

Patient Code Number (last three digits of MRN): _____

Designated Contact Information

We want to make every effort to ensure patient privacy. We ask each patient to choose one or two individual(s) as their Designated Contact Person(s). If the patient is unable to communicate for any reason, the Designated Contact Person(s) will be the only individual(s) given information about the patient’s condition. When requesting information, the Designated Contact Person(s) will be asked to give the patient’s full name and the identifying code number given to them by the hospital. We ask that only the Designated Contact Person(s) be given the identifying code number. Any other inquiries about patient condition will be referred to these individuals.

1. Designated Contact Person:

Name _____ Relationship to pt _____
Home _____ Work _____
Cell _____ Pager _____

2. Designated Contact Person:

Name _____ Relationship to pt _____
Home _____ Work _____
Cell _____ Pager _____

General Admission Information

We want your stay to be as pleasant as possible. This packet is designed to provide you with important and useful information about your stay at The George Washington University Hospital.

The following information is included in this packet:

Patient Information and visitor Guide

- Patient Rights and Responsibilities
- Pain Management
- Be Involved in Your Care
- FAQs on Preventing Infections
- Patient Complaint/Problem Resolution
- Rapid Response Team Information
- Smoking Cessation Information
- Advanced Directive Information and Form
- Volunteer and Chaplain Information
- Senior Advantage Program
- Hospital Safety Information

The hospital is not responsible for patients’ personal belongings. It is highly recommended that personal belongings be sent home with friends or family members.

Belongings taken home by (print name) _____

Please sign below to indicate that you understand that you have been given this information.

Patient/Family _____ **Relationship** _____ **Date** _____



THE GEORGE WASHINGTON
UNIVERSITY **HOSPITAL**

Patient Label



EL4000

Admission Information

Treatment Authorization

As the individual who will be receiving services at _____ (the "Hospital"), or the parent or guardian of the individual listed below as the patient, I agree to the following terms and conditions of this Treatment Authorization Agreement (the "Agreement"). As applicable, I further agree that the terms and conditions of this Agreement apply to any newborn infant(s) I deliver while I am a patient in the Hospital.

Consent to Hospital Procedures

- I consent to medical and surgical procedures that might be performed during this hospitalization or outpatient visit, including emergency treatment or services for the patient. These services may include but are not limited to laboratory tests, X-rays, medical or surgical treatment or procedures, anesthesia, and hospital services rendered to me under the general and special instructions of the attending Physician or Surgeon.
- I hereby authorize the "Hospital" to recognize my attending Physician as the manager of my medical and/or surgical care and treatment. I consent to and authorize my attending Physician and/or his/her designee, to administer treatment (medical, surgical, anesthetic, obstetrical and/or any other therapeutic or diagnostic procedure) that he/she/they may dictate as advisable for my wellbeing. I understand that video or telephone consultation/evaluation may be used as a part of my care or treatment. I understand that the "Hospital" will provide medical and insurance information to my designated primary care Provider and/or referred healthcare Providers for the purpose of continuing care.
- I understand that the "Hospital" may have affiliations with a variety of health care related educational programs. These programs may include but are not limited to: Nursing, Medical, EMT, Surgical Technician and Physical Medicine. I consent to have students participate in my care under the supervision of their instructor(s) and understand that I must express any refusal to have them participate to a management representative such as Charge Nurse, Nurse Manager, shift Manager, department Director, Senior Manager, etc.
- The nature of the operation/treatment has been explained to me. I am aware that the practice of medicine and surgery is not an exact science. **No** warranty or guarantee has been made to me as to a cure or the treatment's result.
- I authorize the "Hospital" to retain, preserve, and to use for scientific or teaching purposes, and properly dispose of any specimen or tissue removed from my body during this hospitalization or outpatient visit.
- I understand that pictures may be taken of my medical/surgical condition or treatment. I understand that pictures might be used for purposes of my diagnosis, treatment, or for educational training programs conducted by the hospital. These pictures will be part of the documentation in my medical record.

Special Consent for HIV Testing and Other Blood Borne Pathogens

I understand that this consent form covers testing for blood borne infectious diseases, including but not limited to hepatitis, acquired immune deficiency syndrome (AIDS), and human immunodeficiency virus (HIV). A physician may order such test(s) for diagnostic purposes to determine the appropriate treatment and/or treatment procedures for me or to protect the attending Physician and/or any employee or agent of the "Hospital" exposed to my bodily fluids in a manner which could transmit such disease.

Non Smoking Campus

I understand that smoking is not permitted on the campus of the "Hospital", except in designated areas, and I agree to comply accordingly.

Treatment Authorization



CO0058

UHS-9011(SMS)
Rev. 04/2019

Patient Identification

DOB:
MRN:

SX:

Treatment Authorization

Physician Providers Are Not Hospital Employees

I acknowledge and agree that the "Hospital" is not responsible for the judgment or conduct of any Physician who treats or provides a professional service to me, but rather each Physician is an independent contractor who is not the agent, servant, or employee of the hospital. The "Hospital" or affiliate agency is not liable for any acts or omission made by any Physician or in following the order of the Physician.

Personal Valuables

I understand that the "Hospital" maintains a safe for the safekeeping of money and other valuables, and that the "Hospital" is not liable for the loss of my valuables unless they are deposited with the "Hospital" for safekeeping. I understand that I am responsible for all my personal effects not deposited in the safe, including, but not limited to, personal grooming articles, jewelry, clothing, documents, medications, eye glasses, hearing aids, dentures and other prosthetic devices.

Signatures - Please read before signing

This is to certify that I, the undersigned, being the patient, or another person legally authorized to act for the patient, have carefully read and fully understand this treatment authorization and am duly authorized to execute the above and accept its terms.

The undersigned acknowledges having read and received a copy of this document. A copy of this authorization shall be as valid as the original.

Patient/Authorized Signature

Date/Time

Witness Signature

2nd Witness Signature for Verbal Consent

Treatment Authorization

Patient Identification

DOB:
MRN:

SX:



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Rev. 04/2019

Assignment of Benefits and Financial Responsibility

As the individual who will be receiving services at _____ (the "Hospital"), or the parent or guardian of the individual listed below as the patient, I agree to the following terms and conditions of this Assignment of Benefits and Financial Responsibility Agreement (the "Agreement"). As applicable, I further agree that the terms and conditions of this Agreement apply to any newborn infant(s) I deliver while I am a patient in the Hospital.

Irrevocable Assignment of Benefits and Right of Action

For good and valuable consideration, I make the following irrevocable assignments to the "Hospital".

- **Assignment of Health Insurance Benefits:** I irrevocably assign to the "Hospital" all benefits for services rendered by the hospital, payable by a health insurance company, health plan, worker's compensation program, ERISA plan, or any other entity responsible for payment of the patient's total hospital bill. This assignment extends to the amount of the patient's total hospital bill(s), with interest as allowed by law. I authorize and expressly direct such entity to pay benefits directly to the "Hospital". I also authorize and instruct any such entity to assign and pay directly to physician groups providing hospital based services such as Pathology, Radiology, Anesthesiology, Cardiology and Emergency Physician Services, any insurance benefits due them.
- **Assignment of Personal Injury Proceeds:** I irrevocably assign and transfer to the "Hospital" all benefits for services rendered to the patient by the hospital payable under Personal Injury Protection, Medical Pay, Uninsured/Underinsured, and/or Liability provisions of any insurance policy under which patient is entitled to benefits as the result of an occurrence causing the patient's injuries and treatment. I agree this assignment extends to the amount of the patient's total hospital bill(s), with interest as allowed by law. I authorize and expressly direct the insurance company to pay benefits directly to the "Hospital". I also authorize and instruct any such entity to assign and pay directly to physician groups providing hospital based services such as Pathology, Radiology, Anesthesiology, Cardiology and Emergency Physician Services, any insurance benefits due them.
- **Assignment of Claims and Right of Action:** I irrevocably assign and transfer to the "Hospital" all patient's rights, title and interest in any claim(s) patient may have against any third party responsible for causing patient's injuries, health insurance company, health plan, worker's compensation program, ERISA plan, or any other entity that is responsible for payment of the patient's hospital bill. I agree this assignment will allow the "Hospital" to pursue all legal and non-legal remedies against any such person and/or entity including the filing of a lawsuit as assignee of the patient. I agree that if it is necessary to retain legal counsel to enforce or utilize these assignment provisions, the "Hospital" is entitled to recover its attorney's fees and court cost as allowed by law. I understand that, subject to the terms of the applicable health plan(s), all persons signing this document may be financially responsible for charges not covered by this assignment of insurance benefits.

Release of Information for Insurance Billing Purposes

For the purpose of obtaining payment for services, I authorize the "Hospital" to disclose any and all medical billing records related to the patient's admission or outpatient visit, to a health insurance company, health plan, worker's compensation program, ERISA plan, or any other entity responsible for payment of the patient's hospital bill. Medical Billing records may include, but are not limited, to records of toxicology screens, hepatitis test results, psychiatric or psychological treatment, alcohol abuse, drug abuse, blood alcohol levels, HIV testing results, AIDS treatment, other records relating to the patient's diagnosis and treatment, and other protected health information. I understand there is a potential for information disclosed related to this authorization to be subject to re-disclosure by the recipient and no longer be protected. This authorization is subject to revocation in writing at any time, except to the extent that the person or entity previously authorized to make the disclosure has already taken action. If not previously revoked, this authorization shall expire one year from the date it is signed by the patient.

Assignment of Benefits

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Assignment of Benefits and Financial Responsibility

Physicians Bill Separately

Some physicians are employees of the hospital and some are independent contractors, not agents or employees of the hospital. I understand that each professional group or individual practitioner who renders professional services to the patient, including, but not limited to the Radiologist, Pathologist, Emergency Physician, Anesthesiologist and Cardiologist, may bill and collect for his/her professional services separate from the hospital's billing and collections. I agree to pay for any physician services performed on the patient's behalf and billed to the patient unless the physician has entered into agreement with the patient's insurance company to accept payment in full or unless otherwise provided by law. This professional billing is subject to the authorizations granted by me in this consent agreement.

Financial Agreement:

I understand that all estimates of charges given to me represent the approximate cost and are not guaranteed. I have the right to request an itemized statement and an explanation of the billing. I understand that I, as the patient or appropriate guarantor, am obligated to pay the account of the hospital/provider/physician in accordance with the regular rates and terms of the "Hospital"/Provider/Physician for the healthcare services the patient receives within 30 days of service, or if insured, within 30 days of either insurance benefits payment or denial. Should the account be referred to an attorney or collection agency for collection, I will pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the maximum legal rate. If payment is received from more than one source causing overpayment for this or any other period of hospitalization, I authorize application of the overpayment to any unpaid hospital bill for which the patient is legally responsible. I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that the information that I submit is subject to verification, including credit agency scoring, and subject to review by federal and/or state agencies and others as required. I authorize my employer to release to the "Hospital" proof of my income. I understand that if any information I have given proves to be untrue, the "Hospital" will re-evaluate my financial status and take whatever action becomes appropriate and/or necessary.

Authorization for Receiving Messages and Automated Calls

I give the "Hospital" and its agents and/or other parties calling on behalf of the "Hospital" (including, but not limited to, debt collectors or others calling regarding your hospital visit, government or charity care programs) permission to contact me by telephone at the telephone number or numbers I provided during the registration process, or at any time in the future, including wireless telephone numbers or other numbers that may result in charges to me. The "Hospital" and its agents may leave messages for me at these numbers and may send text messages or email communications using the email address or addresses I provide. These voice messages and email and text communications may include information required by law (including debt collection laws) related to amounts I owe the "Hospital" as well as messages related to my continued care and treatment. I also understand that the "Hospital" and its agents or other parties calling on the "Hospital's" behalf may use pre-recorded/artificial voice messages and/or use an automatic dialing device (an autodialer) to deliver messages related to my hospital visit, my account, whether I qualify for government programs, whether I qualify for charity care programs or amounts I may owe the "Hospital". I also authorize the "Hospital" and its agents to use the number or numbers provided for such pre-recorded or auto dial messages. If I want to limit these communications to a specific telephone number or numbers, I understand that I must request that only a designated number or numbers may be used for these purposes.

Medicare and Tricare Inpatients Only

I have received a copy of an IMPORTANT MESSAGE FROM MEDICARE (or TRICARE) regarding my rights as a Medicare or Tricare patient.

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Assignment of Benefits and Financial Responsibility

Medicare Certification, Authorization to Release Payment Information And Payment Request

I certify that the information given by me in applying for payment under title XVIII or XIX of the Social Security Act (Medicare) is correct. I authorize any holders of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on the patient's behalf.

When Written Authorization is Required for HMO/PPO Plans

I understand that if my health insurance carrier requires preauthorization, the "Hospital/Provider/Physician cannot guarantee that the patient's visit will be covered without a written pre-authorization document from the insurance carrier. If the "Hospital/Provider/Physician cannot obtain authorization for the patient's visit, I will be responsible for the unpaid balance that will include any charges for this visit's services/procedures/day(s) not authorized by my insurance/managed care plan. I understand that the "Hospital" accepts no liability for failure to meet my insurance carrier's pre-certification or post certification regulations that may be required of me. I agree to properly execute all pre-certification and post certification procedures. I understand that proper network/managed care indicators must be located either on my insurance card or the insurance company's explanation of benefits form to receive my managed care discount. I understand it is my responsibility to know if my managed care plan is affiliated with this "Hospital"/Provider(s) for services being provided to the patient.

Medicaid Managed Care Plans

I assign any and all insurance benefits payable to me to the "Hospital". I understand that I am responsible for payment for services rendered at the "Hospital" including excluded services from my insurance either because the plan deems such services not medically necessary, or for any other reason including pre-certification requirements, second opinions or pre-existing conditions. Should the account be referred to any attorney or collection agency for collection, I understand that I will be responsible for attorney or collection expenses. I give permission to my insurance provider(s), including Medicare and Medicaid, to directly pay this Hospital for my care instead of paying me. I understand that I am responsible for any health insurance deductibles and co-insurance and non-covered services. I further assign my rights to this "Hospital", and hereby appoint this "Hospital" as my personal representative, to (i) submit claims for payment for services and treatment rendered to me to payors, including but not limited to Medicare and Medicaid, and further assign my rights to /for payment for services and treatment rendered to me, and (ii) appeal from any and all denials of coverage, without limitation, to the "Hospital".

Courtesy in Filing Insurance Claims

I understand that as a courtesy, the hospital will file insurance claims for hospital services. I waive any rights of action against the hospital and it's employees for omissions in submitting insurance claims. I understand that I remain liable to the hospital for charges for services and goods for which I am legally responsible.

Private Room: (If applicable)

I understand and agree that if I request and receive a private room, I am responsible for any additional charges associated with this request.

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A Patient's Guide to Understanding Health Information Exchange

What is Health Information Exchange and why is it important?

Health Information Exchange, or HIE, is a way of instantly sharing health information among doctors' offices, hospitals, labs, radiology centers, and other health organizations. HIE allows delivery of the right health information to the right place at the right time, providing safer, more timely, efficient, patient-centered care.

Throughout the State of Maryland, CRISP—an independent nonprofit organization—is responsible for developing and maintaining the HIE. The CRISP HIE will allow the doctors and nurses treating you in a hospital or doctor's office to access your medical history. For example, doctors can review recent lab results whether the test was conducted at your primary care provider, at the hospital, or at participating labs across the State.

What are the benefits of having an HIE?

Currently, when doctors need to share health information about a patient, the process is difficult and usually involves phone calls, frequent mailings, and faxes. Gathering health information on a patient can take hours or even weeks, and sometimes the information is not available at all. Errors are common. Through the HIE, doctors will have immediate access to important information. The HIE will help to avoid unneeded tests and procedures, medical mistakes, and costly medical bills.



How is my medical information kept private?

CRISP takes patient privacy very seriously and recognizes that HIE cannot succeed if patients do not trust that their information is safe. Protecting patient information in the CRISP HIE is a priority. CRISP follows all State and Federal laws (for example, HIPAA) to protect patient information. CRISP considers the privacy and security protections outlined by the law to be minimum standards, and many of our policies go above and beyond what is required by law.



CRISP

Connecting Physicians With Technology
to Improve Patient Care in Maryland





Chesapeake Regional Information System for Our Patients (CRISP) is an independent nonprofit organization dedicated to bringing the benefits of widespread, interoperable health information technology to patients and health care providers across Maryland. CRISP is advised by a wide range of stakeholders responsible for the health care of Maryland's citizens. We receive input and advice from patients; hospital systems; physicians; insurance providers; technology providers; privacy advocates; public health officials; and advocates for seniors, the uninsured, and the medically underserved. Our mission, further supported by our statewide partners, reinforces our commitment to creating a healthier Maryland.

Can I choose not to participate in the HIE?

Yes, patients can choose to opt out of the CRISP HIE. As part of receiving care in Maryland, your health information will be available through the HIE to doctors for the purposes of treatment, unless you choose to opt out. Choosing to opt out generally means that doctors cannot access any of your health information through CRISP.

For more information about the CRISP HIE, visit www.crisphealth.org, call 1.877.95.CRISP (27477), or email HIE@crisphealth.org.

You have several options for opting out of the CRISP HIE; you may select one below.

1. Visit the CRISP Web site at <http://www.crisphealth.org>
2. Call 1.877.95.CRISP (27477)
3. Fax your completed form to 443.817.9587
4. Mail your completed form to:
CRISP
7160 Columbia Gateway Drive, Suite 230
Columbia, MD 21046

Your address will be used to send a letter confirming your opt-out choice.



CRISP

Chesapeake Regional Information System for Our Patients
7160 Columbia Gateway Drive, Suite 230, Columbia, MD 21046

T/ 877.952.7477 F/ 443.817.9587

www.crisphealth.org

Notice of GWUH's Participation in CRISP

CRISP, the Chesapeake Regional Information System for our Patients, Inc. is a Health Information Exchange (HIE) originally started in the state of Maryland and recently expanded to include the District of Columbia.

CRISP takes patient privacy very seriously and recognizes that HIE cannot succeed if patients do not trust that their information is safe. Protecting patient information in the CRISP HIE is a priority. CRISP follows all State, District and Federal laws (for example HIPAA) to protect patient information.

The George Washington University Hospital has chosen to participate in CRISP. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions.

Your signature indicates that you were notified of GWUH's participation in the CRISP Health Information Exchange:

Patient or Authorized Representative Signature

Date

Hospital Representative

Date

- ❖ You may “opt-out” and disable all access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at: www.crisphealth.org



THE GEORGE WASHINGTON
UNIVERSITY **HOSPITAL**



CL0040

**CRISP Participation
Notice**

90-905 (4/15)

Patient Label



Health Information Exchange Patient Opt-Out Form

This form is to be used by patients who **do not** wish to participate in Maryland's statewide Health Information Exchange (HIE).

A Health Information Exchange, or HIE, is a way of sharing your health information among participating doctors' offices, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. The purpose is so that each of your participating caregivers can have the benefit of the most recent information available from your other participating caregivers when taking care of you. When you opt out of participation in the HIE, doctors and nurses will not be able to search for your health information through the HIE to use while treating you. Your physician or other treating providers will still be able to select the HIE as a way to receive your lab results, radiology reports, and other data sent directly to them that they may have previously received by fax, mail, or other electronic communications. Public health reporting, in accordance with law such as the reporting of infectious diseases to public health officials, will also occur through the HIE after you decide to opt out.

This opt-out form only needs to be completed once to opt out of the HIE; it is not necessary to complete for each provider. If you do not live in Maryland but still receive care in Maryland, you should complete this form to opt out. If you wish to reverse your decision you may opt back in at any time by calling CRISP at 1.877.95.CRISP.

You have several options for opting out of the CRISP Health Information Exchange. Please select one below.

1. Visit the CRISP Web site at <http://www.crisphealth.org>
2. Call 1.877.95.CRISP (27477)
3. Fax your completed form to 443.817.9587
4. Mail your completed form to CRISP, 7160 Columbia Gateway Drive, Suite 230, Columbia, MD 21046

Information for Patient Opting Out (Please PRINT Clearly)

First Name* _____

Middle Name _____

Last Name* _____

Address Line 1* _____

Address Line 2 _____

City* _____

State* _____

Zip Code* _____

Primary Phone Number* _____

Secondary Phone Number _____

Email _____

Date of Birth* _____

Sex (M/F)* _____

I would like to be notified of my participation choice in the following way (contact information must be included on form): Email Phone Call Letter Text No Notification

* Required

Reason for Opting Out (optional): _____

If this form is signed by someone other than the person named above, the person signing the form hereby certifies that he/she is acting as: (CHECK ONE) Parent Legal Guardian Other (Specify Relationship) _____ for the person named above.

Contact Information for Individual Completing This Form If Other Than Patient (Please Print Clearly)*

Printed Name _____ Phone Number _____

Patient Information (Please Print Clearly)*

Printed Name _____

Signature _____

Date _____

Respecting Your Privacy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PROTECTED HEALTH INFORMATION

Information about your health is private. And it should remain private. That is why this healthcare institution is required by federal and state law to protect and maintain the privacy of your health information. We call it "Protected Health Information" (PHI).

The basis for federal privacy protection is the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, known as the "Privacy Rule" and "Security Rule" and other federal and state privacy laws.

WHO WILL FOLLOW THIS NOTICE

This Notice describes the information privacy practices followed by our hospital employees, volunteers, and related personnel.

The practices described in this Notice may also be followed by health care providers, who are members of our Medical Staff, if they have opted to abide by its contents. Many of our doctors follow the practices contained within this Notice. Other physicians have created their own Notice. Those members of the Medical Staff who opt not to abide by this Notice are required to give you a separate Notice that will explain their privacy practices.

Each participant who joins in this joint Notice of Privacy Practices serves as their own agent for all aspects of HIPAA Compliance, other than the delivery of this Joint Notice. For physician specific issues or questions, please feel free to contact your physician directly.

Hospital employees, volunteers, and related personnel, including those members of the Medical Staff who have opted to abide by its contents, must follow this Notice with respect to:

- How We Use Your PHI
- Disclosing Your PHI to Others
- Your Privacy Rights
- Our Privacy Duties
- Hospital Contacts for More Information or, if necessary, a Complaint

Your personal doctor may have different policies regarding the use and disclosure of PHI created in their offices.

USING OR DISCLOSING YOUR PHI:

FOR TREATMENT

During the course of your treatment, we use and disclose your PHI. For example, if we test your blood in our laboratory, a technician will share the report with your doctor. Or, we will use your PHI to follow the doctor's orders for an x-ray, surgical procedure or other types of treatment related procedures.

FOR PAYMENT

After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to your insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan.

Or, your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

FOR HEALTHCARE OPERATIONS

Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. Or we might use the PHI from real patients in education sessions with medical students training in our hospital. Other uses of your PHI may include business planning for our hospital or the resolution of a complaint.

SPECIAL USES

Your relationship to us as a patient might require using or disclosing your PHI in order to

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about our other health benefits and services
- Ask you to contribute to our charitable activities, unless you tell us not to ask. You have a right to opt out of receiving such communications.

YOUR AUTHORIZATION MAY BE REQUIRED

In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment or healthcare operations or as required or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI. This includes, for example, uses or disclosures of psychotherapy notes, uses or disclosures for marketing purposes, or for any disclosure which is a sale of your PHI. You may revoke your authorization if you change your mind later.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW

As a hospital or healthcare facility, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

REQUIRED OR PERMITTED USES AND DISCLOSURES

- If you do not verbally object, we may include information identifying you in a visitors' directory of patients while you are an inpatient in our hospital. This information may include your name, general condition and religious affiliation, if any.
- If you do not verbally object, we may share some of your PHI with a family member or friend involved in your care.
- We may use your PHI in an emergency when you are not able to express yourself.
- We may use or disclose your PHI for research if we receive certain assurances which protect your privacy.

WE MAY ALSO USE OR DISCLOSE YOUR PHI

- When required by law, for example when ordered by a court.
- For public health activities including reporting a communicable disease or adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To government regulators or agents to determine compliance with applicable rules and regulations.
- In judicial or administrative proceedings as in response to a valid subpoena.
- To a coroner for purposes of identifying a deceased person or determining cause of death, or to a funeral director for making funeral arrangements.
- For purposes of research when a research oversight committee, called an institutional review board, has determined that there is a minimal risk to the privacy of your PHI.
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a Workers' Compensation program.
- When properly requested by law enforcement officials, for instance in reporting gun shot wounds, reporting a suspicious death or for other legal requirements.
- If we reasonably believe that use or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.

- For national security purposes including to the Secret Service or if you are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- In connection with certain types of organ donor programs.
- For surveys, including patient satisfaction surveys.

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM

Under the federally required privacy program, patients have specific rights.

YOUR RIGHT TO REQUEST LIMITED USE OR DISCLOSURE

You have the right to request that we do not use or disclose your PHI in a particular way. We must abide by your request to restrict disclosures to your health plan (insurer) if:

- the disclosure is for the purpose of carrying out payment or health care operations and is not required by law; and
- the PHI pertains solely to a healthcare item or service that you, or someone else other than the health plan (insurer) has paid us for in full.

In other situations, we are not required to abide by your request. If we do agree to your request, we must abide by the agreement.

YOUR RIGHT TO CONFIDENTIAL COMMUNICATION

You have the right to receive confidential communications of PHI from the hospital at a location that you provide. Your request must be in writing, provide us with the other address and explain if the request will interfere with your method of payment.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

YOUR RIGHT TO INSPECT AND COPY

You have the right to inspect and copy your PHI (or to an electronic copy if the PHI is in an electronic medical record), if requested in writing. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal.

YOUR RIGHT TO AMEND YOUR PHI

If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us. We may refuse to make the amendment and you have a right to

disagree in writing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

YOUR RIGHT TO KNOW WHO ELSE SEES YOUR PHI

You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years, but not before April 14, 2003. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, payment and health care operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed.

YOUR RIGHT TO BE NOTIFIED OF A BREACH

You have the right to be notified following a breach of unsecured PHI.

YOUR RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive the Notice electronically.

WHAT IF I HAVE A COMPLAINT?

If you believe that your privacy has been violated, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or penalize you for filing a complaint with us or the Secretary.

- To file a complaint with us, please contact our Risk Management Department or call the UHS Compliance Hotline at **1-800-852-3449**. Your complaint should provide specific details to help us in investigating a potential problem.
- To file a complaint with the Secretary of Health and Human Services, write to: 200 Independence Ave., S.E., Washington, D.C. 20201 or call **1-877-696-6775**.

CONTACT FOR ADDITIONAL INFORMATION

If you have questions about this Notice or need additional information, you can contact our Risk Management Department (or the UHS Compliance Hotline at 1-800-852-3449).

SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE FULFILL THEM

Federal health information privacy rules require us to give you notice of our legal duties and privacy practices with respect to PHI and to notify you following a breach of unsecured PHI. This document is our notice. We will abide by the privacy practices set forth in this notice. We are required to abide by the terms of the notice currently

in effect. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law. If we change our notice of privacy practices, we will provide you with a copy to take with you upon request and we will post the new notice.

COMPLIANCE WITH CERTAIN STATE LAWS

When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws about the confidentiality of health information in place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI. For example, some state laws dealing with mental health records may require your express consent before your PHI could be disclosed in response to a subpoena. Another state law prohibits us from disclosing a copy of your record to you until you have been discharged from our hospital. When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

Effective Date: This notice takes effect on September 23, 2013 Version # 1

Receipt of Notice of Privacy Practices

I acknowledge that I have received the hospital's Notice of Privacy Practices.

(Patient's Signature) (Date)

(Patient's Authorized Representative) (Relationship to Patient) (Date)

(Witness Signature) (Witness Job Title) (Date)



THE GEORGE WASHINGTON
UNIVERSITY **HOSPITAL**

Patient Label



**Receipt of Notice of
Privacy Practices**