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

GENERAL POLICY: All patients shall be treated, admitted and assigned accommodation without distinction to race, religion, color, national origin, sexual orientation, age or handicapping condition.

CONSENT TO TREATMENT: I have come to The George Washington University Hospital for medical treatment. I ask the health care professionals at the Hospital to provide care and treatment for me that they feel is necessary. The undersigned consents to the procedures, which may be performed during this hospitalization, or on an outpatient basis including emergency treatment or services. I consent to undergo routine tests and treatment as part of this care. These may include but are not limited to laboratory, radiology, medical or surgical tests, treatments, anesthesia or procedures as directed under the general and special instruction of the physician or surgeon. I understand that I am free to ask a member of my health care team questions about any care, treatment or medicine I am to receive. Because The George Washington University Hospital is a teaching hospital, I understand that my health care team will be made up of hospital personnel (to include nurses, technicians, and ancillary staff) under the direction of my attending physician and his/her assistants and designees (to include interns, residents, fellows and medical students). I am aware that the practice of medicine is not an exact science and admit that no one has given me any promises or guarantees about the result of any care or treatment I am to receive or examinations I am to undergo.

PHYSICIANS NOT AS EMPLOYEES: I understand that each physician is an independent contractor who is self employed and is not the agent, servant or employee of the hospital. I understand that I may receive separate billing from each of these providers for services rendered. _____ Initials

RELEASE OF INFORMATION: The George Washington University Hospital is authorized to release any information necessary, including copies of my hospital and medical records, to process payment claims for health care services which have been provided, and to duly authorized local and federal regulatory agencies and accrediting bodies as required or permitted by law. George Washington University Hospital is further authorized to release demographic information to organizations performing patient satisfaction surveys. Such records may include information of a psychological or psychiatric nature, pertaining to my mental condition or treatment for conditions relating to the use of alcohol or drugs. In addition, I authorize my insurance carrier, employer or person otherwise responsible for payment to provide The George Washington University Hospital information necessary to determine benefits or process a claim. This release will be valid for the period of time to process the claim or until consent is revoked by myself. I release and forever discharge The George Washington University Hospital, its employees and agents, and my attending physician from any liability resulting from the release of my medical records or information from them for payment purposes. I understand that my name will be displayed in the signage system outside my hospital room.

PERSONAL VALUABLES: THE GEORGE WASHINGTON UNIVERSITY HOSPITAL WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE TO CLOTHES, PERSONAL PROPERTY OR VALUABLES.

NON-SMOKING POLICY: In accordance with regulatory agency standards, the Hospital is a non-smoking facility.

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS: I assign any and all insurance benefits payable to me to The George Washington University 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 preexisting 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 The George Washington University 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 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 other as required, I authorize my employer to release to The George Washington University Hospital proof of my income. I understand that if any information I have given proves to be untrue, The George Washington University Hospital will re-evaluate my financial status and take whatever action becomes appropriate. I acknowledge by my signature that I have read and received a copy of this statement. I understand that by signing it, I am agreeing to it.

TO BE SIGNED AT THE HOSPITAL

X _____
Signature of patient or responsible party

Unable to sign
( ) Serious Condition
( ) _____

_____ _____ _____ _____
Date Witness Hospital Representative Date

Section 1:

Did you bring an Advance Directive (Living Will/Health Care Power of Attorney) **form with you?**

☐ Yes ☐ No

(If YES, place a copy in the front of the patient's chart / ***If NO, go to Section 2)***

Section 2:

1. I was given information on formulating an Advance Directive (including how to obtain assistance with completing the Advance Directive form). _____**initials**

OR

2. I do not have an Advance Directive and do not wish to formulate one.

_____**initials**

By my signature below, I consent to laboratory studies (HIV, HBV, HCV) in the event a health care worker is exposed to my blood or body fluids. I consent to the appropriate disposal of any tissue or part removed from my body and to the taking of photographs during the procedure/operation/treatment for research, teaching, or scientific purposes as long as my identity is not disclosed.

Signature _____ Date _____

THE GEORGE WASHINGTON UNIVERSITY **HOSPITAL**

CO4000

PATIENT AUTHORIZATION FORM

80-010 (05/13)

Patient Label

GENERAL POLICY: All patients shall be treated, admitted and assigned accommodation without distinction to race, religion, color, national origin, sexual orientation, age or handicapping condition.

CONSENT TO TREATMENT: I give consent to The George Washington University Hospital to treat Baby_____
I ask the health care professionals to provide care and treatment for my newborn that they feel is necessary. The undersigned consents to the procedures, which may be performed during this hospitalization, or on an outpatient basis including emergency treatment or services. I consent for my newborn to undergo routine tests and treatment as part of this care. These may include but are not limited to laboratory, radiology, medical or surgical tests, treatments, anesthesia or procedures as directed under the general and special instruction of the physician or surgeon. I understand that I am free to ask a member of my newborn's health care team questions about any care, treatment or medicine he/she is to receive. Because The George Washington University Hospital is a teaching hospital, I understand that my newborn's health care team will be made up of hospital personnel (to include nurses, technicians, and ancillary staff) under the direction of his/her attending physician and his/her assistants and designees (to include interns, residents, fellows and medical students). I am aware that the practice of medicine is not an exact science and admit that no one has given me any promises or guarantees about the result of any care or treatment my newborn is to receive or examinations he/she is to undergo.

PHYSICIANS **NOT AS EMPLOYEES:** I understand that each physician is an independent contractor who is self employed and is not the agent, servant or employee of the hospital. I understand that I may receive separate billing from each of these providers for services rendered.
_____initials

RELEASE OF INFORMATION: The George Washington University Hospital is authorized to release any information necessary, including copies of my hospital and medical records, to process payment claims for health care services which have been provided, and to duly authorize local and federal regulatory agencies and accrediting bodies as required or permitted by law. George Washington University Hospital is further authorized to release demographic information to organizations performing patient satisfaction surveys. Such records may include information of a psychological or psychiatric nature, pertaining to my mental condition or treatment for conditions relating to the use of alcohol or drugs. In addition, I authorize my insurance carrier, employer or person otherwise responsible for payment to provide The George Washington University Hospital information necessary to determine benefits or process a claim. This release will be valid for the period of time to process the claim or until consent is revoked by myself. I release and forever discharge The George Washington University Hospital, its employees and agents, and my attending physician from any liability resulting from the release of my medical records or information from them for payment purposes. I understand that my name will be displayed in the signage system outside my hospital room.

PERSONAL VALUABLES: THE GEORGE WASHINGTON UNIVERSITY HOSPITAL WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE TO CLOTHES, PERSONAL PROPERTY OR VALUABLES.

NON-SMOKING POLICY: In accordance with regulatory agency standards, the Hospital is a non-smoking facility.

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS: I assign any and all insurance benefits payable to me to The George Washington University 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 preexisting 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 The George Washington University 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, the undersigned, state that the information that I have provided The George Washington University Hospital is correct to the best of my knowledge. I acknowledge by my signature that I have read and received a copy of this statement. I understand that by signing it, I am agreeing to it.

TO BE SIGNED AT THE HOSPITAL

X_____ Unable to sign ☐ Serious Condition
Signature of patient or responsible party ☐ _____

_____ _____ _____ _____
Date Witness Hospital Representative Date

ADVANCE DIRECTIVE
(Only if Inpatient, Day Surgery, or Emergency Room Visits)

Do you have an Advance Directive
(Living Will/Health Care Power of Attorney)? __ Yes __ No
If yes, did you bring it with you? __ Yes __ No
If you did not bring it with you, is there
someone we can contact to obtain a copy? __ Yes __ No
Name_____ Tel._____
Your Advanced Directive wishes must be on your chart.

By my signature below, I consent to laboratory studies (HIV, HBV, HCV) in the event a health care worker is exposed to my blood or body fluids. I also agree to the disposal or use of any tissue or part removed from my body and/or to the taking of photographs during my treatment for research, teaching, or scientific purposes as long as my identity is not disclosed.

Signature_____ Date_____

THE GEORGE WASHINGTON UNIVERSITY **HOSPITAL**

INFANT AUTHORIZATION FORM

CO4022

80-854 (4/15)

Patient Label

WHITE - MEDICAL RECORDS CANARY - BUSINESS OFFICE PINK - PATIENT COPY

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

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.

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.

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

CRISP
Connecting Physicians With Technology to Improve Patient Care in Maryland

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**

CL0040

Receipt of Notice of Privacy Practices

40-100 (4/15)

Patient Label

TCPA Notice

In accordance with the updated requirements of Telephone Consumer Protection Act (TCPA), effective October 16, 2013, please be advised of the following:

AUTHORIZATION FOR RECEIVING MESSAGES AND AUTOMATED CALLS: I give The George Washington University Hospital (including its agents and third party collection agents) 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, including debt collection agencies, may use pre-recorded/artificial voice messages and/or use an automatic dialing devise (an autodialer) to deliver messages related to my account and 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.

Patient or Authorized Representative Signature _____ **Date** _____

Hospital Representative _____ **Date** _____