Kansas City Cardiology

Medical Information Authorization

Name: (Please Print)_____ Date of Birth:_____/_____/_____

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicates that you have been given the opportunity to review and/or request a copy of the Prime Healthcare Medical Groups Notice of Privacy Practice on the date indicated. If you have any questions regarding the information in the Prime Healthcare Medical Group's Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the Medical Group's Patient Privacy Officer as indicated on your Notice.

**The above authorization is required by Federal Law under HIPAA regulations.*

Medical Information Authorization

o * I DO NOT authorize my medical care Provider to leave a voicemail message on my phone which I provided to you in my demographic information.

o * **I DO** authorize my medical care Provider to leave a voicemail message on my phone which I provided to you in my demographic information.

o * I DO NOT authorize the physician or anyone associated with his/her group to discuss my medical condition, treatment or test results with anyone other than myself.

o * **I DO** authorize the physician or anyone associated with his/her medical Group to discuss my medical condition, treatment and test results with the following people (family/friends, not to include physicians):

Name:_____ Phone:_____ Relationship:_____

[ ] Any Info regarding my health/appointments/insurance [ ] Only info regarding: _____

Name:_____ Phone:_____ Relationship:_____

[ ] Any Info regarding my health/appointments/insurance [ ] Only info regarding: _____

Name:_____ Phone:_____ Relationship:_____

[ ] Any Info regarding my health/appointments/insurance [ ] Only info regarding: _____

Name:_____ Phone:_____ Relationship:_____

[ ] Any Info regarding my health/appointments/insurance [ ] Only info regarding: _____

Signature of patient or legal representative:_____ Date:_____/_____/_____

Printed name of patient/legal representative:_____ Relationship:_____

Kansas City Cardiology

Patient Rights and Responsibilities

You, the patient, have the right: To treatment without discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation and gender identity or expression. To expect a family member and your doctor will be informed you are a patient at the medical center. To be treated with dignity and respect in a safe, clean setting, free from abuse, neglect or harassment. To know the identity of doctors, nurses and others involved in your care and you have the right to know when they are students, residents or other trainees. To receive information about what is expected of patients and where you can take complaints. Patients can freely voice complaints and recommend changes without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment and services. To privacy and confidentiality within the limits of the law. (Your rights are described in the Notice of Privacy Practice.) To be told about your illness or injury, the benefits and risks of each treatment, what to expect during treatment and how well you may recover. This information must be given in terms you can understand, so you can give permission before treatment begins. (Except in emergencies when the patient is not conscious or not able to communicate and the need for treatment is urgent.) To request a review by the hospital's Ethics Committee about an ethical issue related to your care. To refuse treatment, if the law allows, and to be told by your doctor what might happen medically, because of your decision. To be told if anything unexpected and significant happens during your medical center stay and any resulting changes in your care. To have your report of pain acknowledged and treated as appropriate. To be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff. To be informed about advance directives and to receive assistance in completing one. This will include naming someone to make decisions about your care if you are not able to. {You will receive treatment even if you do not have an advance directive.) To receive care to make you as comfortable as possible if you are dying, including your spiritual needs regarding death. To have access to space and be allowed to talk privately with people outside of the medical center, whether in person, by mail, or telephone, appropriate to your needs, care, treatment and services. To have access to a medical center interpreter. To have a family member, friend or other representative of your choice present with you for emotional support during your stay. To be told of any research being done related to your care, and to either agree or refuse to be part of the research. To be active in your plan of care, before, during and after your medical center stay, and to be told of choices available to you for health care services after leaving the medical center. To receive help identifying sources of follow up care, and to let you know if our medical center has a financial interest in any referrals. To file a complaint about any part of your care and to know what happened as a result of your complaint. To be allowed to see or get a copy of your medical record as allowed in the hospital's policy. (Written request, 24 hours in advance.) To ask for a detailed copy of your bill, even if insurance is paying. {Contact the Business Office at 816·943-2192.) To be informed of the medical center programs available to you if you are experiencing domestic or intimate partner violence. Call 816-461-4673, and ask for the Bridge Span Advocate, or call the Metro Wide Domestic Violence Hotline at 816-HOTLINE (468-5463). Even if the patient is able to make his/her own decisions, they may appoint a representative to exercise these rights on their behalf. If the patient is not able to make his/her own decisions, is legally incompetent or is a minor, an authorized representative including a guardian can exercise these rights on the patient's behalf.

You have the responsibility: To provide, to the best of your ability, accurate and complete information about your condition, past illnesses, hospitalizations, medication, dietary supplements, past allergic reactions, etc., related to your health. To be aware of financial consequences of using uncovered services or out of network providers and any network or admission requirements under your health plan. To inform physicians, nurses or other health professionals of any change in your condition or reaction to your treatment, or any special needs during your visit, such as spiritual care, interpreters, etc. To ask questions if you do not understand your medical plan of care or treatment instructions. To follow the instructions of health care providers involved in your care. To accept responsibility if you choose to refuse treatment. To be respectful of the rights of other patients, staff and property of the medical center. To follow medical center rules and regulations affecting patient care, conduct, safety and visiting hours. St. Joseph Medical Center and St. Mary's Medical Center are smoke free facilities.

Prime Healthcare is committed to providing quality care to our patients. Physicians' clinical decisions about the patient's care are based on patient needs and not affected by the method of payment between the Medical Center and providers. If you have any questions regarding your patient rights and responsibilities, or have a request, concern or complaint, please contact:

St. Joseph Medical Center
Patient Representative 1000
Carondelet Drive Kansas City, MO
64114 816-943-4721

St. Mary's Medical Center
Patient Representative 201 NW
R.D. Mize Rd. Blue Springs, MO
64014 816.655.5707

State Survey Agency:
Health Standards and Licensure
Dept. of Health and
Senior Services
P.O. Box 570
Jefferson City, MO 65102
573-751-6303 or 800-392-0210
health.mo.gov/askus.php

Accreditation Agency:
The Joint Commission
One Renaissance Blvd.
Oakbrook Terr, IL 60181
800-994-6610
jointcommission.org

The undersigned certifies that they have read, understand and have had the opportunity to ask and receive answers to questions prior to signing.

Signature of Patient / Personal Representative:_____Date:_____/_____/_____