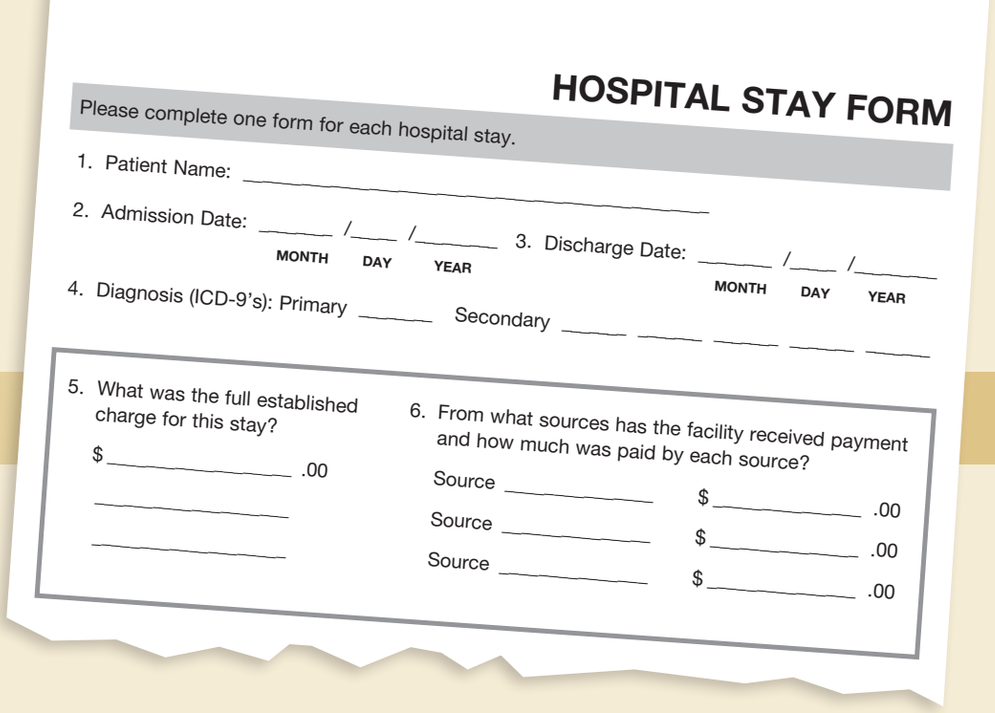
*...information released to MEPS **is protected** by the Public Health Service Act...*



HOSPITAL STAY FORM

Please complete one form for each hospital stay.

1. Patient Name: _____

2. Admission Date: _____ /_____ /_____ (MONTH / DAY / YEAR) 3. Discharge Date: _____ /_____ /_____ (MONTH / DAY / YEAR)

4. Diagnosis (ICD-9's): Primary _____ Secondary _____ _____ _____ _____ _____

5. What was the full established charge for this stay?

$_____ .00

_____

_____

6. From what sources has the facility received payment and how much was paid by each source?

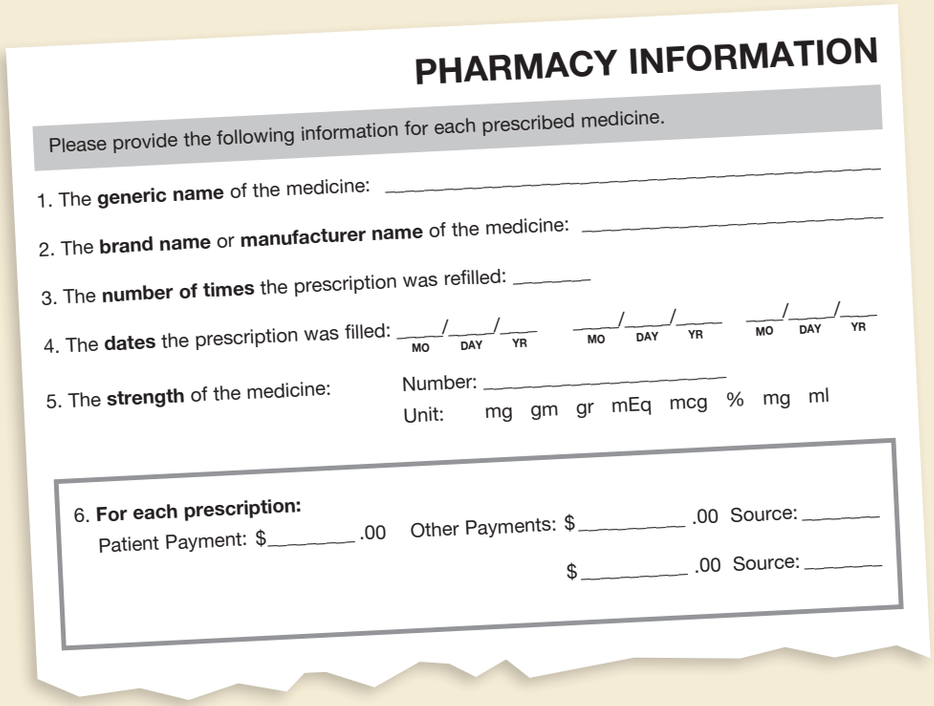
Source _____ $_____ .00

Source _____ $_____ .00

Source _____ $_____ .00

Q. Why do you need this form?

A. Your providers cannot release information about you to a study like MEPS without your written authorization. The Health Insurance Portability and Accountability Act, or HIPPA for short, sets guidelines for the authorization forms that must be signed to allow a provider to release health care information. The MEPS authorization form follows these guidelines.



PHARMACY INFORMATION

Please provide the following information for each prescribed medicine.

1. The **generic name** of the medicine: _____

2. The **brand name** or **manufacturer name** of the medicine: _____

3. The **number of times** the prescription was refilled: _____

4. The **dates** the prescription was filled: ___/___/___ (MO / DAY / YR) ___/___/___ (MO / DAY / YR) ___/___/___ (MO / DAY / YR)

5. The **strength** of the medicine: Number: _____
Unit: mg gm gr mEq mcg % mg ml

6. **For each prescription:**
Patient Payment: $_____ .00 Other Payments: $_____ .00 Source: _____
$_____ .00 Source: _____

Q. How do you protect my information?

A. Just like the information you have already given to the MEPS interviewer, any information your provider gives us will be protected by Sections 944(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)]. Information that could identify you will not be disclosed unless you have consented to that disclosure.

The new HIPAA law creates additional protection for personal health information held by medical providers and pharmacies. But HIPAA protections end when the information is released to others. When information is released to MEPS, the requirements of the Public Health Service Act provide continuing assurance of confidentiality.

More *Questions & Answers*

Q. My providers are very busy. Isn't this a bother to them?

A. Your signature on an authorization form simply gives your doctor, hospital, or pharmacy the opportunity to participate in the study if they choose. It allows them to make their own decisions. Our experience indicates that most health care providers are willing to participate in important research such as MEPS. Usually, an office staff person can fill out the form and the pharmacist can produce a simple computer printout.

Q. What information will you tell my doctor (or pharmacist) about me?

A. To allow medical and pharmacy staff to identify your records, we will provide your name, date of birth, and the signed authorization form. We also will share other information such as your address or name of the policyholder for your health insurance, if needed, to help a doctor or hospital identify the correct records.

Q. Will this affect my Medicare, Medicaid, VA benefits, or any other public assistance I am receiving?

A. No. Signing or not signing this authorization form will not affect your eligibility for any program benefits.

Q. Why do you need to contact my psychiatrist? That information is too personal.

A. Should they choose to participate in the study, psychiatrists, like other doctors, will be asked about the costs, dates, diagnoses, and type of service they provide. They will not be asked about treatment details.

Q. Why does this form have an expiration date that is past the period of time you are interested in?

A. This is only to allow enough time for contact with all of the health care providers in this survey. Large surveys such as this take time.

Research groups use the results of this survey in their attempts to improve access to medical care for older people, veterans, minorities, and children.

Q. Will my doctor (or pharmacist) bill me for the time he or she spent participating in this survey?

A. No. Should a doctor, hospital, or pharmacy have a policy of charging for the information we request, MEPS will pay this charge directly.

Q. My children have advised me not to sign anything. Why should I?

A. A vital part of the research is directed at understanding the special health care needs of older Americans. Many research groups use the results of this survey in their attempts to improve access to medical care for older people. We understand that your children only want to protect you. If they have a particular concern that we could address, the interviewer will be happy to talk to them or they can call Alex Scott at 1-800-945-MEPS (6377).

Q. Who must sign the authorization forms?

A. Authorization forms for adults must be signed by the person who received the services from the provider or pharmacy named in Box A of the authorization form. For teens between 14 and 17 years of age, both the teen who received the services and a parent/guardian must sign the form. For children age 13 or younger, only a parent or guardian must sign the authorization form.

Q. What if I change my mind?

A. You can revoke an authorization at any time by contacting the MEPS study. You can contact the study by telephone by calling 1-800-945-MEPS (6377). You can contact the study by mail at the following address:

Medical Expenditure Panel Survey
ATTN: Alex Scott
c/o Westat
1600 Research Blvd. Room RE 360S
Rockville, MD 20850

If you decide to revoke an authorization, we will stop any efforts to contact that provider. If the provider has already given us information about you, we will erase that information from the study records unless it is already incorporated into research files in which you cannot be identified.

Authorization Forms Instructions

Please follow these instructions as you review and sign authorization forms in black ink.

A

Check the name and address of the hospital, pharmacy, or other medical provider.

If any of this information is not correct, please make changes and initial each correction.

B

Read the statement.

(See enlargement on facing page.)

C

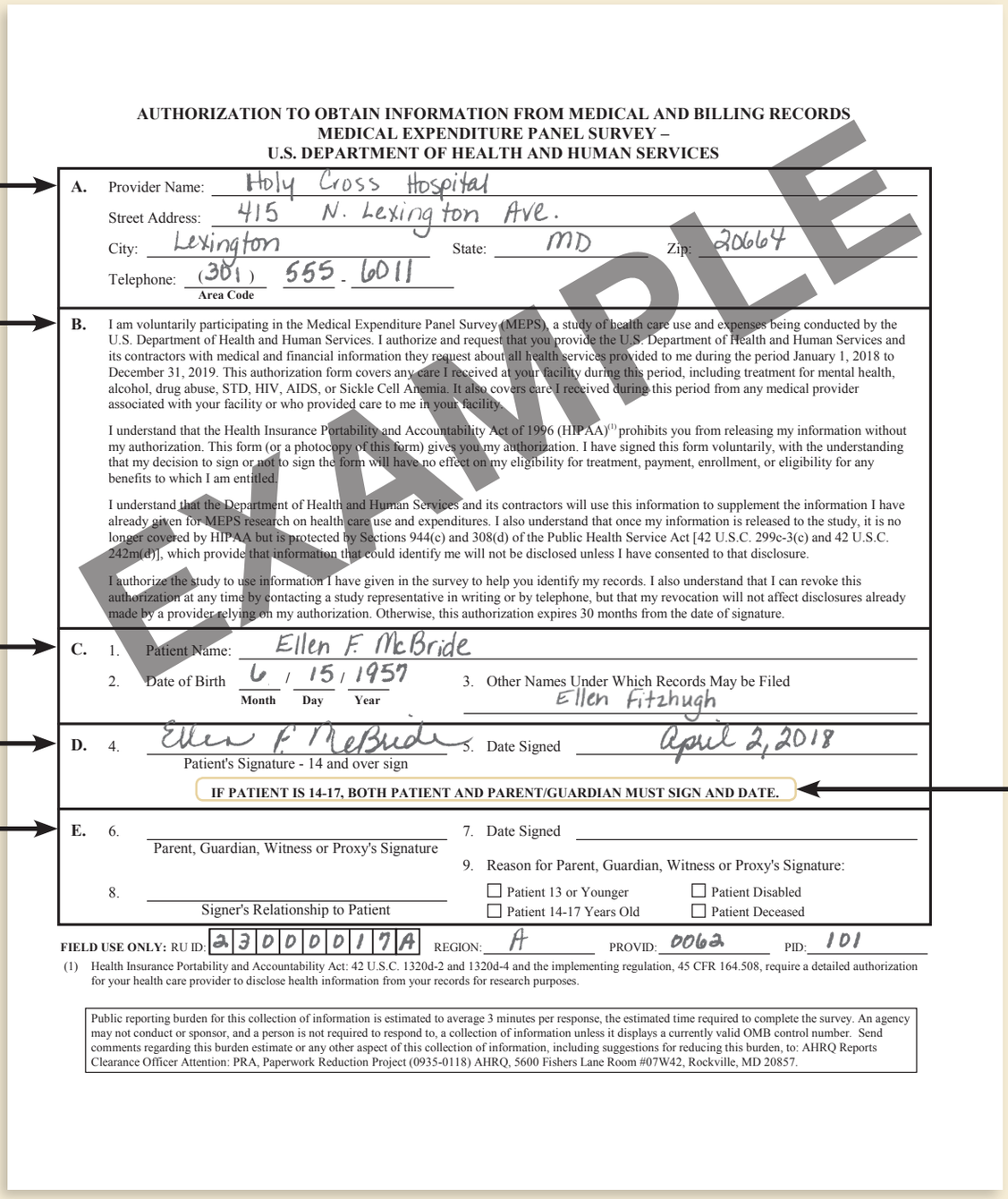
Check the patient's name and date of birth.

If any of this information is not correct, please make changes and initial each correction.

If your records might be filed under some other name (a maiden name or alternate spelling, for example), please complete Item 3.

D & E

Who should sign the form?



AUTHORIZATION TO OBTAIN INFORMATION FROM MEDICAL AND BILLING RECORDS
MEDICAL EXPENDITURE PANEL SURVEY –
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

A. Provider Name: Holy Cross Hospital
Street Address: 415 N. Lexington Ave.
City: Lexington State: MD Zip: 20664
Telephone: (301) 555-6011
Area Code

B. I am voluntarily participating in the Medical Expenditure Panel Survey (MEPS), a study of health care use and expenses being conducted by the U.S. Department of Health and Human Services. I authorize and request that you provide the U.S. Department of Health and Human Services and its contractors with medical and financial information they request about all health services provided to me during the period January 1, 2018 to December 31, 2019. This authorization form covers any care I received at your facility during this period, including treatment for mental health, alcohol, drug abuse, STD, HIV, AIDS, or Sickle Cell Anemia. It also covers care I received during this period from any medical provider associated with your facility or who provided care to me in your facility.

I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA)(1) prohibits you from releasing my information without my authorization. This form (or a photocopy of this form) gives you my authorization. I have signed this form voluntarily, with the understanding that my decision to sign or not to sign the form will have no effect on my eligibility for treatment, payment, enrollment, or eligibility for any benefits to which I am entitled.

I understand that the Department of Health and Human Services and its contractors will use this information to supplement the information I have already given for MEPS research on health care use and expenditures. I also understand that once my information is released to the study, it is no longer covered by HIPAA but is protected by Sections 944(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)], which provide that information that could identify me will not be disclosed unless I have consented to that disclosure.

I authorize the study to use information I have given in the survey to help you identify my records. I also understand that I can revoke this authorization at any time by contacting a study representative in writing or by telephone, but that my revocation will not affect disclosures already made by a provider relying on my authorization. Otherwise, this authorization expires 30 months from the date of signature.

C. 1. Patient Name: Ellen F. McBride
2. Date of Birth 6 / 15 / 1957 (Month / Day / Year)
3. Other Names Under Which Records May be Filed: Ellen Fitzhugh

D. 4. Ellen F. McBride (Patient's Signature - 14 and over sign) 5. Date Signed: April 2, 2018

IF PATIENT IS 14-17, BOTH PATIENT AND PARENT/GUARDIAN MUST SIGN AND DATE.

E. 6. _____ (Parent, Guardian, Witness or Proxy's Signature) 7. Date Signed _____
8. _____ (Signer's Relationship to Patient)
9. Reason for Parent, Guardian, Witness or Proxy's Signature:
☐ Patient 13 or Younger ☐ Patient Disabled
☐ Patient 14-17 Years Old ☐ Patient Deceased

FIELD USE ONLY: RU ID: 2 3 0 0 0 0 1 7 A REGION: A PROVID: 0062 PID: 101

(1) Health Insurance Portability and Accountability Act: 42 U.S.C. 1320d-2 and 1320d-4 and the implementing regulation, 45 CFR 164.508, require a detailed authorization for your health care provider to disclose health information from your records for research purposes.

Public reporting burden for this collection of information is estimated to average 3 minutes per response, the estimated time required to complete the survey. 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: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-0118) AHRQ, 5600 Fishers Lane Room #07W42, Rockville, MD 20857.

IF PATIENT IS:	THEN FORM SHOULD BE SIGNED BY:
a. Age 18 or older	Only patient for Items 4 and 5, unless one of d-f below applies
b. Age 14 through 17	Patient and parent or guardian (Items 4-9)
c. Age 13 or younger	Parent (Items 6-9)
d. Unable to sign name but able to make mark	Witness (Items 6-9)
e. Deceased	Proxy (Items 6-9)
f. Unable to sign name or make mark	Proxy (Items 6-9)