THE UNIVERSITY OF TOLEDO MEDICAL CENTER | THE UNIVERSITY OF TOLEDO PHYSICIANS

Confidential Communications Request Form

The Health Insurance Portability and Accountability Act, permits you the right to request that communications regarding Protected Health Information be provided through specific means and to designated persons.

I authorize The University of Toledo Medical Center, The University of Toledo Physicians and its affiliates, employees and agents, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication, to contact me for any reason by using any telephone number, email and/or mailing address provided.

Primary Phone Number_____ Primary number is: ☐ Home ☐ Cell ☐ Work Office__

E-mail Address: _____

If unable to reach me:
☐ Leave a detailed message at the phone numbers provided above
☐ Leave a message asking me to return your call
☐ _____

The best time to reach me is (day)_____ Select Day at (time)_____

I authorize the release of my information including the diagnosis, health records, examination rendered to me and claims information. This information may be released to:

☐ Spouse _____
☐ Child(ren)_____
☐ Other_____
☐ Information is not to be released to anyone.

This Release of Information will remain in effect for one year or until terminated by me in writing.

PRINT Your Name:_____Date: _____/_____/_____

Your Signature:_____

Witness Signature:_____Date: _____/_____/_____

I have reviewed the form on _____ and confirm that the information accurate

Signature:_____

REQ

THE UNIVERSITY OF TOLEDO MEDICAL CENTER | THE UNIVERSITY OF TOLEDO PHYSICIANS

THE UNIVERSITY OF TOLEDO MEDICAL CENTER (UTMC)
Patient General Consent

UTMC is dedicated to caring for each person with respect and dignity and considers the patient to be a partner who wants to understand and make informed decisions about their health care. UTMC also believes the patient and their family (as desired) can participate if they know their rights and responsibilities.

Rights as a Patient. I understand that at all times I have the right to participate in the decisions about my care (or the patient's care for a legal representative), treatment and services provided. I understand that I (or the patient) have the additional rights listed on the attached sheet.

Treatment consent. I authorize and consent to care rendered at UTMC by physicians, providers, and staff which may include care provided in the emergency department, outpatient, inpatient or other UTMC health care settings where services are provided.

Consent to Download Medication History from Pharmacy/Insurance Database. I consent to allow my medication history to be obtained electronically. I authorize my physician's office to retrieve my medical history electronically for medical purposes. I also authorize my physician's office to retrieve my medication history and/or medical history electronically for scientific or educational purposes as long as my identity is not disclosed. I will advise UTMC if I wish to withdraw this consent.

I Consent to Photographs or Taking of other images. I consent to the making of photographs or other images for medical purposes and also scientific or educational purposes as long as my identity is not disclosed. I will advise UTMC if I wish to withdraw this consent.

Agreement to Pay For All Services Received. I understand that I am responsible for charges or all charges not covered by my insurance and assign all rights to payment by my insurer, if any, or that authorized benefits be paid to The University of Toledo. I understand I have the right to speak with a financial counselor at any time.

Release of Medical Information. I authorize The University of Toledo and physicians to release medical information to any insurer, the Social Security Administration for purposes of payment under the VIII of the Social Security Act, applicable private review organization, auditor or other organization as may be permitted by law. This medical information may include drug/alcohol, psychiatric or HIV information or records about the treatment that I receive.

Academic Medical Center. I understand that physicians and other practitioners, in addition to attending or lead practitioner/surgeons, may be involved in my treatment, including resident physicians and other trainees. They will perform only within the scope of their license and the scope of practice and expertise. Residents may participate under the oversight of the attending physician or surgeon and the name of these individuals will be identified in the record.

_____
Signature of Patient

_____
Print Patient's Name

_____
Date Signed

Signature of Authorized Representative for Minor or Patient Without Capacity:

_____

A F 0 0 1

THE UNIVERSITY OF TOLEDO MEDICAL CENTER | THE UNIVERSITY OF TOLEDO PHYSICIANS

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

ADDRESSOGRAPH

The Notice of Privacy Practices provides information about how We may use and disclose protected health information about you and your privacy rights. Should you need an additional copy, an electronic copy is available on The University of Toledo's website: http://utmc.utoledo.edu/patientguests/services/privacy.html or you may contact the University of Toledo Medical Center's Patient Access Department.

Please acknowledge below that you or an authorized representative has received a copy of the Notice of Privacy Practices.

(Print Patient Name) (Date of Birth)

I acknowledge that I have received the Notice of Privacy Practices.

Signature of Patient or Patient's Representative and Representative's Relationship to Patient (if applicable).

Date Signature (Patient or Patient's Representative)

Relationship to Patient

FOR THE UNIVERSITY OF TOLEDO MEDICAL CENTER USE ONLY

Was written acknowledgment obtained? ☐ Yes ☐ Noi
If NO, please indicate reason below:

- ☐ Notice of Privacy Practices Given – Patient Unable to Sign
- ☐ Notice of Privacy Practices Given – Patient Declined to Sign
- ☐ Notice of Privacy Practices and Acknowledgment E-mailed/ Mailed to Patient
- ☐ Other Reason Patient Did Not Sign (Include Efforts to Obtain Acknowledgement)

Please Specify_____

Signature of Covered Entity Representative Date

Print Name Department

THE UNIVERSITY OF TOLEDO MEDICAL CENTER | THE UNIVERSITY OF TOLEDO PHYSICIANS

Affix Patient Label

PATIENT REGISTRATION QUESTIONNAIRE

Information in your medical record is confidential and is protected under HIPAA/Ohio Laws. Your written authorization will be required for release of information except in the case of a court order. While UT Health recognizes a number of gender/sexes, many insurance companies and legal entities unfortunately do not. Please be aware the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence. If your name and preferred pronouns is/are different from these, please let us know.

Do you have a preferred name? If so, indicate below.	Do you have a Preferred Pronoun, if so indicate below:

THIS INFORMATION IS FOR DEMOGRAPHIC PURPOSES ONLY AND WILL NOT AFFECT YOUR CARE.

Preferred Language (Choose One)		**Legal Sex:**	**What is your Gender Identity?**	**Do you think of yourself? (Sexual Orientation)**
☐ English ☐ العربية Arabic ☐ ខ្មែរ Cambodian ☐ 繁體中文 Chinese ☐ Srpsko-hrvatski Serbo-Croatian ☐ Nederlands Dutch ☐ Français French ☐ Deutsch German	☐ λληνικά Greek ☐ taliano Italian ☐ 한국어 Korean ☐ Polski Polish ☐ Português Portuguese ☐ Русский Russian ☐ Español Spanish ☐ Kiswahili Swahili) ☐ Українська Ukrainian ☐ Other: _____	☐ Female ☐ Male	☐ Female ☐ Male ☐ Trans Female (Male to Female) ☐ Trans Male (Female to Male) ☐ Other ☐ Decline to Answer	☐ Bisexual ☐ Heterosexual or Straight ☐ Lesbian, Gay, or Homosexual ☐ Something else ☐ Don't know ☐ Declined to answer

I agree with the above, and if anything above changes I am to inform the University of Toledo.

Patient/Guardian signature_____ Date_____

Print Name_____

Submit

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