Nebraska Medicine

Employee Health
Patient Information Form And
Consent For Treatment

Please Print				
Last Name	*First Name*		*Middle Initial*	
Address	*City*	*State*	*ZIP*	
Home Phone Number	*Department Name*	*Work Phone Number*		
Social Security Number	*Date of Birth*	*Age*	*Sex* ☐ Male ☐ Female	

Consent to Perform Services

I (or the undersigned acting on behalf of the patient) consent to medical care and treatment including but not limited to: diagnostic procedures, medical examinations and/or treatments, and therapy sessions, by the attending physician, their assistants, or designees, and/or allied health professionals. I also consent to a substance abuse test if requested by my employer, and agree to provide a urine, blood, breath, specimen as explained by Employee Health personnel. I also authorize Employee Health to report any medical findings, or medical or substance abuse test results, to my employer. I acknowledge that no guarantees have been made to me as to the results of diagnosis, treatments, tests or examinations.

Financial Responsibility

I also understand, and agree, that if my employer, or its representatives, deny my claim for workers' compensation benefits, that I am responsible for all charges incurred by me for the treatment of my injury or illness. I also agree to accept financial responsibility for treatment I request for any non-work related illness or injury. I also agree to immediately pay Employee Health for such charges as billed to me by Employee Health.

Notice of Privacy Practices: (mark one below)

a. ___ I acknowledge receipt of the Notice of Privacy Practices by signing below.
b. ___ Notice of Privacy Practices provided at previous visit.
c. ___ Acknowledgement of Notice of Privacy Practices not received (must complete both i. and ii.):
   i. Reason: _____
   ii. Describe good faith effort to obtain acknowledgement: _____

Consent:

_____ _____
Patient Signature *Date*

_____ _____
Guardian Signature (If patient is under the age of 19.) *Relationship*

_____
Witness

Employee Health Department • 988444 Nebraska Medical Center • Omaha, NE 68198-8444
Phone: (402) 552-3563 • Fax: (402) 552-2025

Nebraska Medicine

IMMUNIZATION AND ALLERGY VERIFICATION AUTHORIZATION

Name: _____ Birth date: _____

Address: _____ Daytime Telephone: _____

As part of your **post-offer medical assessment and/or initial animal contact clearance and renewals (as needed)**, we require verification of certain immunizations and allergies. Employee Health requests your permission to access your **Immunization and Allergy Records** within your medical record at Nebraska Medicine and disclose your **Immunization and Allergy Records** to Nebraska Medicine to verify required immunizations in connection with your employment. Access to your **Immunization and Allergy Records** would include any immunizations and allergies documented in your record, which would include the required employment immunizations as well as any additional immunizations you may have had. The following is a non-exclusive list of immunizations that may be included in your **Immunization Record**:

Hepatitis B Surface Antibody (HBsAB)	Tdap (Tetanus, diptheria, pertussis)	Hib
Mumps IGG (MumpG)	MMR (Measles, Mumps, Rubella) - series (2)	Human papillomavirus
Q Fever antibody (QFEVAB)	Varicella - series (2)	Polio
Rast mouse (Rast; mouse)	Varicella - zoster	Japanese encephalitis
Rast Rat (Rast; rat)	Meningococcal	Lyme disease
Rubella IGG (RUBG)	Mumps	Plague
Rubeola IGG (MEAT)	TB skin test	Pneumococcal
TB interferon (TBINF)	Hepatitis B Immune Globulin	Rotavirus
Varicella IGG (VZVT)	Q Fever	Respiratory syncytial virus
Influenza	Rabies (series)	Smallpox
Hepatitis B vaccine - series (3)	Adenovirus	Typhoid
Tetanus	Anthrax	Yellow Fever
Td (Tetanus, diptheria)	Cholera	Zoster
		PPD Test

Employee Health will only have access to the **Immunization and Allergy Records** portions of your medical record. In accordance with HIPAA, all other health information in your medical record is not viewable by Employee Health staff when documenting or retrieving your **Immunization and Allergy Records**. No genetic information will be accessed as part of this **Immunization and Allergy Record** access.

AUTHORIZATION:

☐ I **authorize** Employee Health to access my **Immunization and Allergy Records** and disclose it to Nebraska Medicine for post-offer immunization verification.

☐ I **decline** Employee Health accessing my **Immunization and Allergy Records**. I understand I am still required to separately provide verification of required immunizations as part of the post-offer medical assessment.

EXPIRATION: This authorization shall remain in effect from the date signed until termination of employment and/or revoked by me.

I UNDERSTAND:

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment at Nebraska Medicine.
- Once disclosed to Nebraska Medicine for employment purposes, immunization information included in employment files may be subject to re-disclosure if allowed under the laws applicable to Nebraska Medicine as an employer but are not protected by HIPAA.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me and delivered to Nebraska Medicine Employee Health.
- My revocation will be effective upon receipt, but will not impact on uses or disclosures made while my authorization was valid.
- I have a right to receive a copy of this authorization.

_____ _____

Signature of Individual | Signature of parent, guardian, or authorized Representative

_____ _____

Date | Relationship of above person to individual

Nebraska Medicine

EMPLOYEE HEALTH AUTHORIZATION

Name: _____ Birth date: _____

Address: _____ Daytime Telephone: _____

At Nebraska Medicine, we believe the electronic integration of health information ensures greater access to important medical information at the time of care. Nebraska Medicine Employee Health requests your permission to integrate your Employee Health treatment record into your medical record at Nebraska Medicine so that it is viewable by the providers and staff that may become involved in providing care to you. The information that would be viewable by staff includes:

Employee information:
- Results of the pre-employment physical
- Tuberculosis screening and test documentation
- Respirator medical evaluation questionnaire
- Respirator training and fit test record
- Immunizations
- Lab work
- Social Security number
- Employer and Employee ID
- Interpreter needs
- Preferred language
- Travel history

Emergency Contact information:
- Name and demographic information
- Status as legal guardian or healthcare agent
- Status as hearing impaired or visually impaired
- Spoken language
- Preferred language
- Written language
- Special needs or hearing-visual needs
- Requirement for an interpreter
- Directions for notification on admission
- Comments provided by employee

With your authorization, providers and staff with assigned job responsibilities will have access to this information from your Employee Health Record in the course of providing treatment to you. This authorization does not authorize Employee Health to access your medical record.

AUTHORIZATION:

☐ I **authorize** Employee Health to disclose the above information from my Employee Health record to Nebraska Medicine for incorporating into my medical record.

☐ I **decline** incorporating my Employee Health into my Nebraska Medicine medical record.

EXPIRATION: This authorization shall remain in effect from the date signed until termination of employment and/or until revoked by me.

I UNDERSTAND:
- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment at Nebraska Medicine.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me and delivered to Nebraska Medicine Employee Health.
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have a right to receive a copy of this authorization.

_____ _____

Signature of Individual | Signature of parent, guardian, or authorized Representative

_____ _____

Date | Relationship of above person to individual

Notice of Privacy Practices

How Your Medical Information Is Used

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice applies to the following organizations and clinics:

- The Nebraska Medical Center and its medical staff, including academic and private practice physicians, and allied health professionals while providing services at these locations, as an organized health care arrangement.
- The Bellevue Medical Center and its medical staff and allied health professionals as an organized healthcare arrangement.
- University of Nebraska Medical Center (UNMC)
- UNMC Physicians
- Nebraska Pediatric Practice, Inc.
- University Dental Associates (UDA)

The organizations listed above will use and distribute this Notice as their Joint Notice of Privacy Practices and follow the information practices described in this Notice when using or disclosing records and information. They will share your health information with each other, as necessary, to carry out treatment, payment, or health care operations as described in this Notice.

Understanding Your Health Information

Each time you visit a hospital, clinic, physician, or other health care provider, a record of your visit is made. Typically, this health record contains your medical history, symptoms, examination and test results, diagnosis, treatment, care plan, insurance, billing, and employment information. This health information, often referred to as your health record, serves as a basis for planning your care and treatment and is a vital means of communication among the many health professionals who contribute to your health care. Your health information is also used by insurance companies and other third-party payers to verify the appropriateness of billed services.

Our Responsibilities

We are required by law to:

- Maintain the privacy of your health information during your lifetime and for 50 years following your death.
- Provide you with an additional current copy of our Notice upon request.
- Abide by the terms of our current Notice.
- Notify you following a breach of unsecured protected health information in the event you are affected.

We will not use or disclose your health information without your written authorization, except as described in this Notice.

Uses And Disclosures Without Your Written Authorization

We may use and disclose your health information without your written authorization for Treatment, Payment and Health Care Operations

We will use and disclose your health information for treatment purposes
For example: Information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment. Health care team members will communicate with one another personally and through the health record to coordinate care provided. We will also provide your physician or subsequent health care provider with copies of various reports that should assist him or her in treating you in the future.

We will use and disclose your health information for payment purposes
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. We may disclose health information about you to other qualified parties for their payment purposes. For example, if you are brought in by ambulance, we may disclose your health information to the ambulance provider for its billing purposes.

We will use and disclose your health information for health care operations
For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of health care we provide. In some cases, we will furnish your health information to other qualified parties for their health care operations. The ambulance company, for example, may want information regarding your condition to help them know whether they have done an effective job of stabilizing your condition.

Health Information Exchange
We may make your protected health information available electronically through an information exchange service to other health care providers, health plans and health care clearinghouses that request your information. Participation in information exchange services also lets us see their information about you.

Teaching
As the primary teaching site for UNMC, residents, fellows, and students in medicine, dentistry, nursing, pharmacy, allied health and graduate studies, may be assisting with your care under the supervision of a licensed health care provider as a part of their professional health care training program.

Other Uses and Disclosures of your health information without your written authorization

Notification
We may use or disclose health information to notify or assist in notifying a family member, personal representative, or another person responsible for your care of your location and general condition.

Communication With Family and Others
We may disclose relevant health information to a family member, friend, or other person involved in your care. We will only disclose this information if you agree, are given the opportunity to object and do not, or if in our professional judgment, it would be in your best interest to allow the person to receive the information or act on your behalf.

Directory
Unless you notify us that you object, or we are otherwise prohibited by law, we may use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy, and, except for religious affiliation, to other people who ask for you by name.

Business Associates
There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your health information to our business associates so that they can perform such services. However, we require the business associate to appropriately safeguard your information.

Appointment Reminders
We may contact you as a reminder that you have an appointment for treatment or medical care.

Treatment Alternatives
We may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fundraising
We may use and disclose your health information to our business associates and affiliated foundations for fundraising purposes. We may contact you in an effort to raise money for clinical programs, research and education. If you do not want us to contact you for fundraising efforts, you must notify the Development Office by telephone toll-free at 800-647-6216, by email at development@nebraskamed.com or in writing at 987430 Nebraska Medical Center, Omaha, Nebraska, 68198-7430.

Research
Research is conducted under strict UNMC Institutional Review Board (IRB) guidelines designed to protect the subjects of research. Health information about you may be disclosed to researchers preparing to conduct a

research project. For example, it may be necessary for researchers to look for patients with specific medical characteristics or treatments to prepare a research protocol. For actual research studies we would obtain your specific authorization, if information that directly identifies you is disclosed. The only exception would be circumstances when the IRB grants a waiver of authorization as permitted under federal guidelines.

Public Health
We may disclose health information about you for public health activities. These activities may include disclosures:

- To a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability;
- To appropriate authorities authorized to receive reports of abuse and neglect;
- To FDA-regulated entities for purposes of monitoring or reporting the quality, safety or effectiveness of FDA-regulated products; or
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- With parent or guardian permission, to send evidence of required immunizations to a school.

Workers' Compensation
We may disclose health information to the extent authorized and necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Correctional Institutions
If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose to the correctional institution, its agents or the law enforcement official your health information necessary for your health or the health and safety of other individuals.

Law Enforcement
We may disclose your health information for law enforcement purposes:

- At the request of a law enforcement official and in response to a subpoena, court order, investigative demand or other lawful process;
- If we believe it is evidence of criminal conduct occurring on our premises;
- If you are a victim of crime and we obtain your agreement, or under certain circumstances, if we are unable to obtain your agreement;
- To identify or locate a suspect, fugitive, material witness or missing person;
- To alert authorities that a death may be the result of criminal conduct;
- To report a crime, the location of the crime or victim, or the identity, description or location of the person who committed the crime.

Health Oversight Activities
We may disclose health information for health oversight activities authorized by law. For example, oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Threats to Health or Safety
Under certain circumstances, we may use or disclose your health information if we believe it is necessary to avert or lessen a serious threat to health and safety and is to a person reasonably able to prevent or lessen the threat or is necessary for law enforcement authorities to identify or apprehend an individual involved in a crime.

Specialized Government Functions
We may disclose your information for national security and intelligence activities authorized by law, for protective services of the president; or if you are a military member, to the military under limited circumstances.

As Required by Law
We will use or disclose your health information as required by federal, State or local law.

Lawsuits and Administrative Proceedings
We may release your health information in response to a court or administrative order. We may also provide your information in response to a subpoena or other discovery request, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Funeral Directors, Medical Examiners, and Coroners
We may disclose your health information to funeral directors, medical examiners, and coroners consistent with applicable law to carry out their duties.

Organ Procurement Organizations
Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Incidental Uses and Disclosures
There are certain incidental uses or disclosures of your health information that occur while we are providing services to you or conducting our business. For example, after surgery the nurse or doctor may need to use your name to identify family members that may be waiting for you in a waiting area. Other individuals waiting in the same area may hear your name called. We will make reasonable efforts to limit these incidental uses and disclosures.

Uses And Disclosures That Require Your Written Authorization

The following uses and disclosures will only be made with your written authorization:

- Uses and disclosures not listed above as permitted without your written authorization;

- most uses and disclosures of psychotherapy notes;
- uses and disclosures for our marketing purposes; and
- disclosures that constitute a sale of your health information.

Your authorization may be revoked in writing at any time except with respect to any actions we have taken in reliance on it.

Your Health Information Rights

You have the following rights regarding your health information:

Right to Inspect and Copy
You may request to look at your medical and billing records and obtain a copy. You must submit your medical records request to the Health Information Management Department. Contact the office listed on your billing statement to request a copy of your billing record. If you ask for a copy of your records, we may charge you a copying fee plus postage. If we maintain an electronic health record about you, you have the right to request your copy in electronic format.

Right to Request Amendment
You may request that your health information be amended if you feel that the information is not correct. Your request must be in writing and provide rationale for the amendment. Please send your request to the Health Information Management Department. We may deny your request, and will notify you of our decision in writing.

Right to an Accounting of Disclosures
You may request an accounting of certain disclosures of your health information showing with whom your health information has been shared (does not apply to disclosures to you, with your authorization, for treatment, payment or health care operations, and in certain other cases).

To request an accounting of disclosures, you must send a written request to the Health Information Management Department. Your request must state a time period that may not be longer than six years.

Right to Request Restrictions
You may request restrictions on how your health information is used for treatment, payment or health care operations or disclosed to certain family members or others who are involved in your care. We may deny your request with one exception. If we agree to a voluntary restriction, the restriction may be lifted if use of the information is necessary to provide emergency treatment.

We are required to agree to your request that we not disclose certain health information to your health plan for payment or health care operations purposes, if you pay in full for all expenses related to that service prior to your request and the disclosure is not otherwise required by law. Such a restriction will only apply to records that relate solely to the service for which you have paid in full. If we later receive an authorization from you dated after the date of your requested restriction which authorizes us to disclose all of your records to your health plan, we will assume you have withdrawn your request for restriction.

To request a restriction, you must send a written request to the Health Information Management Department, specifying what information you wish to restrict and to whom the restriction applies. You will receive a written response to your request.

Right to Request Private Communications
You may request that we communicate with you in a certain way in a certain location. You must make your request in writing to the patient registration staff and explain how or where you wish to be contacted.

Right to a Paper Copy of this Notice
You may request an additional paper copy of this Notice at any time from any patient registration area.

You may contact the Health Information Management Department at:

989100 Nebraska Medical Center
Omaha, Nebraska 68198-9100
Phone: (402) 559-4705
Hours: 8:00 a.m. - 4:30 p.m. CST

Changes to this Notice

We reserve the right to change this Notice as our privacy practices change and to make the new provisions effective for all health information we maintain. We will post a current Notice in patient registration areas and on our websites.

For More Information or to Report a Problem

If you have questions or would like additional information, you may contact the Patient Relations Department. If you believe your privacy rights have been violated, you may file a complaint with the Patient Relations Department or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

You may contact the Patient Relations Department at:

982133 Nebraska Medical Center
Omaha, Nebraska 68198-2133
Phone: 800-647-6216 or 402-559-8158
Hours: 8:30 a.m. – 5:00 p.m. CST

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