NIMIIPUU HEALTH

Patient Comment Form

INSTRUCTIONS: Please complete this form so that we can follow up on your comment(s) as quickly as possible and get back to you with a solution. Please summarize and be sure to include all pertinent information (who, when, where).

What are your recommendations for a resolution?

"I understand that by making this comment I do hereby authorize the Nimiipuu Health, and any and all staff or employees, to release otherwise confidential information from my medical records as necessary to fully investigate this comment. I also release Nimiipuu Health, its staff and employees, from any and all civil or criminal liability which may arise as a result, direct or otherwise, from the disclosure of this information."

Signed _____ Date: _____

Address: _____ Telephone: _____

PLEASE SUBMIT OR FAX TO: NIMIIPUU HEALTH - ATTN: PATIENT ADVOCATE
P O DRAWER 367
LAPWAI, ID 83540 FAX: (208) 843-2102