DIALYSIS ADVOCATES
Assisting Patients and Caregivers For Optimum Treatment Results.

Advocacy Form

Name *(Last, First, M.I.):*			☐ M ☐ F	**DOB:**	
Address	State	Zip Code:	Phone	Cell Phone	
			enter	enter.	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed					
Dialysis Clinic:	Address			**City** State	Phone
Doctor					

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

Network number: **Contact:** Phone

CARE ISSUES

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

☐

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. DISCRIPTION 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: Displinary 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.

Arlene-mullin@dialysisadvocates.com (202) 567-1616 Fax 888-213-5733

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 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