

**COOK CHILDREN'S HEALTH CARE SYSTEM  
ACKNOWLEDGMENT OF PRIVACY PRACTICES/FINANCIAL DISCLOSURE**

I understand that I have the right to restrict how my Health Information (defined below) is used or disclosed by Cook Children's Health Care System and its affiliated companies (hereinafter collectively referred to as "CCHCS") to carry out treatment, payment, or health care operations. I may seek to restrict these uses or disclosures by designating my restrictions in writing, however, I understand that CCHCS is authorized by federal law to refuse to abide by my requested restrictions and that restrictions on use of Health Information for payment, treatment, or health care operations may prevent me from receiving medical Services at CCHCS.

**RELEASE OF INFORMATION:** I consent and authorize CCHCS and any practitioner providing medical goods and services to patient to release information contained in any financial records and/or medical records, including diagnosis and treatment at CCHCS or by any practitioner providing medical goods and services to the patient, including but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), Hepatitis A, B and C, drug/alcohol abuse and treatment, psychiatric diagnosis and treatment records and/or laboratory tests results, medical history, treatment progress, and/or other such related information (collectively "Health Information") for the purpose of payment, treatment, or health care operations to one or more of the following:

1. Insurance Company, self-funded or health plan, its agents, representatives, attorneys or independent contractors, Medicare Medicaid, any other person or entity that may be responsible for paying or processing for payment any portion of my CCHCS bill or conducting utilization management/review and financial/medical audits;
2. To any person or entity affiliated with or representing CCHCS and any practitioner providing medical goods and services to patients for the purpose of payment, treatment and health care operations;
3. To any other hospital, nursing home, or other health care institution to which the patient is transferred;
4. Patient's primary, attending, consulting, referring, and/or family physician for follow up, physician information and/or continuity of care to include prospective or current home health company, to referring facility health care staff or to CCHCS.

In addition, I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy Notice, a copy of which has been provided to me. I have read or will read the Privacy Notice and ask CCHCS if I have any questions about the information contained in the Privacy Notice. I agree to the uses/disclosure of my/my child's Health Information as described in the Privacy Notice. Moreover, I understand that the Privacy Notice may be amended by CCHCS from time to time and that I may obtain an amended Privacy Notice at any time by contacting CCHCS' registration/front office personnel or by obtaining an updated version at [www.cookchildrens.org](http://www.cookchildrens.org).

I give permission for the release of Health Information to be transmitted by U.S. Mail, facsimile or other electronic medium. I may revoke this Consent to Release Health Information in writing at any time, unless action has already been taken in reliance thereupon; in which case, I may revoke this Consent for future communications.

I give my permission to CCHCS and its agents, employees and representatives to use the contact information, including cell phone numbers, I have provided to contact me for payment (including but not limited to autodialed or prerecorded collection calls), treatment or any other health care purposes.

**MEDICARE/TRICARE PATIENTS ONLY:** I acknowledge receipt of the written material entitled "Important Message for Medicare/Tricare."

**FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS AND RIGHTS:** I hereby irrevocably assign, transfer and convey to CCHCS and any practitioner providing care and treatment to me/my child, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee welfare benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I receive from CCHCS. I agree to assist CCHCS in processing claims for such benefits including providing all necessary information to CCHCS or the payor in a timely manner. If my/my child's treatment was caused by events which result in legal action, I assign to CCHCS an interest in any claims I/my child may have arising from or in connection with the delivery services by CCHCS to me/my child. I understand that CCHCS's charges for the services rendered or products received are set out in CCHCS's Charge Master and I hereby promise to pay the full billed charges for all of the services rendered to me/my child less any applicable contractual discounts. In cases where no insurance policy is applicable or my insurance considers CCHCS out-of-network, I understand that I may be responsible for the full billed charges. I understand I am responsible for all health insurance copayments and deductibles and any other amounts properly payable by me as permitted by law or contract. Charity care may be available if CCHCS eligibility criteria are met.

**DESIGNATION OF AUTHORIZED REPRESENTATIVE:** I designate and appoint CCHCS (and its agents) as my authorized representative and authorize it to act on my behalf to (1) request and receive a copy of the summary plan description; (2) pursue a benefit claim; (3) appeal an adverse benefit determination; and/or (4) file a legal/equitable action to recover benefits from my employee welfare benefit plan, insurance policy, any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by me/my child at CCHCS, any requests for documents relating to this claim and appeal of an adverse determination of the claim. This document shall remain in force until a written revocation by me is delivered to CCHCS.

**MEDICAID PATIENTS ONLY:** I understand that the amount owed to CCHCS for covered services will be satisfied by amounts paid by Medicaid for such services and that I will not be balance billed by CCHCS for Medicaid covered services. I further understand that the services or items that I request to be provided to me may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my/my child's care. I understand that the Texas Health and Human Services Commission or its health insuring agent determines the medical necessity of the services or items that are received. I also understand that I am responsible for payment of the services or items I receive if these services or items are determined not to be reasonable and medically necessary for my/my child's care. If I am a Medicaid STAR patient, I acknowledge that some of these provisions may not apply.

I hereby certify and affirm that I have the legal authority to make the above assignment of benefits and designation of authorized representative and, if other than a parent of the child receiving treatment, will provide upon request appropriate legal documentation of such authority (e.g., legal guardianship, power of attorney, court order).

**I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND RECEIVED A COPY OF THE CCHCS NOTICE OF PRIVACY PRACTICES.**

Patient's Name Printed: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Signature of Patient, if adult, or Patient's Parent/Legally Authorized Representative \_\_\_\_\_

Relationship \_\_\_\_\_

Witness \_\_\_\_\_

Time of Signing: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Hour \_\_\_\_\_ a.m. / p.m.

PRINT OR IMPRINT PATIENT INFORMATION



C&DMIT



801 Seventh Avenue  
Fort Worth, Texas 76104-2796