

## ADVOCACY FORM

<b>Name</b> <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>	
<b>Address</b>	State	Zip Code:	Phone	Cell Phone
			enter	enter.
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
<b>Dialysis Clinic:</b>	Address		<b>City</b>	State Phone
<b>Doctor</b>				

**HAVE YOU CONTACTED CMS-ESRD NETWORK? IF SO, WHEN AND WHO?**

<b>Network number:</b>	<b>Contact:</b>	Phone

**CARE ISSUES**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Harrassment/Intimidation                    | <input type="checkbox"/> Termination  | <input type="checkbox"/> Transportation denied                              |
| <input type="checkbox"/> Physical abuse                              | <input type="checkbox"/> Request for records denied                           | <input type="checkbox"/> Family denied access during dialysis               |
| <input type="checkbox"/> Verbal abuse                                | <input type="checkbox"/> Transfer denied                                      | <input type="checkbox"/> Have you filed a complaint about a worker?         |
| <input type="checkbox"/> Infection                                   | <input type="checkbox"/> Did not sign behavioral contact                      | <input type="checkbox"/> Did you file a complaint about your care?          |
| <input type="checkbox"/> Machine turned from view                    | <input type="checkbox"/> False accusations                                    | <input type="checkbox"/> Was a police report filed about abuse or incident? |
| <input type="checkbox"/> Did you file a complaint with ESRD network? | <input type="checkbox"/> Did you receive a written response to your concerns? |   |
| <input type="checkbox"/> Did you file a complaint with the clinic?   | <input type="checkbox"/>  |   |

I am releasing Dialysis Advocates and/or Agents my HIPPA Authorization allowing **Arlene Mullin/Dialysis Advocates, LLC** to allow the releasing of any information that they deem necessary to advocate for my complaint. I also authorize Dialysis Advocates to release my HIPPA to Civil Rights, Justice Department, and to use email to anyone they choose. Be it the ESRD Networks, or any other agency including lawyers.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I have appointed Dialysis Advocates to be my legal Advocate per Medicare CFR's. I understand that I can send an email and have this revoked at any time.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness: \_\_\_\_\_ Phone number \_\_\_\_\_

**HIPPA AUTHORIZATION FORM**

I \_\_\_\_\_, hereby authorize the use or disclosure of my protected health information as described below:

1. I hereby convey to Dialysis Advocates and/or agents my HIPPA Authorization permitting access to and release any information deemed necessary to advocate in my behalf, including, but not limited to, the complaint regarding \_\_\_\_\_ . I also authorize Dialysis Advocates to release my HIPPA to Civil Rights, Us Justice Department or any other government agency, and to use email to transmit my records to anyone or any entity they choose.
2. DISCRPTION OF INFORMATION TO BE DISCLOSED if checked.
  - \_\_\_ The health information that may be disclosed is the following:
  - \_\_\_ -Medical Records and all notes with client's name listed i.e.: progress notes or flow sheets. (Run sheets)
  - \_\_\_ All treatment records
  - \_\_\_ Other: Disiplinary actions against patient, to discuss situations of actions. All past and present and future health care information may be shared.
  - \_\_\_ requesting a meeting with myself and my appointed Advocate.

3. PURPOSE OF USE OR DISCLOSURE; the purpose of this is the Patients Request.
4. VALIDITY OF AUTHORIZATION FORM. This Authorization form is valid for from the date signed. Can be revoked by emailing [arlene-mullin@dialysisadvocates.com](mailto:arlene-mullin@dialysisadvocates.com) If another form is required provide to patient in a timely manner.
5. ACKNOWLEDGEMENT

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or agent receiving it and would then no longer be protected by Federal privacy requirement.

I ALSO UNDERSTAND THAT ALL INFORMATION WILL GO THROUGH DIALYSIS ADVOCATES AND WILL RECEIVE INFORMATION BY DIALYSIS ADVOCATE'S ONLY AND DO NOT WANT ANY AGENCY OTHER THAN THE JUSTICE DEPT OR CIVIL RIGHTS TO CONTACT ME IN PERSON.

I AGREE TO THE FOLLOWING: Signature \_\_\_\_\_ Date: \_\_\_\_\_

Patients name Printed

Witness: \_\_\_\_\_

Please put the complaint on a separate piece of paper: We will need the top filled out and address of clinic.

Are you a minority? \_\_\_\_\_

### ISSUE HISTORY

Enter text