Form Approved
OMB No. 0920-New
Expiration Date: XX/XX/XXXX

Expanding PrEP in Communities of Color (EPICC+)

Attachment 4h
Aim 2a Cohort HIPAA Form English

Public reporting burden of 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 CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: OMB-PRA (0920-New)

Sample Cohort HIPAA Form

CONDITIONS OF TREATMENT

FSU IRB Approved 14 December 202

NOTICE OF LIMITED LIABILITY
Medical care, treatment or services ("Medical Care") provided by employees and/or agents of the University of South Florida Board of Trustees ("USF Health") are subject to the provisions of § 768.28 Florida Statutes. Liability for the negligent acts and omissions of these USF Health employees and/or agents is limited by law to $200,000 per claim or judgment by any one person and to $300,000 for all claims or judgments arising out of the same incident or occurrence.

I. Authorization for Medical Care. I voluntarily consent to any Medical Care that may be considered necessary and/or advisable in the judgment of my Healthcare Provider.

A. I understand that my Healthcare Provider is an employee or agent of USF Health. I also understand that my Healthcare Provider will be providing Medical Care to me in a healthcare teaching and research setting. Therefore, my Medical Care may be provided by residents and/or fellows under appropriate supervision and may be observed, and in some instances aided, by students under appropriate supervision.

B. I understand that USF Health physicians may enter into formal supervisory relationships with Advanced Practice Providers (APP) such as Physician Assistants or Advanced Practice Registered Nurses in conformity with Florida law. I may receive Medical Care from an APP in lieu of a physician and I understand that I have the right to choose the Healthcare Provider of my preference. I understand that I have the right to refuse any Medical Care and I have the right to discuss all of my Medical Care with my Healthcare Provider.

C. I acknowledge that, in the course of my medical care and treatment, specimens may be obtained for laboratory analysis that contain my DNA. However, USF Health will only use such specimens as needed to make medical diagnosis and treatment decisions. My consent will be obtained for use of my DNA outside of medical diagnosis and treatment.

II. Authorization for Release of Information. USF Health (through its employees, agents, affiliates or contracted copying services) may disclose my medical record and account information to:

A. Any person or corporation which is or may be liable for all or any portion of my charges, including but not limited to insurance companies, health care service plans, and worker's compensation carriers to the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement.

B. Any referring physician to ensure continuity of my Medical Care.

C. Other Healthcare Providers within USF Health. USF Health maintains a single, combined medical record that includes all Medical Care provided to a patient by all Healthcare Providers across USF Health and each Healthcare Provider has access to this medical record.

III. Health Information Exchanges. I understand USF Health participates in one or more health information exchanges (HIEs) (currently known as "Care Everywhere"). Through Care Everywhere, USF Health is able to share information from my electronic medical record that may include but is not limited to my allergies, diagnoses, lab and imaging results, immunizations, medical history, medications, visit summaries, and it may also

include sensitive information, such as HIV and sexually transmitted diseases, if applicable, with other health care providers. I agree that if I do not want my medical record shared with other health care providers who participant in the HIE, I must opt- out by filling out a USF Health, Care Everywhere Status Change form obtained from a USF Health front desk staff member or from USF Health Information Management at 813-974-4280 or at health.usf.edu/patient-forms.

IV. Financial Agreement.

A. **Assignment of Insurance Benefits (if applicable).** I request my insurance carrier to pay to USF Health or its affiliates, all benefits due me related to my pending claim for Medical Care. I agree to pay all applicable deductible and coinsurance amounts due and other fees for services rendered for which my insurance plan/HMO is not liable for payment to the Provider and agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect such amounts.

B. **Medicare B Authorization (if applicable).** I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare & Medicaid Services or its intermediaries or carriers, or to the billing agent of this physician or supplier, any information needed for this or a related medical

claim. I permit a copy of this authorization to be used in place of the original and request payment of insurance benefits either to myself or to the party who accepts assignment.

C. **Self-Paying Patient (if applicable).** I have been informed that the USF Health does not have a contract to participate with my insurance plan or HMO, and/or the requested Medical Care has not been authorized by my insurance plan/HMO, as applicable. I am requesting Medical Care as a fee-for-service, self-paying patient. I agree that I am responsible for all charges incurred as a result of this visit, including but not limited to all medical/surgical professional services, laboratory, radiological, and any other ancillary services. I agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect this account.

V. Prior Express Consent for Communications for Debt Collection and Payment Purposes. I expressly agree and consent that, in order for USF Health or its employees, agents or affiliates to service my account (including debt collection and payment purposes) USF Health, or any of its employees, agents or affiliates, may contact me by telephone at any telephone number associated with my account, including any wireless/cellular telephone numbers, which could result in charges to me. USF Health, or any of its employees, agents or affiliates, may also contact me for debt collection and payment purposes by sending text messages or e-mails using any e-mail address or phone number I provide. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device.

VI. Acknowledgement of Receipt of Joint Notice of Privacy Practices and Notice of Organized Health Care Arrangement.

I acknowledge that I have been provided a copy of the USF Health Joint Notice of Privacy Practices and Notice of Organized Health Care Arrangement at health.usf.edu/patient-forms and have thereby been advised of how my health information may be used and/or disclosed, and how I may obtain access to and control this information.

VII. (Optional) Permission to Verbally Discuss my Medical Care. My Healthcare Providers may discuss my Medical Care with the following individuals:

______________________	______________________
Name and Relation	Phone #
______________________	______________________
Name and Relation	Phone #

By signature below, I acknowledge that I have read, understand, and agree to the foregoing as applicable to me and/or my minor child(ren), if provided Medical Care by or on behalf of USF Health. A signed copy shall be as valid as the original.

______________________	______________________
Patient Name (Print)	Signature (Patient or Representative)
	______________________
	Date

Relationship to Patient (Please select one)

- o Self
- o Parent
- o Legal Guardian