

EXAMPLE ONLY

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

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

Network number:	Contact:	Phone

CLICK ALL THAT APPLY **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 _____ **Patient** _____ **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 _____ **Patient** _____ **Date** _____

Witness: _____ **Must be signed** _____ Phone number _____

HIPPA AUTHORIZATION FORM

I _____ **Patient** _____, hereby authorize the use or disclosure of my protected health information as described below:

- 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.
- 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: Disciplinary 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 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 _____ **Patient** _____ Date: _____

Patients name Printed

Witness: _____ **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

Be as detailed as possible keeping in order of dates and incidents, names.