



RUSH UNIVERSITY MEDICAL CENTER

Patient Information

Patient Name: _____ **DOB:** _____ **SSN:** _____

Primary Care Doctor: _____ **Phone Number:** _____

Past Medical History: Circle those that apply

- | | | |
|---------------------|-----------------------|-------------------------|
| High Blood Pressure | Asthma | Heart Failure |
| Diabetes | Kidney disease | Neurologic problems |
| Heart attack | Liver disease | Thyroid problems |
| High cholesterol | History of blood clot | Trouble with anesthesia |
| Emphysema/COPD | Bleeding problems | |

Cancer (Type and dates): _____

Other: _____

Past Surgical History: (Type and Dates)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (Name, dose and frequency)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: (Medication and reaction)

_____	_____	_____
_____	_____	_____

Social History:

Tobacco Use (Past or Present): ___ Yes ___ No Current Smoker: Yes or No

Packs per day: _____ Number of years smoked: _____ Year quit: _____

Do you drink Alcohol: ___ Yes ___ No Drinks per week: _____

Family Medical History: Please list relation with listed medical problem

Heart disease: _____

Anesthesia Problems: _____

Diabetes: _____

Kidney disease: _____

Lung Cancer: _____

Blood Clots: _____

Other Cancers: _____

Bleeding Problems: _____

Reviewed by: _____

Date: _____

Rush University Medical Center

NOTICE OF PRIVACY PRACTICES

Effective date: 4/14/03

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.

SUMMARY

Each time you visit a hospital, physician or other health care provider, a record of your visit is made. This record typically contains information regarding your symptoms, diagnosis, examination and test results, current and future treatment, as well as billing-related information. This notice applies to all records regarding your care generated by Rush University Medical Center, whether made or received by our hospital personnel or given to others outside the hospital for business purposes. If your personal physician is not an employee of the hospital or does not perform services on behalf of the Medical Center, then he or she may have different policies or notices regarding the physician's use and disclosure of medical information created in the physician's office or clinic.

WHO WILL FOLLOW THIS NOTICE?

Rush University Medical Center provides health care to our patients in conjunction with physicians and other professionals and organizations. The information privacy practices in this notice will be followed by:

- Any Rush University Medical Center employee, trainee, volunteer or employed health care professional who treats you.
- All departments and units of our organization.
- Any business associate of Rush University Medical Center with whom we share health information.
- The Rush Group Health Plan.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This

notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF MEDICAL INFORMATION

The following categories describe examples of the way we use and disclose medical information.

For Treatment: We may use your medical information to provide you treatment or health-related services. For example, different departments may share your medical information to coordinate the different things you may need, such as prescriptions, lab work, meals and X-rays or other diagnostic tests.

For Payment: We may use and disclose your medical information to obtain payment for services we provide you, including but not limited to clearinghouses in connection with collections and billing activities. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We also may disclose your medical information to another covered entity (e.g., your insurer) or health care provider for their payment activities.

- U.S. Department of Health and Human Services
- Food and Drug Administration

Law Enforcement/Legal Proceedings: We may disclose your medical information in response to a court or administrative order, subpoena, discovery request or other lawful process under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your medical information to law enforcement officials. We may disclose limited information to a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the medical information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances.

We may disclose your medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your medical information to the extent necessary to protect your health or safety or the health or safety of others. We may disclose medical information when necessary to assist law enforcement officials in capturing an individual who has admitted to participation in a crime or has escaped from lawful custody.

In addition, we may disclose to military authorities the medical information of armed forces personnel under certain circumstances. We may disclose to authorized federal officials medical information required for lawful intelligence, counterintelligence and other national security activities.

We will not use or disclose your medical information if that disclosure is prohibited or significantly limited by other applicable law, including but not limited to the

- Illinois Nursing Home Care Act; Illinois Medical Practice Act; Illinois Mental Health and Developmental Disabilities Code; Illinois AIDS Confidentiality Act; Genetic Information Privacy Act; Illinois Mental Health and Developmental Disabilities Confidentiality Act; and the Federal Drug Abuse, Prevention, Treatment and Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

YOUR HEALTH INFORMATION RIGHTS

Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care, with limited exceptions. You may request

that we provide copies in a format other than photocopies (e.g. an electronic file). We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies we will charge a fee to cover the staff time needed to locate and copy your medical information, and postage if you want the copies mailed to you. If you request an alternative format, to cover our expenses we will charge a fee for providing your medical information in that format. If you prefer, we will prepare a summary or an explanation of your medical information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

An Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations and certain other activities or those disclosures that you have authorized, since April 14, 2003, and up to 6 years prior to the request. We will provide you with the date on which we made the disclosure, the name of the person or group or business (e.g., a physician's office or a health care clearinghouse) to which we disclosed your medical information, a description of the medical information we disclosed, the reason for the disclosure and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable fee covering our costs for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request. If we do agree, we will comply with your request (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is formally put in writing and signed. All restriction requests must be forwarded to the Privacy Office for grant/denial determination.



#A@2HP010

RUSH UNIVERSITY MEDICAL CENTER

ACKNOWLEDGMENT

I hereby acknowledge receipt of the Notice of Privacy Practices.

Patient's Name:	Date of Birth:
Patient's Signature:	
Date:	Social Security Number:

If this acknowledgment is by someone other than the patient (a personal representative) please complete the following:

*A personal representative is a person legally authorized to act on behalf of an individual for health care decisions, including, in most cases, a parent or court appointed guardian, executor or administrator.

Personal Representative's Name: _____

Personal Representative's Signature: _____

Relationship to Patient: _____

If unable to obtain written acknowledgment of receipt of the Notice of Privacy Practices document good faith efforts to obtain acknowledgment and the reason why the acknowledgment was not obtained below.

Signature of Rush Workforce Member _____

Print Name: _____

Date: _____



Michael J. Liptay, MD
Director and Division Head

L. Penfield Faber, MD
Anthony W. Kim, MD
William H. Warren, MD

Alison L. Walsh
Administrator

Patient Communication/Learner Assessment

In order that we may better serve you, please answer the following questions.

- When learning new information about your health, do you have any difficulty because of the following?

<input type="checkbox"/> I cannot hear well	<input type="checkbox"/> I do not speak English well
<input type="checkbox"/> I cannot see well	<input type="checkbox"/> I cannot read English well
<input type="checkbox"/> I have trouble remembering things	<input type="checkbox"/> No difficulties
<input type="checkbox"/> Other, please specify: _____	
- If there is someone needed to help you (e.g. act as an interpreter), please name that person

If you need an interpreter, please specify the language needed: _____
- How do you prefer to learn?

<input type="checkbox"/> Written instructions	<input type="checkbox"/> Oral instructions	<input type="checkbox"/> Demonstrations
---	--	---
- Do you have religious or cultural beliefs you want us to consider when we are planning your care?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------
- Can we leave messages regarding your health?

At your home:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Telephone #: () _____
At work:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Telephone #: () _____
On a cell phone:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Telephone #: () _____
- Do you prefer to communicate through electronic mail (e-mail)?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please print your e-mail address: _____
------------------------------	-----------------------------	---
- Please list the individuals that you would like to have access to your health information:
At any time you may revoke the right you have given the individuals listed below.

<u>First and Last Name</u>	<u>Relationship</u>	<u>Please circle all that applies to each individual</u>
_____	_____	1. Test results (MRI, x-ray, labs, etc.) 2. Sensitive information: (HIV and AIDS results, sexually transmitted disease results, behavioral/mental health notes) 3. Viewing of medical record 4. Billing 5. All
_____	_____	1. Test results (MRI, x-ray, labs, etc.) 2. Sensitive information: (HIV and AIDS results, sexually transmitted disease results, behavioral/mental health notes) 3. Viewing of medical record 4. Billing 5. All
_____	_____	1. Test results (MRI, x-ray, labs, etc.) 2. Sensitive information: (HIV and AIDS results, sexually transmitted disease results, behavioral/mental health notes) 3. Viewing of medical record 4. Billing 5. All

In accordance with the Health Information Privacy Act passed on April 14, 2003, you must sign below to have the practices listed above take place.

Patient Signature

Date