PRIVACY NOTICE DISTRIBUTION cc800

Attachment “A”

ACKNOWLEDGMENT OF PRIVACY PRACTICES/FINANCIAL DISCLOSURE

I understand that I have the right to restrict how my Health Information (defined below) is used or disclosed by Cook Children's Health Care System (hereinafter referred to as "CCHCS") to carry out treatment, payment or health care operations. I may seek to restrict these uses or disclosures by designating my restrictions on this form; however, I understand that CCHCS is authorized by federal law to refuse to abide by my requested restrictions and that restrictions on use of Health Information for payment, treatment, or health care operations may prevent me from receiving medical services at CCHCS.
RELEASE OF INFORMATION. I consent and authorize CCHCS and any practitioner providing medical goods and services to patient to release information contained in any financial records and/or medical records, including diagnosis and treatment at CCHCS or by any practitioner providing medical goods and services to the patient, including but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), Hepatitis A, B and C, drug/alcohol abuse and treatment, psychiatric diagnosis and treatment records and/or laboratory tests results, medical history, treatment progress, and/or other such related information (collectively "Health Information") for the purpose of payment, treatment, or health care operations to one or more of the following:
1. Insurance Company, self-funded or health plan, its agents, representatives, attorneys or independent contractors, Medicare, Medicaid, any other person or entity that may be responsible for paying or processing for payment any portion of my CCHCS bill or conducting utilization management/review and financial/medical audits;
2. To any person or entity affiliated with or representing CCHCS and any practitioner providing medical goods and services to patients for the purpose of payment, treatment and health care operations;
3. To any other hospital, nursing home, or other health care institution to which the patient is transferred;
4. Patient's primary, attending, consulting, referring, and/or family physician for follow up, physician information and/or continuity of care to include prospective or current home health company, to referring facility health care staff or to CCHCS.

In addition, I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy Notice, a copy of which has been provided to me. I have read or will read the Privacy Notice and ask CCHCS if I have any questions about the information contained in the Privacy Notice. I agree to the uses/disclosure of my/my child's Health Information as described in the Privacy Notice. Moreover, I understand that the Privacy Notice may be amended by CCHCS from time to time and that I may obtain an amended Privacy Notice at any time by contacting CCHCS' registration/front office personnel.
I give permission for the release of Health Information to be transmitted by U.S. Mail, facsimile or other electronic medium. I may revoke this Consent to Release Health Information in writing at any time, unless action has already been taken in reliance thereupon; in which case, I may revoke this Consent for future communications.

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS. I hereby assign to CCHCS, and any practitioner providing care and treatment to me/my child, any and all benefits and all interest and rights (including causes of action and the right to enforce payment) for services rendered under all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan. If my/my child's treatment was caused by events which result in legal action, I assign to CCHCS an interest in any claims I/my child may have. I hereby promise to pay for all services rendered to me/my child to the extent I am legally responsible for such payment; I understand I am responsible for all health insurance copayments and deductibles and any other amounts properly payable by me as permitted by law or contract. Charity care may be available if CCHCS eligibility criteria are met.
If I am a MEDICAID PATIENT, I understand that the amount owed to CCHCS for covered services will be satisfied by amount paid by Medicaid for such services and that I will not be balance billed by CCHCS for Medicaid covered services. I further understand that the services or items that I request to be provided to me may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the Texas Department of Human Services or its health-insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care. If I am a Medicaid Star patient, these provisions may not apply.
FOR MEDICARE/TRICARE PATIENTS ONLY: I acknowledge receipt of the written material entitled, "Important Message from Medicare/Tricare."

Patient's Printed Name: _____ Date of Birth: _____

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND RECEIVED A COPY OF CCHCS NOTICE OF PRIVACY PRACTICES.

_____ _____

Signature of Patient, if adult, or Patient's Parent/Legally Authorized Representative Relationship

_____

Witness

Time of Signing: Month _____ Day _____ Year _____ Hour _____a.m./p.m.