UNIVERSITY OF CONNECTICUT / UNIVERSITY OF CONNECTICUT HEALTH CENTER

INSURANCE/BILLING INFORMATION RELEASE
&
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Form Version 1.1
Date: 5/1/12

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I consent to allow the UCONN Fire Department, to use and disclose my protected health information (PHI), to carry out my treatment, to obtain payment and to carry out health care operations. My PHI may be disclosed to my health plan and/or its agents as necessary to verify benefits, authorize services, and process medical/dental claims. My PHI may be disclosed to outside health agencies or institutions involved in my continuing care when I am transferred to another facility and/or for emergency care purposes. My physician may also share my PHI with referring physicians for continuing care as deemed appropriate by me. My PHI may include medical/dental information or any information pertaining to the examination, treatment, history, which may include Psychiatric, HIV/AIDS, sickle cell, alcohol and/or drug information, coded medical/dental information and charges to my health plan and/or their acting intermediaries and/or agents. This consent is subject to revocation at any time except to the extent that action has been taken in reliance on it; withdrawal of consent shall be addressed in writing to the Fire Chief (Attn: Records Requests).

ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES: I understand that specific information regarding the uses and disclosures of my PHI can be found in the UCONN Fire Department Notice of Privacy Practices which has been provided to me and which I have a right to review before I sign this. I further understand that the UCONN Fire Department has a right to change its Notice of Privacy Practices and that I may obtain a revised copy on UCONN Fire Department's web site at http//fire.uconn.edu. I understand that I have the right to request to restrict how my PHI is used and disclosed for treatment, payment and health care operations. I further understand that UCONN Fire Department is not required to agree to my requested restrictions. However, if they agree to a requested restriction, they are bound by it.

ASSIGNMENT OF BENEFITS: I authorize my health plan to pay benefits directly to UCONN Fire, or any provider under contract with them. I understand that in the event my health plan or healthcare contract does not cover services, I will be responsible for payment. Examples include co-payments, deductibles, charges considered to be beyond usual, customary, and reasonable or uncovered services (such as cosmetic surgery).

NON-ASSIGNMENT OF BENEFITS OR SELF-PAY: I understand that if my health plan does not consider UCONN Fire, or any other provider under contract with them, a participating provider, charges incurred will be paid by me. I further agree to accept full financial responsibility for payment of charges rendered to the above patient.

PATIENT: ☐ **Refused to acknowledge written receipt of Notice of Privacy Practices or agree to assignment of benefits**

☐ **Unable to acknowledge written receipt of the Notice of Privacy Practices or agree to assignment of benefits, though good faith efforts have been made. (Check one below)**

- ☐ **Patient signs with "X" or other mark only (Complete Section I below)**
- ☐ **Physically or Mentally Incapable w/ representative (Complete Section II below)**
- ☐ **Physically or Mentally Incapable w/out representative (Complete Section III below)**

I have read and agree to all parts of this form unless I have so noted:________________________________

PATIENT SIGNATURE ____

Date/Time:________________

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ALTERNATE SIGNATURE PAGE

SECTION I. - Patient Mark Only

If patient signs with an "X" or other mark, it is recommended that a witness sign below.

WITNESS SIGNATURE ____ **Date/Time:**_______________

SECTION II. - Physical or Mental Incapacity WITH Authorized Representative

Reason Patient is unable to sign:____

____

Authorized Representatives are only those listed below - (Check one):

- ☐ Patient's Legal Guardian ☐ Patient's Power of Attorney
- ☐ Relative or other who receives government benefits on behalf of the patient
- ☐ Relative or other who arranges treatment or handles patient's affairs
- ☐ Representative of an agency or institution that furnished care, services or assistances to the patient

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered.

AUTH REP SIGNATURE ________________________________ Printed Name:______________________
DATE/TIME:____

SECTION III. – EMERGENCY ONLY – Paramedic & Facility Representative

This section to be completed only if the following are true – (1) the call was an emergency transport, (2) the patient was physically or mentally incapable of signing, and (3) there was no authorized representative (as outlined in Section II) was available or willing to sign on behalf of the patient at the time of service.

Reason Patient is unable to sign:____

____

The patient was received by this facility on the noted date/time. This signature is not an acceptance of financial responsibility.

FACILITY REP SIGNATURE ________________________________ **Printed Title:**___________________
DATE/TIME:____

If Receiving Facility Signature cannot be obtained, secondary documentation in the form of a Facility Face Sheet or Admissions Record clearly indicating the time and date is required from the facility. The release of this information by the hospital to the ambulance service is expressly permitted by Section 164.506(c) of HIPAA