**NIH Clinical Center Ambulatory Care Services Patient Registration Form – Offsite Visit**

**Disclaimer-**

Public reporting burden for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-xxxx*). Do not return the completed form to this address.

**OMB Number: 0925-XXXX**
**OMB Expiration Date: TBD**

# NIH CLINICAL CENTER
# AMBULATORY CARE SERVICES PATIENT REGISTRATION FORM – OFFSITE VISIT

*Required Field

## Patient Information

*Name: ______________________________ *Date of Birth: ___/___/____
Last First Middle

SSN: ____-___-_____ *Sex: _________ Marital Status: ________________

*Address: ______________________________________________

*City: ______________________ *State: ________ *Zip Code: __________ Country: ___________

* (a contact #) Home Phone: _____________ Work Phone: _____________ Cell Phone: _____________

Email: (for secure email communication with provider if provider elects to): ______________________

Primary Language: __________________ *Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Religious Preference: ____________________ *Race (check one):
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hawaiian/Pacific Island
- ☐ Multiple Race
- ☐ Unknown
- ☐ White

If admitted would you like a Clergy visit: ( ) yes ( ) no

Country of Citizenship: ______________________________

## Supplemental Information

How were you referred to the NIH (check one)

☐Self Referral (select one below) ☐Physician Referral (complete referring physician information)

How did you hear about the NIH:
- ☐Family/Friend
- ☐Physician
- ☐Media
- ☐Newspaper/Magazine
- ☐Internet
- ☐Flyers/Mailings
- ☐Community Outreach

Name: ______________________________
Address: ______________________________
______________________________
City: ________________ State: ________
Zip Code: ______________________________
Phone: ______________________________
Fax: ______________________________

Are you employed by the NIH? ( ) no ( ) yes

Are you related to a NIH employee? ( ) no ( ) yes If yes, relationship to employee: ______________

How would you like to be notified of follow-up appointments? ( ) Mail ( ) Phone ( ) Mail & Phone ( ) None

Do you have a Private Physician: ( ) no ( ) yes

Are you employed by: ( ) Government ( ) Self Employed ( ) Private ( ) Other: ________________

**NIH CLINICAL CENTER**
**AMBULATORY CARE SERVICES PATIENT REGISTRATION FORM – OFFSITE VISIT**

## Contact Information

***Next of Kin:** ____________________ **Relationship:** ____________________

**Address:** ________________________________________

**City:** __________ **State:** __________ **Zip Code:** __________ **Country:** __________

**Home Phone:** __________ **Work Phone:** __________ **Cell Phone:** __________

***Emergency contact:** ____________________ **Relationship:** ____________________

**Address:** ________________________________________

**City:** __________ **State:** __________ **Zip Code:** __________ **Country:** __________

**Home Phone:** __________ **Work Phone:** __________ **Cell Phone:** __________

## Physician/Dentist to Receive Reports (Doctor Outside the NIH) - Complete if you would like for your doctor(s) outside the NIH to receive your medical reports from the NIH.

**Physician's Name:** ____________________ **Specialty:** ____________________

**Address:** ________________________________________

**City:** __________ **State:** __________ **Zip Code:** __________ **Country:** __________

**Office Phone:** ____________________ **Fax:** ____________________

**Physician's Name:** ____________________ **Specialty:** ____________________

**Address:** ________________________________________

**City:** __________ **State:** __________ **Zip Code:** __________ **Country:** __________

**Office Phone:** ____________________ **Fax:** ____________________

**Information Provided by:** ____________________ **Relationship to Patient:** ____________________

| MEDICAL RECORD | General Admission Consent |
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**CONDITIONS GOVERNING ADMISSION:** The primary purpose of the Clinical Center is the conduct of biomedical research concerning health and disease. You will be evaluated, as an inpatient or outpatient, for consideration as a participant under a clinical research plan called a study or protocol. Your admission may be for general screening, diagnostic procedures, or specific treatment. You may be asked to undergo a number of tests to evaluate your suitability for a study. All of these activities are done for research purposes. Before you are enrolled on a specific protocol, or undergo any experimental tests or treatments, you will be asked to read and sign a separate informed consent document. The study and the status of your health determine the duration of your treatment at the Clinical Center, and whether you are seen as an inpatient or outpatient. You are not obligated to stay and may leave at any time. If you have personal, religious or ethical beliefs which might limit the types of medical treatment (such as blood transfusions) that you would agree to receive (or would want your child to receive), these issues should be discussed in detail with your NIH physicians. Adults may choose to record restrictions on their own medical care in a separate advance directive document. If you have any questions about preparation of an advance directive document, contact a member of your health care team.

You may be enrolled in more than one study. While you are enrolled in any study, the NIH will provide study-related care at the Clinical Center, including the evaluation of any complications that may be study-related. Your admission to the Clinical Center does not mean that you are automatically eligible for long-term care at the NIH. When your NIH physicians determine that your participation in clinical research at the NIH has been completed, you will be so notified and returned to the care of your primary physician. Your NIH physicians will provide your primary physician with a complete written summary of your care at the NIH, and will do their best to provide additional information, if necessary.

Medical records are maintained at the Clinical Center in accordance with the Privacy Act of 1974 and the Public Health Service Act (PL 100-607). Much of the medical information obtained about you will be stored in a computer system. The information is used partly for the same purposes as a typical medical record, that is, for your personal benefit. It is also used for research by NIH scientists, some of whom may have no personal contact with you. Much of the information will eventually be used in publications, but your identity will not be revealed. In addition, certain diseases or conditions, including infectious diseases, may be reported to appropriate representatives of the State or Federal Government as required by law. For further explanation regarding information practices at the Clinical Center, please refer to the "Patients' Rights, Informed Consent, Confidentiality," Patient Handbook: Clinical Center, Section 2, Office of Clinical Center Communications, CC, NIH, 1991.

**CONSENT TO ADMISSION:**

I, ______________________________, hereby consent to admission to the Clinical Center and I understand that, prior to entering the research protocol(s) selected for me, I will be provided with additional information and my consent will be sought for participation in each study.

- I further consent to such routine hospital care, diagnostic procedures, and medical treatment which the medical and professional staff of the Clinical Center may deem necessary or advisable.
- I authorize preservation of any specimens taken for laboratory or pathology examination for the purpose of medical research and/or education, or to the disposal of such specimens in a manner determined appropriate by the staff.
- I authorize the use of medical information obtained about me as specified above and the disclosure of such information to the physician(s) or organization(s) I have identified to receive ongoing medical updates.
- I authorize NIH staff (as appropriate) to make photographs, videos, or other recordings that document my condition/treatment in order to provide, coordinate, or manage my care. These images will be maintained as NIH records until destroyed.

*This form has been fully explained to me and I understand its contents. I further understand that no guarantees have been made to me as to the results of treatments or examinations done at the Clinical Center.*

______________________________ ______________
Signature of Patient/Research Volunteer — Date

______________________________ ______________ ______________
Signature of Parent/Legal Guardian for Minor — Date — Relationship to Minor

______________________________________________
Address (Parent or Legal Guardian) — City — State — Zip Code — Telephone

WITNESS: ______________________________ ______________
Clinical Center Staff Member — Date

| Patient Identification | General Admission Consent<br>NIH-1225-1 (9-06)<br>P.A. 09-25-0099<br>File in Section 4: Admission/Discharge |
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| MEDICAL RECORD | Information Practices |
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We, here at the Clinical Center (CC), strive to provide privacy for all our patients and to maintain the confidentiality of the sensitive personal information they share during the course of treatment. As stated in the Patients' Bill of Rights, "The patient has the right to privacy concerning the medical program. Case discussion, consultation, examination, and treatment are confidential and will be conducted discreetly. The patient has the right to expect that all communications and records pertaining to care will be treated as confidential to the extent permitted by law." Sound policies and procedures have been put in place at the CC to support these efforts while not excessively inhibiting the traditional, open exchange of information upon which the research mission of the National Institutes of Health (NIH) rests. However, there are usual and unavoidable risks to confidentiality to be found in any health care organization and, while we will do our best, we cannot guarantee absolute and total confidentiality for any patient. Therefore, if you believe that information about you is of interest to the media, or that you are otherwise particularly vulnerable to the release of some sensitive personal information, you should discuss the matter in depth with your research team and/or the Patient Representative, who can be reached at 496-2626.

The collection, maintenance and use of patient information in medical records or other data storage systems at the CC is governed by laws and implementing regulation including the Privacy Act of 1974, the Freedom of Information Act and applicable provisions of the Public Health Service Act. Under those laws and implementing regulations, employees of the NIH and the Department of Health and Human Services may have access to any information necessary to perform their assigned duties. In addition, there are certain statutory exceptions and published routine uses of personally-identified information that do not require prior approval for release to individuals or organizations that are not a part of the NIH. Those are discussed at length in the Patient Handbook under Section 2: "Patients' Rights, Informed Consent, Confidentiality." In brief, they are:

1. Physician(s), organization(s), or an individual identified by the patient to receive ongoing medical updates.
2. The Social Work Department may share information to assist patients in the community.
3. The Travel Office may inform public carriers of patients' special requirements, such as wheelchairs.
4. Information regarding diagnostic problems or having unusual scientific value may be shared with consultants.
5. Information may be shared during audits of the operation of the CC or with accreditation organizations.
6. Congress may request information for matters within their jurisdiction or on behalf of constituent patients.
7. Certain diseases or conditions, including infectious diseases, or concerns about abuse and neglect may be reported to appropriate governmental representatives as required by law.
8. Information may be released for statistical or research analysis without personal identifiers.
9. Contractors may require access to certain information in order to provide a service. In such cases, all contractor personnel shall be subject to the requirements of the Privacy Act.
10. Information may be released to facilitate the defense of a federal employee or the U.S. involved in a law suit.
11. The Bureau of the Census or the National Archives may request records for survey, census or historical preservation.
12. Information may be released in response to a court order or for law enforcement purposes.

Except for the uses described above, generally medical and personal information about a patient is not given to anyone without the specific written permission of the patient. However, if at some later time, a hospital or physician who is caring for you need information immediately, and if waiting to obtain your permission could endanger your health, the information will be released immediately, and you will be notified of the release by letter. Such information may be transmitted via facsimile.

The following individuals or offices stand ready to assist you with many aspects of information practices at the Clinical Center. Please do not hesitate to contact them if the need arises:

| | | |
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| • Authorization for Release of Information: | Medicolegal Section: | (301) 496-3331 |
| • Media Interaction and Policy: | CC Communications: | (301) 496-2563 |
| • Breach of Confidentiality: | Privacy Officer: | (301) 496-4240 |
| • Special Privacy Requirements: | Patient Representative: | (301) 496-2626 |
| • Secure Medical Email Inquiries: | Medicolegal Section: | (301) 496-3331 |

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*I have read this explanation of information practices at the CC and have been given the opportunity to discuss it and ask questions. Furthermore, I understand that if I have any questions or concerns about the use of information at the CC, I may contact any of the persons or offices listed above for assistance.*

☐ *I authorize copies of my records to be sent to my provided home address.* ☐ *Please do not automatically send records to my home address.*

Signature of Patient/Healthy Volunteer or Parent/Legal Guardian for Minor ____________ Date ____________

Signature of Witness ____________ Date ____________

The National Institutes of Health (NIH) Clinical Center is offering a service enabling electronic communications between patients and their health care providers and other authorized NIH staff (for example, Scheduling, Admissions, or Medical Record Department staff, etc.). By specifying an email address below and signing the form, you consent to electronic communications.

☐ *I agree to the use of secure electronic communications and specified the email address to which electronic communications can be addressed below. By signing this form I certify that I am the individual who I claim to be. I understand that the knowing and willful request for or acquisition of a medical record pertaining to an individual under false pretenses and the making of a false statement are both criminal offenses punishable by imprisonment. Specify only the email address that you frequently use and monitor:*

____________ @ ____________

Signature of Patient/Healthy Volunteer or Parent/Legal Guardian for Minor ____________ Date ____________

| Patient Identification | Information Practices<br>NIH-2753 (5-12)<br>P.A. 09-25-0099<br>File in Section 4: Authorization |
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