UT Southwestern Medical Center

Health History Questionnaire

Pt. Name:_____

Address:_____

_____

City State Zip

MRN: _____

DOB: _____

SSN: XXX-XX-___ ___ ___ ___ SEX:_____

DOS: _____

Allergies:

Medication or Substance	Reaction

Current Medications and Over-the-Counter Medicines:

Name	Dose	Frequency

Medical History:

	Yes	No	Date First Noted (approximately)	Comments
Allergies	◯	◯		
Anemia	◯	◯		
Angina	◯	◯		
Anxiety Disorder	◯	◯		
Arthritis	◯	◯		
Asthma	◯	◯		
Atrial Fibrillation	◯	◯		
Bowel Disease	◯	◯		
Breast Cancer	◯	◯		
Colorectal Cancer	◯	◯		
Congestive Heart Failure	◯	◯		
Chronic Obstructive Pulmonary Disease (COPD)	◯	◯		
Coronary Artery Disease	◯	◯		

UT Southwestern
Medical Center

Health History Questionnaire

Pt. Name:_____
Address:_____
_____
City State Zip
MRN: _____
DOB: _____
SSN: XXX-XX-___ ___ ___ ___ SEX:_____
DOS: _____

Medical History (continued):

	Yes	No	Date First Noted (approximately)	Comments
Depression	◯	◯		
Diabetes Type 1	◯	◯		
Diabetes Type 2	◯	◯		
Diverticulitis	◯	◯		
Gallbladder Disease	◯	◯		
Gastric Ulcers	◯	◯		
GERD	◯	◯		
Heart Attack/MI	◯	◯		
Hepatitis	◯	◯		
High Cholesterol	◯	◯		
Hypertension	◯	◯		
Hyperthyroid Disease	◯	◯		
Hypothyroid Disease	◯	◯		
Refuses Blood Products	◯	◯		
Lung Cancer	◯	◯		
Memory Loss	◯	◯		
Migraines	◯	◯		
Multiple Sclerosis	◯	◯		
Osteoporosis	◯	◯		
Prostate Disease	◯	◯		
Renal Disease	◯	◯		
Rheumatoid Arthritis	◯	◯		
Seizures	◯	◯		
Sickle Cell Anemia	◯	◯		
Sleep Apnea	◯	◯		
Strokes	◯	◯		
Other:				

UT Southwestern Medical Center

Health History Questionnaire

Pt. Name:_____
Address:_____
_____
City State Zip
MRN: _____
DOB: _____
SSN: XXX-XX-___ ___ ___ ___ SEX:_____
DOS: _____

Surgical History:

	Yes	No	Occurrence Date (approximately)	Comments
Abdominal Aortic Aneurysm	◯	◯		
Appendectomy	◯	◯		
Back Surgery	◯	◯		
Bowel Surgery	◯	◯		
Brain Surgery	◯	◯		
Breast Lumpectomy	◯	◯		
Breast Mastectomy	◯	◯		
Cardiac Bypass	◯	◯		
Cardiac Catheterization	◯	◯		
C-Section	◯	◯		
Cosmetic Surgery	◯	◯		
ENT Surgery	◯	◯		
Eye Surgery	◯	◯		
Gallbladder Surgery	◯	◯		
Heart Surgery	◯	◯		
Hernia Repair	◯	◯		
Hip Surgery	◯	◯		
Hysterectomy	◯	◯		
Kidney/Bladder Surgery	◯	◯		
Knee Surgery	◯	◯		
Lung Surgery	◯	◯		
Moh's Surgery	◯	◯		
Prostate Surgery	◯	◯		
Shoulder Surgery	◯	◯		
Spleen Surgery	◯	◯		
Tonsillectomy	◯	◯		
Tubal Ligation	◯	◯		
Vasectomy	◯	◯		
Other (please specify):				

UT Southwestern Medical Center

Health History Questionnaire

Pt. Name:_____

Address:_____

_____

City State Zip

MRN: _____

DOB: _____

SSN: XXX-XX-___ ___ ___ ___ SEX:_____

DOS: _____

Family History:

Relationship	Name	Status (Alive or Deceased)	History of Alcohol or Drug Problems	Allergies	Problems with Anesthesia	Arthritis	Blood Diseases	Cancer	Diabetes	Genetic	Gastrointestinal Problems	Genitourinary (GU)	Heart	Hypertension	Lipid Problems	Neurological	Psychiatric Problems	Stroke	Thyroid	Other (please specify)
Mother																				
Father																				
Sister																				
Brother																				
Maternal Grandmother																				
Maternal Grandfather																				
Paternal Grandmother																				
Paternal Grandfather																				
Daughter																				
Son																				
Other (please specify)																				

Substance History:

Do you use tobacco?

◯ Current Every Day Smoker ◯ Current Some Day Smoker ◯ Never ◯ Former Smoker ◯ Passive

Type of Tobacco?

◯ Cigarettes ◯ Pipe ◯ Cigars

Quit Date _____ **Packs per Day** _____ **Years** _____

Smokeless Tobacco Use?

◯ Current User ◯ Never Used ◯ Former User

Type of Smokeless Tobacco?

◯ Snuff ◯ Chew

Are you ready to quit? ◯ Yes ◯ No

Do you use alcohol?

◯ Yes ◯ No **Comment:** _____

Drinks per week:

_____ **Glasses of wine** _____ **Cans of beer** _____ **Shots of liquor**

_____ **Drinks containing 0.4 oz of alcohol**

Do you use recreational drugs?

◯ Yes ◯ No **Comment:** _____

Use per Week: _____

Types? ◯ Cocaine ◯ Marijuana ◯ Methamphetamine ◯ Stimulants ◯ Heroin

◯ Depressants ◯ Hallucinogens

UT Southwestern
Medical Center

General Outpatient Clinic
Review of Systems

In general, are you currently experiencing any of the following on a regular basis?

YES	NO		YES	NO		YES	NO	
		Constitutional			**Cardiovascular**			**Musculoskeletal**
○	○	Fever	○	○	Chest Pain	○	○	Muscle pain
○	○	Chills	○	○	Palpitations	○	○	Neck pain
○	○	Weight loss	○	○	Leg (or ankle) swelling	○	○	Back pain
○	○	Weight gain	○	○	Severe shortness of breath	○	○	Joint pain
○	○	Fatigue			which awakens you from sleep	○	○	Falls
○	○	Excessive sweating	○	○	Difficulty breathing when lying flat			**Allergy / Endocrinology**
○	○	Night sweats			**Respiratory**	○	○	Environmental allergies
○	○	General weakness	○	○	Cough	○	○	Seasonal allergies
○	○	Hot flashes	○	○	Coughing up blood	○	○	Excessive (frequent) thirst
		Skin	○	○	Coughing up sputum/mucus	○	○	Heat intolerance
○	○	Rash	○	○	Shortness of breath	○	○	Cold intolerance
○	○	Itching	○	○	Wheezing	○	○	Easily bruise or bleed
○	○	Change in mole(s)	○	○	Noisy or high-pitched breathing			**Neurological**
○	○	Unusual hair loss	○	○	Pain with breathing	○	○	Dizziness
○	○	Breast concerns			**Gastrointestinal**	○	○	Tremors
		Head	○	○	Heartburn	○	○	Sensory change
○	○	Headaches	○	○	Change in appetite			*(Numbness, tingling)*
○	○	Difficulty hearing	○	○	Nausea	○	○	Speech change
○	○	Ringing in ears	○	○	Vomiting	○	○	Weakness in a specific location
○	○	Ear discharge	○	○	Abdominal pain			*(one arm, leg, or other area)*
○	○	Ear pain	○	○	Diarrhea	○	○	Seizures
○	○	Nosebleeds	○	○	Constipation	○	○	Loss of consciousness
○	○	Nasal congestion	○	○	Blood in stool			**Mental and emotional**
○	○	Loss of smell	○	○	Black stool	○	○	Substance abuse
○	○	Snoring	○	○	Incontinence of stool	○	○	Hallucinations
○	○	Difficulty swallowing			**Genitourinary / Urogenital**	○	○	Feeling nervous or anxious
○	○	Sore throat	○	○	Urgent/sudden need to urinate	○	○	Insomnia
○	○	Mouth sores	○	○	Blood in urine	○	○	Memory lapses or loss
		Eyes	○	○	Painful or burning urination	○	○	Depression
○	○	Blurred vision	○	○	Frequent need to urinate			**OTHER CONCERNS**
○	○	Double vision	○	○	Need to get up at night to urinate			
○	○	Light sensitivity	○	○	Loss of bladder control			
○	○	Eye pain	○	○	Sexual difficulties			
○	○	Eye discharge	○	○	**WOMEN:** Vaginal discharge			
○	○	Redness	○	○	**WOMEN:** Vaginal concerns			
			○	○	**MEN**: Penile discharge			

UT Southwestern
Medical Center

Patient Registration and Consent for Treatment

Pt. Name:_____

Address:_____

_____

City State Zip

MRN: _____

DOB: _____

SSN: XXX-XX-___ ___ ___ ___ SEX:_____

DOS: _____

Welcome to UT Southwestern Medical Center (UT Southwestern). Please take a moment to review and sign this Registration and Consent for Treatment. We regret that we are unable to accept any alterations to this form and will not be able to provide health care to you if the form is not signed as presented. UT Southwestern reserves the right to make changes to this form. If changes are made, you will be presented with a new form for signature. Our clinic staff is available to answer any questions you may have.

Social Security Disclosure Statement

Disclosure of your Social Security Number (SSN) is requested from you in order for UT Southwestern to facilitate positive patient identification. No statute or other authority requires that you disclose your SSN for that purpose. Failure to provide your SSN, however, may result in a lack of positive patient identification. Further disclosures of your SSN are governed by the Public Information Act (Chapter 552 of the Texas Government Code) and other applicable law.

I. Patient Rights and Responsibilities

UT Southwestern acknowledges that I have rights as a patient, and I acknowledge that I have responsibilities as a patient. These are discussed in the Patient Rights and Responsibilities and the Notice of Privacy Practices documents; copies are available to me upon request.

II. Consent For Treatment

I, _____, voluntarily present to UT Southwestern for medical and/or dental evaluation, diagnosis, and/or treatment. I consent and authorize my provider(s) or his or her designee(s) to provide diagnostic and therapeutic treatment, which may be necessary or advisable in their professional judgment. As a teaching institution, UT Southwestern welcomes medical residents; students in other disciplines, including nursing; and university approved observers engaged in an educational purpose; all of whom are under the direct supervision of a privileged provider or staff member. By signing this consent form, I do not waive my right to refuse recommended tests or treatment(s).

III. Release of Information

I understand that as part of my health care, UT Southwestern's personnel and my physician create and maintain a record of the care and services provided. I also understand that such information may be used and/or disclosed in the management and delivery of care and services provided by UT Southwestern to me, as described in the Notice of Privacy Practices.

I understand and acknowledge that UT Southwestern participates in an electronic medical record exchange program with other health care facilities and providers ("Exchange Participants"). I understand that when I seek treatment from UT Southwestern or Exchange Participants, my health information may be shared electronically between UT Southwestern and Exchange Participants in order to provide care and services to me, and I do hereby authorize UT Southwestern to share my health information in this manner with Exchange Participants. I also understand that my health information may include certain "Sensitive Information" such as genetic information and diagnoses or treatments for substance abuse, mental illness (excluding psychotherapy notes) or communicable diseases (including HIV or AIDS), and that some Sensitive Information cannot be disclosed through the medical record exchange program without a separate authorization by me.

I understand and acknowledge that as part of receiving my health care at UT Southwestern, my physician and other personnel engaged in my care may electronically request my prescription medication history from participating pharmacies, pharmacy benefit managers, or payers, and that such prescription medication history may become part of my medical record.

IV. Payment for Services/Assignment of Benefits

I understand that, regardless of my assigned insurance benefits, I am financially responsible for payment of services rendered to me. In addition, I will be financially responsible for my spouse and my child/children that is/are born or treated by UT Southwestern or its physicians. If the providers involved in my care accept third-party reimbursement for all or part of the services I receive, I hereby agree to assign such benefits to UT Southwestern and authorize my insurance company, governmental program, or other entity to make payment directly to UT Southwestern. I understand that UT Southwestern may disclose a limited amount of health information to third-parties to obtain payment for the health care services provided.

I agree to pay co-payments, co-insurance, deductibles, and outstanding balances. UT Southwestern will honor any arrangements and/or agreements entered into with my insurance company or third-party payers. I understand that I will not be billed for amounts which UT Southwestern is contractually or legally obligated to discount. If I am injured and receive treatment at UT Southwestern, I agree to assign to UT Southwestern my interest in any lawsuit or settlement to the extent necessary to fully pay UT Southwestern for this treatment. If my account becomes delinquent and is referred to an attorney or collection agency for collections, I agree to pay reasonable and necessary attorney's fees and collection expenses.

I certify that the information given by me in applying for payment under any medical insurance program, including Medicare and Medicaid, is correct.

Patient's Printed Name	Patient's Signature	Time	Date
*Legal Representative's Printed Name	Legal Representative's Signature	Time	Date

_____

If representative, specify relationship to the patient

**Note* Proof of legal authority may be required for legal representatives.*

Form # AMA/PRCFT-001 / 07.05 (Rev. 11.06.14) White – Health Information Management Department Yellow – Patient

UT SOUTHWESTERN MEDICAL CENTER

UNIVERSITY HOSPITALS & CLINICS

Authorization to Disclose Protected Health Information

Pt. Name:_____

Address:_____

_____
City State Zip

DOB: _____

SSN: XXX-XX-___ ___ ___ ___ SEX:_____

Instructions: Complete all applicable sections to have information disclosed from UT Southwestern Medical Center at Dallas (UT Southwestern) to another provider or requestor. UT Southwestern will not condition treatment, payment, enrollment or eligibility for benefits based on the completion of this form.

Patient Notice
This Section Applies to All Requests

I hereby authorize UT Southwestern Medical Center at Dallas (UT Southwestern) to disclose my protected health information. I understand a processing fee may apply for the requested information. Identification will be required for patient privacy and confidentiality.

A. I understand that the information is to be released for the following purpose:

Please fill in all bubbles that apply:

◯ Attorney ◯ Billing or Claims ◯ Patient Request ◯ Social Security Disability ◯ Treatment/Consultation

◯ Review Record: _____

B. I understand the information requested will be: Please mark one: ◯ Mailed to or ◯ Picked up by:

Name:_____

Attn:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____

Section 1 Ambulatory Outpatient Medical Record & Billing Request
Information to be Routed and Processed by the Ambulatory Services Custodian of Medical Records

A. Information to be released:

(Fill in all bubbles that apply)

◯ Billing Records ◯ Progress Notes ◯ Labs

◯ Complete Medical Record (includes information regarding insurance, demographics, referral documents and records received from other facilities)

◯ Other:_____

B. Time period or date of information to be released: From:_____ To:_____
(Month / Year) (Month / Year)

Section 2 Hospital Inpatient Medical Record & Billing Request
Information to be Routed and Processed by the Inpatient Custodian of Medical Records

A. Information to be released:

(Fill in all bubbles that apply)

◯ Blood Type ◯ Emergency Room Records ◯ Laboratory Reports ◯ Pathology Reports
◯ Consultation Reports ◯ Face Sheet ◯ Medication Sheets ◯ Progress Notes
◯ Discharge Summary ◯ History & Physical ◯ Newborn Records ◯ X-ray Reports
◯ EKG/ECHO ◯ Itemized Bill ◯ Operative Records ◯ Billing Records
◯ Outpatient Building ◯ Other:_____

B. Time period or date of information to be released: From:_____ To:_____
(Month / Year) (Month / Year)

Section 3 Oral Surgery Film, Reports, and Billing Request

A. Information to be released: ◯ Dental Images/Reports ◯ Billing Records

B. Time period or date of information to be released: From:_____ To:_____
(Month / Year) (Month / Year)

White – Health Information Management Department Yellow – Patient

Form # MSA/ADPHI-001 / 01.05 (Rev. 11.09.12)

UT SOUTHWESTERN MEDICAL CENTER

UNIVERSITY HOSPITALS & CLINICS

Authorization to Disclose Protected Health Information

Pt. Name:_____

Address:_____

_____
City State Zip

DOB: _____

SSN: XXX-XX-___ ___ ___ ___ SEX:_____

Section 4 Radiology Film, Images, and Billing Request

A. Time period or date of information to be released: From:_____ (Month / Year) To:_____ (Month / Year)

B. **Location of information:**

- ◯ Aston Radiology
- ◯ Rogers MRI
- ◯ Meadows MRI
- ◯ PET center
- ◯ Zale Lipshy Radiology
- ◯ Outpatient Building Imaging Center
- ◯ St. Paul Radiology
- ◯ Simmons Breast Center
  - ◯ Temporary transfer
  - ◯ Permanent transfer

Information requested:

- ◯ CT / CAT Scan
- ◯ MRI
- ◯ Xray / Images
- ◯ PET scan
- ◯ Nuclear Medicine scan
- ◯ Ultrasound / Sonogram
- ◯ Bone density
- ◯ Mammograms
- ◯ Reports

*Note: Temporary transferred studies must be returned within 30 days from release date.

Would you prefer your images be recorded onto a CD? ◯ No ◯ Yes

Section 5 Home Health Records and Billing Request
Information to be Routed and Processed by the Home Health Custodian of Medical Records

A. Information to be released: ◯ Home Health Records ◯ Billing Records

B. Time period or date of information to be released: From:_____ (Month / Year) To:_____ (Month / Year)

Section 6 Psychiatry or Genetics Records and Billing Request
Information to be Routed and Processed by the Psychiatry or Genetics Custodian of Medical Records

A. Information to be released: ◯ Psychiatry Records ◯ Genetics Records ◯ Billing Records

B. Time period or date of information to be released: From:_____ (Month / Year) To:_____ (Month / Year)

Patient Acknowledgement

- I understand that the records used and disclosed pursuant to this authorization may include information relating to: Genetic counseling; Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) treatment; history of drug or alcohol abuse; mental, behavioral health, or psychiatric care; and/or other sensitive information.
- I understand that I may revoke this authorization in writing at any time, except to the extent that UT Southwestern has relied on this authorization. The written revocation should be addressed to the Release of Information Department. Unless otherwise revoked, I understand that the date or event upon which this authorization expires is **180 days** from the date of signature. A photostatic copy of this authorization is considered as valid as the original.
- I understand that to the extent any recipient of this information, as identified above, is not a "covered entity" under the Federal or Texas privacy laws, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient, and, therefore, may be subject to re-disclosure by the recipient.
- I understand that according to Chapter 159 of the Texas Occupational Code Section 159.005 (e) and HIPAA, a re-disclosure could be made from records received from another health care provider involved in my care or treatment.

Patient's Printed Name	Patient's Signature	Time	Date
*Legal Representative's Printed Name	Legal Representative's Signature	Time	Date

_____
If representative, specify relationship to the patient

**Note* Proof of legal authority may be required for legal representatives.*

Radiology Use Only	**Release of Information Use Only**
Date Received_____ Date Processed_____	Date Received_____ Date Processed_____
Processed By_____ Date Records Mailed/Picked Up_____	Processed By_____ Date Records Mailed/Picked Up_____
Date Authorization Revoked, if applicable _____	Date Authorization Revoked, if applicable _____
Fee for Records _____	Fee for Records _____
Fee Waived By _____	Fee Waived By _____

Form # MSA/ADPHI-001 / 01.05 (Rev. 11.09.12) White – Health Information Management Department Yellow – Patient

UT Southwestern
Medical Center

Authorization for Verbal Release of Protected Health Information to Designated Persons

AT THE PATIENT'S REQUEST, THIS AUTHORIZATION GRANTS PERMISSION TO UT SOUTHWESTERN MEDICAL CENTER TO COMMUNICATE IN PERSON OR BY TELEPHONE WITH THE FOLLOWING PERSONS, DESIGNATED BY THE PATIENT, TO ASSIST WITH THE PATIENT'S HEALTH SERVICES. THIS AUTHORIZATION IS APPLICABLE FOR VERBAL INFORMATION ONLY AND IS NOT VALID FOR THE RELEASE OF THE WRITTEN MEDICAL RECORD.

I AUTHORIZE UT Southwestern Medical Center to communicate my health information to the person(s) listed below (Designated Persons") for the following purposes: to discuss my health care, diagnosis, prognosis, and treatment plans; and to discuss billing and payment for medical services provided by UT Southwestern Medical Center.

Please print the following information for each Designated Person:

Name:_____ Relationship to the patient:_____

Address:_____ Telephone:_____

_____ Alternate Telephone:_____

_____

I UNDERSTAND that this authorization applies to all departments, healthcare providers and/or employees at UT Southwestern Medical Center.

I UNDERSTAND that this authorization is voluntary.

I UNDERSTAND that once this information is disclosed to the Designated Person(s), it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

I UNDERSTAND that this authorization will be effective for this hospital admission, unless revoked by me, and for one year following my death. I further understand that I may revoke this authorization at any time

If I revoke the authorization, it will not have any effect on any actions taken by UT Southwestern Medical Center prior to the processing of the revocation.

I UNDERSTAND that my refusal to sign this authorization will not negatively affect my health care services at UT Southwestern Medical Center.

BY SIGNING THIS AUTHORIZATION I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE STATEMENTS CONTAINED HEREIN. I UNDERSTAND THAT UT SOUTHWESTERN MEDICAL CENTER WILL PROVIDE ME WITH A COPY OF THIS SIGNED AUTHORIZATION FORM.

PATIENT:
Print name:_____

Signature:_____

Time: _____ Date:_____

IF PATIENT HAS A LEGAL REPRESENTATIVE, COMPLETE THE FOLLOWING:
Print Name of Patient:_____
Print Name of Legal Representative:_____
Relationship to Patient:_____
By signing this authorization, I certify that I have the legal authority to serve as the above named patient's legal representative*.
Signature of Legal Representative:_____
Time: _____ Date:_____

**Proof of legal authority may be required. For more information on qualifications to serve as a patient's legal representative, see UT Southwestern Medical Center's Guidelines for Legal Representatives.*

White – Health Information Management Department Yellow – Patient

FORM # 81063 (07/07) (Rev. 08/15) (Reviewed 09/13)

UT Southwestern
Medical Center

Authorization for Verbal Release of Protected Health Information to Designated Persons

Revocation of Authorization

This section is to be completed ONLY in the event the patient seeks to revoke the authorization on Page 1 after signature.
By my signature below, I am revoking this authorization. I understand that this revocation will be effective when received by UT Southwestern Medical Center and will not be effective to the extent that UT Southwestern Medical Center has relied on my authorization prior to receiving notice of my revocation.

The designated person(s) to be revoked:_____
PATIENT:_____
Print name:_____
Signature:_____
Time: _____ Date:_____

IF PATIENT HAS A LEGAL REPRESENTATIVE, COMPLETE THE FOLLOWING:
Print Name of Patient:_____
Print Name of Legal Representative:_____
Relationship to Patient:_____
By signing this authorization, I certify that I have the legal authority to serve as the above named patient's legal representative*:
Signature of Legal Representative: _____
Time: _____ Date:_____
**Proof of legal authority may be required. For more information on qualifications to serve as a patient's legal representative, see UT Southwestern Medical Center's Guidelines for Legal Representatives.*

This Section for Internal Use Only

Date revocation received:_____ Date revocation processed:_____

Name of employee processing request:_____

FORM # 81063 (07/07) (Rev. 08/15) (Reviewed 09/13) White – Health Information Management Department Yellow – Patient

UT Southwestern Medical Center

Notice of Privacy Practices Acknowledgement of Receipt Form

Pt. Name:_____
Address:_____
_____
City State Zip
MRN: _____
DOB: _____
SSN: XXX-XX-___ ___ ___ ___ SEX:_____
DOS: _____

Your signature below indicates that you have been offered a copy of UT Southwestern Medical Center's Notice of Privacy Practices. If you have any questions about the Notice of Privacy Practices, please call The UT Southwestern Medical Center's Privacy Officer at 214-648-6080.

I have been offered the Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Print Patient Name Date

_____ _____
Legal Representative Signature Date

_____ _____
Print Legal Representative Name Date

_____ _____
Relationship to Patient Date

Please describe relationship to patient if other than self. _____

_____

_____

_____

FOR OFFICE USE ONLY:
UT Southwestern Medical Center will make a good faith effort to obtain a written acknowledgment of receipt of the Notice provided to the individual. If the patient is unwilling and or unable to sign this acknowledgment, UT Southwestern Medical Center must document its good faith efforts to obtain such acknowledgment and record the reason why the acknowledgement was not obtained.

Reason:_____

Notice mailed to patient Date: _____ Staff Signature: _____

Form # NPPARF-001 / 03.05 (Rev. 12.11)
Reviewed 09/13
White – Health Information Management Department
Yellow – Patient