FORM_HIP_PROTECTED HEALTH INFORMATION Authorization to Release Form

System Documents

I, _____, hereby authorize _____ (the "Center") to disclose health information regarding the following patient:

Patient Name: _____ Date of Birth: _____
Address: _____ Patient's Phone: _____
_____

1. The information is to be disclosed to the following persons or organizations:
   Name: _____
   Address: _____
   _____

2. Purpose. The purpose of the use or disclosure is:
   ☐ At the request of the patient
   ☐ Other:
   _____
   _____

   If the purpose is for marketing, will the Center receive direct or indirect compensation or payment in return for using or disclosing the patient's health information? ☐ YES ☐ NO

3. Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to services provided on or around _____ *(insert dates)*:

   ☐ The following medical records:

   - ☐ Discharge summary
   - ☐ Lab results
   - ☐ History and physical exam
   - ☐ Consultation reports
   - ☐ X-ray reports
   - ☐ HIV/AIDS test results and treatment
   - ☐ Alcohol and drug treatment records
   - ☐ Operative record
   - ☐ Progress notes
   - ☐ Photographs, videotapes, or other images
   - ☐ Mental or behavioral health records
   - ☐ Psychotherapy notes
   - ☐ Genetic test results
   - ☐ Entire medical record
   - ☐ Summary of treatment
   - ☐ Other (specify):

   ☐ The following billing and payment information:

   _____
   _____

   ☐ Other information:

   _____

4. Revocation. I understand that I may revoke this authorization at any time by sending a written notice to the Center. However, the revocation will not have any effect on any uses or disclosures the Center may have made before the revocation was received.

5. Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) calendar months after the date this authorization is signed.

6. Redisclosure. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.

7. Refusal to Sign. I understand that I may refuse to sign this Authorization and that the Center will not condition treatment on whether I sign this Authorization.

8. Certification. I certify that I am *(check whichever applies)*:

☐ the patient, and the identification that I have provided is true and correct.
☐ the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of ____________________.

Signed this _____ day of ____________, 200__.

Signature:

____

Print name:

____

Address:

____

____

Phone No:

____

Witness: ______________________________

Print Name: ______________________________

Date: ______________________________

(ONE COPY TO BE RETAINED BY THE REQUESTING PARTY)

- -

For Office Use Only:

Date received: ________________ Expiration date: ______________

How was identity verified? ____________________ Copy made? ☐ Yes ☐ No

How was authority verified?: ____________________ Copy made? ☐ Yes ☐ No

By: ______________________________ Title: ______________

Date: __________

DIGESTIVE
HEALTH CENTER AT
REDBIRD SQUARE

Patient's Rights and Notification of Physician Ownership

Every patient has the right to be treated as an individual and to actively participate in and make decisions regarding his/her care. The facility and medical staff have adopted the following patient rights and responsibilities, which are communicated to each patient or the patient's representative/ surrogate prior to the procedure.

PATIENT RIGHTS

- Patients shall be treated with respect, consideration, and dignity
- Patients shall be provided appropriate privacy
- Patient records shall be treated confidentially and, except when authorized by law, patients shall be given the opportunity to approve or refuse their release
- Patients shall be provided, to the degree known, appropriate information concerning their diagnosis, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information shall be provided to a person designated by the patient or to a legally authorized person
- To be informed of their right to change providers if other qualified providers are available
- Patients shall be given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons
- Information shall be available to patients and staff concerning:
  - Patients' rights
  - Patient conduct and responsibilities
  - Services available at the Center
  - Provisions for after-hours and emergency care
  - Fees for services
  - Payment policies
  - Patient's right to refuse to participate in experimental research
  - Methods of expressing complaints and suggestions to the Center
- Marketing or advertising regarding the competence and/or capabilities of the organization shall not be misleading to patients
- If the need arises, reasonable attempts are made to communicate in the language or manner primarily used by the patient

PATIENT RESPONSIBILITIES:

- To provide complete and accurate information to the best of their ability about their health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
- To follow the treatment plan prescribed by their provider, including pre-operative and discharge instructions
- To provide a responsible adult to transport them home from the facility and remain with them for 24 hours, if required by their provider
- To inform their provider about any living will, medical power of attorney, or other advance healthcare directive in effect
- To accept personal financial responsibility for any charges not covered by their insurance
- To be respectful of all healthcare professionals and staff, as well as other patients

Continued

If you need an interpreter:

If you will need an interpreter, please let us know and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.

Rights and Respect for Property and Person

The patient has the right to:

- Exercise his or her rights without being subjected to discrimination or reprisal.
- Voice a grievance regarding treatment or care that is, or fails to be, furnished.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.
- Confidentiality of personal medical information.

Privacy and Safety

The patient has the right to:

- Personal privacy
- Receive care in a safe setting
- Be free from all forms of abuse or harassment

Statement of Nondiscrimination:

- **Digestive Health Center at Red Bird Square** complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- **Digestive Health Center at Red Bird Square** cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.
- **Digestive Health Center at Red Bird Square** 遵守適用的聯邦民權法律規定, 不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Advance Directives:

An "Advance Directive" is a general term that refers to your instructions about your medical care in the event you become unable to voice these instructions yourself. Each state regulates advance directives differently. STATE laws regarding Advanced Directives are found in Texas Health and Safety Code §166.-001-048. In the state of Texas, a patient has a right to an advance directive which will communicate their wishes about medical treatment at some time in the future when they are unable to make their wishes known because of illness or injury. In addition to this advance directive, Texas law provides for two other types of directives: the Medical Power of Attorney; and the Out-Of-Hospital Do Not Resuscitate Order. You have the right to informed decision making regarding your care, including information regarding Advance Directives and this facility's policy on Advance Directives. Applicable state forms will also be provided upon request. A member of our staff will be discussing Advance Directives with the patient (and/or patient's representative or surrogate) prior to the procedure being performed.

Complaints/Grievances: If you have a problem or complaint, please speak to one of our staff to address your concern. If necessary, your problem will be advanced to center management for resolution. You have the right to have your verbal or written grievances investigated and to receive written notification of actions taken.

The following are the names and/or agencies you may contact:

Jessica Raphael, MBA, RN, CCM
DIGESTIVE HEALTH CENTER AT RED BIRD SQUARE
3107 W Camp Wisdom Rd, Suite 189
Dallas, TX 75237 | (214) 331-2922

You may contact the state to report a complaint;
Health Facility Compliance Group (MC1979)
Texas Department of State Health Services,
PO Box 149347; Austin, TX 78714 – 9347

Complaint hotline: 888.973.0022 Form: Health Facility
Form: Health Facility Complaint Form
Email: mailto:hfc.complaints@dshs.state.tx.us
State Web site: http://www.dshs.texas.gov/facilities/asc/default.aspx

Medicare beneficiaries may also file a complaint with the Medicare Beneficiary Ombudsman.

Medicare Ombudsman Web site: http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Medicare: www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)
Office of the Inspector General: http://oig.hhs.gov

This facility is accredited by the **Accreditation Association for Ambulatory Health Care (AAAHC)**. Complaints or grievances may also be filed through: AAAHC 5250 Old Orchard Road, Suite 200, Skokie, IL 60077 Phone: 847-853-6060 or email: info@aaahc.org

Physician Financial Interest and Ownership: Physician Financial Interest and Ownership: The center is owned, in part, by the physicians. The physician(s) who referred you to this center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with federal regulations. **THE FOLLOWING PHYSICIANS HAVE A FINANCIAL INTEREST IN THE CENTER:**

Dr. Vineel Kankanala
Dr. Prashant Kedia
Dr. Janardhan Konda
Dr. Jeffrey Linder
Dr. Charles Lostak
Dr. Randal Macurak
Dr. Armond Schwartz
Dr. Paul Tarnasky
Dr. Walter Young

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