASAP.
* You will be notified by May 31 of your application status and receive additional camp and flight information if accepted.
* Campers will travel to Nome the morning of July 7 and return home the afternoon of July 14.
* All travel, food, and lodging will be provided by Kawerak, the National Park Service and Alaska Geographic.
* There is no cell phone access at camp, but we will have a satellite phone in case of an emergency.
* If you have a family emergency while your child is at camp you will be able to contact Kawerak’s front desk at 443-5231 to pass along information.
* If you have questions please feel free to contact:
  
  Lisa Ellanna at 443-4340
  Colleen Reynolds at 443-4343
  Tanya Wongittilin at 443-4342

*Please keep this page for your information*
 Archaeology Camp 2019
Kawerak Katirvik Cultural Center Participant
Application
*APPLICATION DEADLINE-May 24th*

Name: ______________________________________

Age: _____ Birthday: _________________________

Address: P.O. Box: _________

City/Village: ___________________________ Zip Code: ___________

Parent Phone/Cell Phone No.: ___________________________
Camp Applicant/Cell Phone No.: ___________________________
Facebook/email address: __________________________________

Why would you like to attend Archaeology Camp?
______________________________________________________
______________________________________________________
______________________________________________________

List your hobbies/what do you like to do in your free time?
______________________________________________________
______________________________________________________
______________________________________________________

What would you like to learn at Camp?
______________________________________________________
______________________________________________________
______________________________________________________

Please list any other camps you have participated in:
______________________________________________________
______________________________________________________
As a participant of Archaeology Camp I understand and agree to the following:

- I will respect and follow the Camp Rules, as explained to me by my camp staff.
- I am responsible for my own actions and will act in a mature manner at all times.
- I agree to attend and participate in all scheduled activities, including my share of chores with a healthy attitude.
- I will NOT use alcohol, tobacco or other drugs during this gathering.
- I will honor the schedule; therefore, I will NOT be leaving the gathering, unless as a part of an organized activity.
- I will be accountable for my whereabouts at all times and will keep a staff person informed of my plans and activities.
- I give permission for images and/or video of myself to be used for any news, promotion, and education materials produced by Kawerak or related agencies.
- I UNDERSTAND THAT I WILL BE SENT HOME IF I DO NOT COOPERATE

I have read and hereby agree to abide by the above terms and conditions.

Signature: ___________________________ Date: ______________

(Youth Applicant/Participant)

I have read and discussed with my child the above Youth Participation Agreement terms and conditions and the consequences of violating the agreement.

Signature: ___________________________ Date: ______________

(Parent/Guardian)

Print Name: ___________________________
Telephone (home): ________________  Cell: ________________
Telephone (work): ________________
Emergency Contact Name and Phone #: ___________________________

Medical information:
The following information is needed by any hospital, medical practitioner or first responder not having access to the participant’s medical history:

Allergies: ___________________________
Medical conditions: ___________________________
Medication being taken: ___________________________
Date of last tetanus shot: ___________________________
Physical impairments:

****Please provide copy of a TB test record from a medical provider with these forms****

Other pertinent Facts to which those treating the participant should be aware:
## ALASKA GEOGRAPHIC YOUTH PROGRAMS
## HEALTH AND EMERGENCY CONTACT INFORMATION

### Participant Information

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<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>Middle</th>
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<tr>
<th>Age</th>
<th>Date of Birth</th>
<th>Height</th>
<th>Weight</th>
<th>Gender</th>
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<th>Mailing Address</th>
<th>City</th>
<th>State/Zip Code</th>
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<th>Day/Cell Phone</th>
<th>Home Phone</th>
<th>Email Address</th>
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### Emergency Contact Information (Please list two contacts that are available on course dates)

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<tr>
<th>Name, Contact #1</th>
<th>Name, Contact #2</th>
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<th>Relationship to participant</th>
<th>Relationship to participant</th>
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<th>Language spoken at home</th>
<th>Language spoken at home</th>
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### Insurance and Medical Provider

<table>
<thead>
<tr>
<th>Insurance Company</th>
<th>Policy Provider</th>
<th>Phone Number</th>
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<table>
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<tr>
<th>Physician's Name</th>
<th>Phone Number</th>
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### General Health Questions

*Do you currently have or have a history of:*

1. Asthma/Respiratory Ailments
2. Diabetes
3. Dietary Restrictions
4. Epilepsy
5. Heart Conditions
6. High Blood Pressure
7. Joint Injuries or Pain
8. Recent Hospitalizations (last 5 years)
9. Taking Prescription Medication

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</table>
10. Gastrointestinal disturbances
11. Head injury or history of concussions
12. Hepatitis or other liver disease
13. Dizziness or fainting episodes
14. Bleeding or blood disorders?
15. Are you currently in, or have you had, psychotherapy with a mental health professional?
16. Disorders of the urinary or reproductive tract?
17. Contact Lenses/Glasses
18. Tobacco use?

If you answer yes to any of the above, or if you have any other condition that would be important for trip leaders or health providers to know, please give a brief explanation below: All information will remain confidential.

**Allergies and Medications**
19. Any Allergies? Insects, bee stings, food allergies, etc. Please list below:
20. Have you been hospitalized for allergies?
21. Do you carry epinephrine?

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Reaction</th>
<th>Treatment</th>
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22. Are you on any medications?:

Please list medication below:

<table>
<thead>
<tr>
<th>Medication(s)</th>
<th>Dosage</th>
<th>Side Effects</th>
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**Muscle/Skeletal Health**
23. History of musculoskeletal pain (back, neck, shoulder, ankle, knee injuries including sprains)

If yes, please explain:
Asthma
24. Do you have asthma? □ Yes □ No

25. If yes, do you carry your own inhaler? □ Yes □ No

Mental Health
Are you currently seeking treatment or have a history (in last 6 months) of treatment for the following:
26. ADHD □ Yes □ No 30. Depression □ Yes □ No
27. Anxiety □ Yes □ No 31. Suicidal Thoughts □ Yes □ No
28. Autism □ Yes □ No 32. Alcohol/Substance Abuse □ Yes □ No
29. Bipolar Disorder □ Yes □ No 33. Other □ Yes □ No

If yes, please explain. All information will remain confidential.

Fitness
34. What exercise activities do you regularly participate in?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency</th>
<th>Intensity (easy/moderate/hard)</th>
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Swimming Ability
35. Please check the box that applies to your swimming ability.
□ I am very comfortable swimming □ Able to swim, but not very well □ Unable to swim

Please note any other pertinent medical concerns Alaska Geographic staff should be aware of:

This information provided above is a complete and accurate statement of any physical or psychological conditions which may affect my participation on this trip. I have truthfully completed this form to the best of my knowledge and not withheld information that would be helpful to Alaska Geographic acting in loc parentis for the duration of the trip. I realize the failure to disclose information could result in harm to myself or fellow students. I agree to inform Alaska Geographic should there be any changes in my health status prior to the start of the course.

Participant Signature: ___________________________ Date: __________

Parent or Guardian Signature: _________________________ Date: __________

(If participant is under age 18)
Acknowledgement of Risk and Release of Liability
Alaska Geographic

Name: ___________________________ Date: ____________

In consideration of Alaska Geographic, its agents, employees, officers, contractors and all other persons or entities associated with it, I agree as follows:

RISK ACKNOWLEDGEMENT
Although Alaska Geographic has taken reasonable steps to provide me with skilled staff and appropriate equipment for the activity that I am about to undertake, I acknowledge that this activity has risk, including inherent risks that cannot be eliminated without drastically altering the character of this activity. The same elements that help create the unique character of this activity may cause loss or damage to my equipment, accidental injury, illness, permanent disability or death. I understand that Alaska Geographic does not want to reduce my enthusiasm for the activity, but wants me informed in advance about the activities’ inherent risks.

Alaska Geographic activities generally take place in the outdoor environment where I will be subject to many risks, both environmental and otherwise. Activities may vary depending on the course or event, but often include hiking, river crossings, camping, sea kayaking, canoeing, snowshoeing, skiing, trail work, volunteer labor and being a passenger in a vehicle, airplane, train or watercraft. Other activities may be undertaken depending upon the intent of the course. All of these activities have common and inherent risks associated with them. Due to the remote and challenging nature of Alaska, the terrain and conditions during our travel and activities will pose additional risk. More detailed information about the physical activities and challenges for your particular course are included in the overview documents provided to you.

Illness and medical conditions can jeopardize my safety and in some cases the environmental conditions and/or physical challenge during our activities can exacerbate the situation causing complications or death. The activities may occur in remote places that are a significant distance from definitive medical care. In addition, the difficulty of communication and transportation can significantly delay evacuation to a medical facility. I agree that my physical fitness at the start of the program allows me to safely participate. Any medical concerns I have related to the activities, I have verified with a physician that I am safely able to participate. All information on the medical form is complete to the best of my knowledge and I will notify Alaska Geographic of any changes in my condition before the start of the program. I authorize Alaska Geographic to obtain and/or provide emergency hospitalization, surgical, or medical care for me.

Decisions are made by the instructors and participants, often while immersed in the wilderness context. These decisions are dependent upon a variety of perceptions and evaluations that by their nature are imprecise and subject to error in judgment. Participants may experience unsupervised time during periods where the staff is not needed for their technical expertise. At all times, I, as a participant am responsible for my own safety, and should take reasonable responsibility for the safety of other participants in the program.

I agree to submit any disagreement under this document or with Alaska Geographic first to confidential mediation. Each party agrees to meet in Anchorage, Alaska with a mutually agreed upon mediator.

I am aware that the proposed Alaska Geographic activities include the risk of injury or death. I recognize that the description of risks given above is not complete, and that other unknown risks may result in property loss, injury, or death. I fully acknowledge the inherent risks in these activities, both those identified in this document as well as those not identified. My participation in this activity is voluntary, I am not forced to participate, and I am participating with full knowledge of these risks.

Alaska Geographic 241 North C Street, Anchorage AK 99501
RELEASE FROM LIABILITY
In addition to acknowledging the inherent risks of the activities I will undertake, I further agree, to the maximum extent permitted by applicable law, to the following waiver and release from liability:

I agree, for myself, my heirs and my personal representatives, to hold harmless, release and forever discharge Alaska Geographic, and its current and former officers, employees, agents, and insurers, from and against any and all claims, relating to any accident, illness, personal injury, property damage, removal from participation in the activity, or death. I specifically acknowledge that hazards or accidents may arise from the negligence, or alleged negligence, of Alaska Geographic staff and contractors, and I specifically intend to waive and release claims against Alaska Geographic which may arise from negligence. This waiver and release does not waive or release claims arising from gross negligence or intentional misconduct.

I understand that this release is voluntary in that there are other classes or activities that I could choose to undertake. I have read this release and understand it fully. I understand that signing this release is a condition of my participation in the activities and that this release is legally binding on me, my heirs, successors, and assigns. I am giving up certain rights to sue Alaska Geographic and its representatives for injuries, damages, or losses that I may incur, even if caused by the alleged negligence of Alaska Geographic, its employees, agents, and contractors.

Therefore, I, and my parent(s) or guardian, if I am a minor, assume and accept full responsibility for me and for injury, death, and/or loss of personal property and expenses suffered by me and them as a result of the risks identified in this document and activity descriptions.

MEDIA PERMISSION: I give Alaska Geographic permission to use photographic images, written material, video and/or audio that include me or created by me for media produced and distributed by Alaska Geographic and its partner organizations. This includes use on websites and social media sites used by Alaska Geographic and its partner organizations.

I, and my parent(s) or guardian, if I am a minor, have read, understood, and accepted the terms and conditions stated herein and acknowledge that this agreement shall be effective and binding upon myself, my heirs, assigns, personal representative of estate, and all of my family members. This agreement will apply until replaced or cancelled in writing, or for up to one year from date of signature.

Signature: ___________________________ Date: ________________

If the participant is under 18, I am signing this as parent or guardian to reflect my agreement to this document. (Please include the minor’s signature in the above section.)

Signature: ___________________________ Date: ________________
REGISTRATION FORM

NAME: ___________________________ UA ID (or SSN): __________

Please print (Last) (First) (MI)

Previous names used at the University of Alaska: ___________________________

SEMESTER OF ENROLLMENT: Year __________ Fall ☐ Spring ☐ Summer ☐ Date of Birth (MM/DD/YYYY): __________________________

CURRENT MAILING ADDRESS:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
(City) (State) (Zip)

Phone: ___________________________ Cell Phone #: __________________________

Email Address: ___________________________

YES! Please text me class information updates.

DEMOGRAPHIC INFORMATION:
Your response helps us better serve students and impacts NWC's eligibility for some funding sources. See Page 2 for information and codes.

Sex: ☐ Male ☐ Female ☐ Prefer not to answer Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race: ___________________________ Yes/Military Status: ___________________________

US Citizen? ☐ Yes ☐ No If no, Nation of birth: ___________________________
Nation of citizenship: ___________________________

Visa Type: ___________________________ Permanent Resident? ☐ Yes ☐ No

For instructions on withholding directory information, please see INFORMATION RELEASE on reverse side.

PRIOR EDUCATION INFORMATION
Did you graduate from high school? ☐ Yes Graduation date? (MM/Year): __________________________ Name of high school: __________________________
High School location: (city/state): __________________________

☐ No If NO, did you complete the GED? ☐ Yes ☐ No Date GED completed? (MM/Year): __________________________ Location of GED (state): __________________________

COURSE INFORMATION (Complete all information requested below. Refer to the class schedule on UAOnline for course information)

<table>
<thead>
<tr>
<th>CRN</th>
<th>Dept.</th>
<th>Course Number</th>
<th>Section</th>
<th>Course Title</th>
<th># of Credits</th>
<th>&quot;Yes&quot; if Audit</th>
<th>Instructor Signature (required after last day of late registration)</th>
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I understand I am responsible for all applicable UAF academic regulations, tuition and fees whether or not I successfully complete the course or courses in which I am enrolling. The university may drop me for non-payment.

I promise to pay attorney's fees and other reasonable collection costs necessary for the collection of any amounts owed UA. If I do not pay, the university may take my Permanent Fund Dividend under Alaska Statutes 14.40.251 and 43.23.073.

Student's Signature ___________________________ Date: __________________________

Advisor's Signature (for degree-seeking students only): ___________________________ Date: __________________________

Processed By: ___________________________ Date: __________________________

Office use only

Page 1 of 2 10/2016
SECONDARY STUDENT PARENT/GUARDIAN AGREEMENT

Student name

Student UA ID or social security number

Student Birthdate

The secondary student registration process at the University of Alaska Fairbanks requires parents/guardians of secondary students to agree to these terms. This agreement identifies some of the issues encountered by secondary students, but should in no way be considered comprehensive. This agreement needs to be completed once for a secondary student attending the University of Alaska Fairbanks.

As a parent/guardian of the above secondary student, I understand and agree that:

- University work is much more rigorous and less guided than secondary course work. Adult themes and diverse perspectives are essential to University materials and discourse.
- The student must meet the prerequisites of the course or courses in which they want to enroll.
- A secondary student who registers in University courses is fully responsible for complying with all policies and procedures of the University. This includes being aware of and adhering to the University Student Code of Conduct and payment deadlines.
- It is the student’s responsibility to contact their high school counselor before enrolling at UAF if they want to use university credit to meet high school requirements.
- Courses taken will establish an official university transcript. This may impact future admissions, financial aid eligibility and/or ability to graduate with honors.
- Regardless of age, FERPA rights are transferred to the student upon registration. Parents/Guardians will not be able to access student records without a valid FERPA Release Form on file with the University.
- If a student decides to no longer attend a course, they must complete the appropriate steps to drop or withdraw from that course. Failure to do so may result in a failing grade and/or financial obligations including late fees.

I affirm that the information I have provided on this form is true and that I am in agreement with any additional charges that may be added to my account resulting from the above selections. I agree to pay all current semester charges, including but not limited to tuition, fees, housing, meal plan charges, and any additional fees on this form. I promise to pay attorney’s fees and other reasonable collection costs, which may be based on a percentage at a maximum of 40% of the debt, necessary for the collection of any amounts owed to University of Alaska. If I do not pay, the university may take my Permanent Fund Dividend under Alaska Statutes 14.40.251 and 43.23.073 and pursue other collection methods.

Parent/guardian name

Parent/guardian UA ID or social security number

Parent/guardian Birthdate

Parent/guardian signature

Date

Office Use Only

Processed By: __________________________ Date: _______________ Page ___ of ___
AUTHORIZATION FOR USE OF IMAGES AND OR VIDEO

Name: __________________________________________

(Youth Applicant/Participant)

Date of Birth: ____________________

Please Check:

_____ Yes, I give permission/authorization for images and/or video of my child to be used for any news, promotion, or education materials produced by Kawerak or related agencies.

_____ No, I do not give permission/authorization for images and/or video of my child to be used for any news, promotion, or education materials produced by Kawerak or related agencies.

Acknowledgement: I hereby acknowledge that I will respect and follow the Camp Rules at the Kawerak Kativik Cultural Center’s Archaeology Camp, as explained to me by my camp staff. I hereby agree to abide by and enforce all such rules at all times while at the Solomon site and all other camp activities.

Release: I understand that there are inherent risks involved in camping and with camp activities at Archaeology Camp. I understand that Kawerak, Inc. and the Solomon Traditional Council does not warrant, guarantee, promise or make any representations as to the condition of the camp site or any facilities, equipment, or other improvements thereon, or the fitness thereof for any purpose. I hereby release, discharge and hold harmless Kawerak, Inc. and/or Solomon Traditional Council, their officers, directors, employees, agents, representatives, successors and assigns, of and from all liability, claim, demand or action, arising from or related to bodily injury or personal injuries know or unknown, death, or property damage resulting from my participation at Archaeology Camp. I personally assume all risks and take full responsibility for my participation and any resulting loss or damage to persons or property while participating at the Archaeology Camp.

Indemnification: I hereby agree to defend, indemnify and hold harmless to the fullest extent of law Kawerak, Inc. and/or Solomon Traditional Council and their officers, directors, employees, agents, representatives, successors and assigns against third party claims related to my participation at the Archaeology Camp, to the extent of my own negligence or fault.

Authorization For Emergency Treatment: I, the undersigned participant, or parent, guardian or custodian if the participant is under 18, hereby consent to and authorize the administration and performance of all needed medicines, surgical treatment, anesthetic, or other medical treatment, which, in the opinion of the attending physician, may be necessary and advisable in the event of any medical emergencies to the participant. I further consent to and authorize first responders, including persons on site at the camp, to administer initial emergency medical treatment (first aid) in the event of such emergency. It is understood that efforts shall be made to contact the undersigned parent, guardian or custodian (if applicable) prior to rendering emergency treatment to the participant.
Acceptance of Terms

I, __________________________, have carefully read all portions of this Acknowledgement and Release form, know the contents thereof, agree to all terms, and sign this form as a voluntary and knowing act.

Signature: _________________________ Date: ______________

If signed on behalf of a minor:
Relationship of person signing Release and Acknowledgment to Minor: ________________
(Note: must be Minor’s parent, guardian or custodian)

Participant’s Name: ___________________________ Date of Birth: ______________
Address: __________________________________________________________________________
Participant’s health and accident insurance: ____________________________________________

Emergency Contact Name: ____________________________________________________________
Phone #: ____________________________
**NSHC Authorization to Use and Disclose Health Information**

(Norton Sound Health Corporation to Release Information to Other Party)

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Birth Date: <em>/__/</em>___</th>
<th>Ph. #: <em>/__/</em>___</th>
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</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Medical Record #:</td>
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</tbody>
</table>

I authorize Norton Sound Health Corporation (NSHC) to disclose Patient's health information as described below:

**Health information is to be disclosed to and received and used by:**

**Fill in the name of the person or facility with an address, number & a fax number**

**Name/Facility or Self:** Kawerak, Kativik Cultural Center  
**Address:** PO Box 1882, Nome, AK 99762  
**Phone Number:** 907 443-4342 / 5231  
**Fax Number:** 907 443-4452

*Select Format: □ Paper Form □ Secure Compact Disc (CD)*

**For the purpose(s) of:** □ At my request  
**X** Other purposes (specify each purpose): verification of negative TB

**Purpose for attendance at Kativik Cultural Center annual Youth Archaeology Camp, July 7-14, 2019**

**Description or nature of information to be disclosed and includes information in any medium, including paper, electronic, and other formats:**

□ Discharge summaries  
□ History & physical exams  
□ Consultations  
□ Operative reports  
□ Physician progress notes  
□ Nursing notes  
□ Medication records  
□ Pathology reports  
□ Radiology & imaging reports  
□ Laboratory reports  
□ EKG Reports  
□ Emergency Dept. records  
□ Billing statements  
□ Clinic or office notes

**Specially Protected Information about:**  
□ Mental health treatment  
□ Drug/alcohol abuse diagnosis, treatment, & referral  
□ HIV/AIDS Information

**Records for the following dates or treatment:** **Most recent TB screening results**  
(Specify the information you are requesting with the Months, Dates, and or Years)

□ ALL MEDICAL RECORDS:

All health records from NSHC (Minimum Necessary for purposes of disclosure) (Excludes the above Specially Protected Information unless box(es) checked.)

**Notice:**

1. There is the potential for information disclosed under this authorization to be re-disclosed by the recipient and no longer protected by federal or state privacy laws. But, if the information being disclosed under this authorization includes HIV/AIDS, mental health, and drug/alcohol abuse information, then federal or state law may prevent the recipient from re-disclosing this information.

2. I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for benefits, or to obtain payment for services unless this authorization is sought for purposes of research-related treatment, to determine my eligibility or enrollment in a plan, for underwriting or risk determinations, or if the services related to the information to be disclosed are performed solely for the purpose of providing that information to someone else.

3. I may revoke this authorization at any time by notifying, in writing, the Director of Health Information Management of NSHC; however, any such revocation will not apply to any disclosure or action already undertaken based on this authorization.

4. I will receive a copy of this authorization after it is signed. I may inspect or request copies of information disclosed by this authorization.

**Dates**

Unless revoked, this authorization is valid for the following time period:

| Beginning date: _/__/____ | Ending (expiration) date: _/__/____ |

**Signature:**

I have read this authorization; I have had an opportunity to ask questions; I understand this authorization; and I willingly am signing this authorization.

Signature of Patient or legal/personal representative

Date: _/__/____

**If not signed by Patient, Authority to sign on behalf of Patient:**

(Specify relationship to the Patient)

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Authorization to Use or Disclose Health Information  
Adopted _________, 2011  
By the NSHC Board of Directors
PATIENT E-MAIL OR TEXT MESSAGE AUTHORIZATION FORM

I, ____________________________, authorize Norton Sound Health Corporation (NSHC) to contact me at the following email address or phone number:

______________________________________________________________________________

Risks:

- I understand that if NSHC contacts me by e-mail or text, the most likely risk to my personal health information is that information intended for me could be sent to the wrong person by mistake.
- I also understand that there is a risk that my e-mail account could be hacked, and that e-mail sent to me could be monitored, intercepted, read, and/or altered before it reaches my e-mail in-box.
- I have been informed that internet e-mail is sent via relay servers, and that anyone with access to a relay server has the ability to read an e-mail saved on the relay server. I have also been informed some relay servers store copies of the messages even after they have been sent to the final recipient.

Acknowledgement and Agreement:

1. I have read and understand the risks associated with e-mail communications, and I understand there may be additional risks not described here.
2. I understand that NSHC cannot control who reads my e-mail or text messages, while in route or when delivered to my e-mail account or phone.
3. I hold NSHC harmless from any liability for sending my protected health information by e-mail or text message, or for any unintentional misdirection of e-mail or text messages to someone other than me.

I have read and understand the risks associated with e-mail and text communications. By signing this authorization, I confirm that it accurately reflects my wish to receive health information by e-mail or text message, and I will not hold NSHC liable for any unintentional disclosure of my health information in an e-mail or text message. I understand that I may revoke this authorization in writing at any time.

Name of Patient ____________________________ Patient Date of Birth ____________________________

Signature of Patient or Legal Representative ____________________________ Date ____________________________

Printed Name of Patient’s Legal Representative ____________________________ Relationship to Patient ____________________________

If not signed by patient, description of authority: ____________________________