Tulane University

DEPARTMENT: General Counsel's Office -- HIPAA	**POLICY DESCRIPTION:** Consent and Release
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APPROVED: April 1, 2004	**REVISED: December 1, 2008**
EFFECTIVE DATE: April 1, 2004	**POLICY NUMBER: GC-024**

Tulane University – Consent and Release

SCOPE OF POLICY

This policy applies to Tulane University Medical Group, its participating physicians and clinicians, and all University employees and business units who provide management, administrative, financial, legal, and operational support to or on behalf of Tulane University Medical Group and have been designated as part of the Tulane University HIPAA Health Care Component. This policy pertains to protected health information covered by Tulane University Medical Group's Notice of Privacy Practices.

STATEMENT OF POLICY

This policy requires Tulane University Medical Group patients to sign a Consent and Release form before receiving care and prohibits billing audits on the records of any patient who has not signed either the form or a billing authorization.

IMPLEMENTATION OF POLICY

All patients must sign the attached Consent and Release form before receiving care at any Tulane University Medical Group clinic or by any Tulane University Medical Group practitioner**,** including care at Tulane University Hospital and Clinic. The Tulane University Hospital and Clinic form alone is not sufficient.

If a patient has not signed the Consent and Release form, no insurer, auditor, or other party may perform a billing audit on that patient 's records unless the insurer, auditor, or other party has obtained a billing authorization that includes:

1. the name of the payer, and if applicable, the name of the audit firm that is to receive the information;
2. the name of the institution that is to release the information;
3. the full name, birth date, and address of the patient whose records are to be released;
4. the extent or nature of the information to be released, with inclusive dates of treatment; and
5. the provider's patient account number; and
6. the signature of the patient or his legal representative and the date the consent is signed.

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The TUMG Billing Office must confirm for the audit representative that a Consent and Release is available for the particular audit that needs scheduling. The TUMG Billing Office will also inform the requestor if there are any federal or state laws prohibiting or restricting review of the medical record and if there are institutional confidentiality
policies and procedures affecting the review.

Tulane University Medical Group's HIPAA policies do not prohibit or restrict the ability of an insurance company or its auditor to review patient records as necessary to determine the extent of the insurer's responsibility for a claim submitted by Tulane University Medical Group.

VIOLATIONS

The Privacy Official has general responsibility for implementation of this policy. Employees who violate this policy will be subject to disciplinary action up to and including termination of employment. Anyone who knows or has reason to believe that another person has violated this policy should report the matter promptly to his or her supervisor or the Privacy Official. All reported matters will be investigated, and, where appropriate, steps will be taken to remedy the situation. Where possible, every effort will be made to handle the reported matter confidentially. Any attempt to retaliate against a person for reporting a violation of this policy will itself be considered a violation of this policy that may result in disciplinary action up to and including termination of employment.

Tulane University Medical Group

CONSENT AND RELEASE

ASSIGNMENT OF BENEFITS: I authorize direct payment to Tulane University Medical Group (TUMG), of all medical benefits, settlements, or judgments applicable to my treatment by TUMG physicians and other clinicians at the hospital or clinic. This authorization is applicable to all future charges and fees from, and including, this day forward, unless revoked in writing by me. I understand that I am personally responsible for payment of all fees applicable to my treatment by TUMG physicians at the hospital or clinic, including copayments, deductibles, and fees for non-covered services, irrespective of other insurance coverage or other parties' responsibility to me for such fees. If unpaid balances are overdue and are referred for collection, I agree to pay the attorney's fees, court costs, and/or collection agency fees associated with collection.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE, ACCEPTS THE TERMS THEREOF, AND HAS RECEIVED A COPY THEREOF.

RELEASE OF INFORMATION: I authorize TUMG and/or its physicians and other clinicians to disclose all or part of my medical or billing records to any insurance carrier or persons employed by such carrier for the purpose of collecting insurance benefits and auditing claims, so long as I am listed on this account as having coverage with such carrier. This authorization includes release of information to group health plans for group insurance coverage, workman's compensation carriers, and welfare agencies, if applicable to my claim for treatment. I hereby indemnify and release TUMG and its physicians and clinicians from any and all responsibility relative to the release of such information.

________________________	________________________	________________________
PATIENT NAME	DATE OF BIRTH	PATIENT SIGNATURE
NAME OF AUTHORIZED AGENT, IF ANY	SIGNATURE – IF SIGNED BY AUTHORIZED AGENT	RELATIONSHIP TO PATIENT
WITNESS NAME	WITNESS SIGNATURE	DATE OF SIGNING TIME

CONSENT FOR TREATMENT DATE ____________________ TIME ____________________

I, OR ______________________________ FOR ______________________________ KNOWING THAT (I AM/HE OR SHE IS) SUFFERING FROM A CONDITION REQUIRING DIAGNOSIS AND/OR MEDICAL OR SURGICAL TREATMENT, DO HEREBY VOLUNTARILY CONSENT TO SUCH DIAGNOSTIC PROCEDURES AND HOSPITAL, MEDICAL, AND SURGICAL CARE AS NECESSARY IN THE JUDGMENT OF PHYSICIAN(S) IN CHARGE. I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE, AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE ME AS TO THE RESULTS OF EXAMINATION OR TREATMENT. I HEREBY AUTHORIZE TULANE UNIVERSITY MEDICAL GROUP TO RETAIN OR DISPOSE OF ANY SPECIMENS OR TISSUES TAKEN FROM MY BODY DURING MY TREATMENT, AND TO USE SUCH SPECIMENS OR TISSUES FOR SCIENTIFIC, EDUCATIONAL, OR RESEARCH PURPOSES, TO THE EXTENT THAT SUCH SPECIMENS AND TISSUES ARE NOT KEPT AT TULANE UNIVERSITY HOSPITAL AND CLINIC.

WITNESS______________________________ SIGNATURE______________________________
(PATIENT OR PERSON AUTHORIZED TO CONSENT RELATIONSHIP)

DATE________________ TIME________________

REFUSAL OF CONSENT FOR TREATMENT

I ______________________________ REFUSE TO CONSENT TO ______________________________

______________________________ UPON______________________________

______________________________I HAVE BEEN ADVISED OF THE CONSEQUENCES AND RISKS OF SUCH REFUSAL, AND HEREBY RELEASE THE PHYSICIANS, CLINICIANS, AND TULANE UNIVERSITY MEDICAL GROUP FROM LIABILITY FOR INJURIES ARISING FROM SUCH REFUSAL.

WITNESS ______________________________ SIGNATURE ______________________________
(PATIENT OR PERSON AUTHORIZED TO CONSENT RELATIONSHIP)