PROTECTED HEALTH INFORMATION, THIRD-PARTY PAYER NOTICE TO PATIENTS, ADVANCE DIRECTIVES

1. Protected Health Information

a. Notice of Privacy Practices: I acknowledge receipt of the Texas Health Resources Notice of Privacy Practices. _____ Initials

b. Use and Disclosure of information: I understand that my medical records are confidential and cannot be disclosed without my written authorization except when otherwise permitted or required by law. This disclosure is addressed in the Notice of Privacy Practices I have received. I understand that my medical information may include communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment and alcohol and substance abuse diagnosis or treatment, and I authorize release of that information as part of my medical record. I understand that the hospital must keep my medical records for a time required by law and then may dispose of them as permitted or required by law.

c. Consent for Health Information Exchange: I authorize the Texas Health Resources hospitals and Texas Health Physicians Group to use my medical information described in the previous paragraph for my continuing medical treatment and to release my medical information described above to my health care providers using the Health Information Exchanges in which hospitals participate. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient provider and no longer protected. A Health Information Exchange is an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards. Your information will be stored with the HIE system, but it will not be visible to or able to be used by providers unless you opt-in to participate. Providers will attempt to exclude clearly identified mental health and substance abuse health information from the HIEs, however some information may be included.

I understand that treatment or payment cannot be conditioned on my signing this authorization. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. I may submit a revocation request to the Health Information Management Department (Medical Records Department) of the Texas Health hospital or Texas Health Physicians Group for processing. This authorization will remain in effect indefinitely, unless I revoke it in writing. Obstetric patients only: I also give this authorization for any child(ren) born to be during this hospitalization.
The HIE is not able to manage restrictions on disclosure of your health information. A restriction is a request by the patient to not disclose certain information to certain people or companies. If the restriction is or was agreed to by us or other participating HIE healthcare providers, then you must elect to opt-out of the HIE in order to protect your restriction. This must be done at each HIE participating provider you visit.

I authorize release of my medical information to the Health Information Exchanges in which hospitals participate:
_____ Yes _____ No
(Patient Access Services: Enter "No" in the RHIO field when the patient declines to participate.)

d. Authorization for Verbal Release of Protected Health Information Privacy Selection:
Directory Information. I understand that "Directory Information", such as my presence in the hospital and room number, as described in the Texas Health Resources Notice of Privacy Practices, may be released to all who ask for me by name, unless I object by specifically asking to be a "No Information" patient as described below:

☐ **No Information** - I do not authorize release of any information, including Directory Information, regarding my admission or treatment. I choose to be a "No Information" patient, and I realize that mail, flowers, telephone calls, and visitors will be refused on my behalf. (The hospital staff will not be able to acknowledge my presence.) I also understand that if I make phone calls from the hospital, caller identification systems may result in my location being disclosed to persons who receive the calls.
Medical Information and Disclosure. I understand that medical information about my condition and treatment, may not be released, except in situations as described in the Texas Health Resources Notice of Privacy Practices, **unless I give my permission as provided below:**

I authorize this hospital and medical staff members to discuss my medical history, diagnosis, treatment, and prognosis with the person(s) listed below. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health, and drug, alcohol or chemical abuse:

☐ Spouse _____
☐ Children _____
☐ Parent(s) _____
☐ Others _____
☐ None

Note: *I understand my medical information will not be discussed via telephone with the person(s) named above if I choose to be "No Information" since telephone calls will be refused on my behalf.*
The above *Authorization for Verbal Release of Protected Health Information* will expire at the end of my hospitalization or outpatient service unless I revoke the consent prior to that time.

2. Notice to patients - Third party payer information:
I acknowledge that based on the information I have provided at this time about my insurance or other third-party coverage, this Hospital __ IS / __ IS NOT a participating provider under my insurance plan or other third-party payer coverage.

I understand that some of the doctors, including facility-based doctors who provide services to me while I am in the Hospital, may or may not be a participating provider with the same third-party payers as the Hospital. For example, my admitting doctor, hospitalists, emergency room doctors, pathologists, radiologists, anesthesiologists, neonatologists, and others, bill separately from the hospital and might not participate in the same health plans as this hospital. I will be responsible for paying those providers subject to the terms of my health plan or insurance, if any.

I understand I may ask for a list of facility-based doctors who have been granted medical staff privileges to provide medical services at this Hospital. I may request information from a facility-based doctor(s) regarding whether he/she has a contract with my health benefit plan and under what circumstances I may be responsible for payment of any amounts not paid by my health benefit plan.

3. Advance directives:

a. To be completed for Hospital outpatients and emergency room patients only

Are you presenting an Out-of-Hospital DNR order or bracelet?	___ Yes ___ No	Copy provided?	___ Yes ___ No

b. To be completed for Hospital inpatients and outpatients undergoing invasive procedures only:

1. Who is answering the following questions? Patient?	___ Yes ___ No	Person with patient?	___ Yes ___ No
2. Was printed information about advance directives offered to you?	___ Yes ___ No	Information received?	___ Yes ___ No
3. Do you have a directive to physician (living will)?	___ Yes ___ No	Copy provided?	___ Yes ___ No
4. Do you have a medical power of attorney?	___ Yes ___ No	Copy provided?	___ Yes ___ No
5. Do you have a mental health directive?	___ Yes ___ No	Copy provided?	___ Yes ___ No
6. Are you presenting an out-of-hospital DNR order or bracelet?	___ Yes ___ No	Copy provided?	___ Yes ___ No
7. Would you like to discuss advance directives with a Hospital staff member?	___ Yes* ___ No	Referred to: _____	

I understand it is my responsibility to provide a copy of my advance directives to the Hospital.
(*Hospital Staff Note: Shaded area indicates that advance directive follow-up documentation is required).

4.Patient rights and responsibilities: I have received written information regarding my rights and responsibilities as a patient. This information tells me how to register complaints I might have.
Outpatients only: If I am registering as an outpatient, I understand this form shall be valid during my present visit and future outpatient visits at the Hospital until revoked by me or I sign a new Protected Health Information, Third-Party Payer Notice, Advance Directives form.

Acknowledgement:
I, the undersigned, certify that I have read and fully understand the information in this Protected Health Information, Third Party Payer Notice to Patients, Advance Directives form. I understand that if I need to change any information I have provided on this form, I will notify a Hospital staff member promptly.

Signature of patient or authorized representative	Relationship to patient	Date	Time
Witness	Title	Date	Time

If the person signing this form is not the patient, please give full name, phone number and address:

Name

Phone number Address

HOSPITAL NAME MUST BE FILLED IN BLANK BELOW

PATIENT IDENTIFICATION

Texas Health Resources® _____

9100

Protected Health Information, Third-Party Payer Notice, Advance Directives
998543137 (Rev. 11/12) Page 1 of 1