Memorial Hermann Health Centers for Schools
Patient Demographic Downtime Form

PATIENT INFORMATION				
First Name	Middle Name	Last Name	Previous Name	Preferred Name
Address		City, State		Zip Code
Home Phone	Mobile Phone ☐ Call ☐ Text ☐ Both	Work Phone	Email ☐ No Email	

Preferred Contact Method (choose one) ☐ Mobile Phone ☐ Home Phone ☐ Work Phone ☐ Email ☐ Mail

Date of Birth (MM/DD/YYYY)	Sex assigned on your birth certificate ☐ Male ☐ Female	Gender Identity ☐ Identify as male ☐ Identify as female ☐ Transgender male ☐ Transgender female ☐ Genderqueer ☐ Choose not to disclose

Language ☐ English ☐ Spanish ☐ Vietnamese ☐ Chinese ☐ Arabic ☐ Other *(Please Specify)* _____ ☐ Decline

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other _____ ☐ Decline

Emergency Contact	Relationship to Patient	Emergency Contact Phone

_____ _____
Translated Into **By**

Translated copy of consent given to patient: ☐ Yes ☐ No ☐ Spanish ☐ Chinese ☐ Vietnamese

_____ _____ _____ _____ _____ ☐ AM ☐ PM
Parent / Guardian Signature **Print Name** **Relationship to patient** **Date** **Time**

Parent / Guardian unable to sign due to: _____

Parent / Guardian Date of Birth: _____

_____ _____ _____ _____ _____ ☐ AM ☐ PM
Staff Witness to Signature **Print Name** **Title** **Date** **Time**

MEMORIAL HERMANN
School Based Clinics

Patient Demographic Downtime Form

18574 (3/26)

Patient Name: _____

Medical Record #: _____

Date of Birth: _____

Memorial Hermann Health System
Authorization for Communications/Use & Disclosures of PHI Downtime Form

AUTHORIZATION FOR ELECTRONIC HEALTHCARE COMMUNICATIONS:
Memorial Hermann sends helpful health information by regular (unencrypted) text messaging and/or email communication (such as appointment reminders). There is some risk that the information in regular text, RCS, SMS or email could be read by someone other than you. **You can opt-out of text messages by texting STOP to the respective number.** Your opt-out request will generate one final message confirming that you have been unsubscribed. You will no longer receive text messages from the number. If you want to join again, sign up using My Memorial Hermann or text START to the phone number that initially texted you. **For help, text HELP to the opt-out number or call 713-222-CARE for assistance.** Messaging frequency may vary and messaging data rates may apply for any messages sent to or by you. In addition to managing your preferences in My Memorial Hermann, you may need to answer the call or respond directly to the caller to opt-out.

AUTHORIZATION FOR HOME/CELL TELEPHONE COMMUNICATION (BILLING):
I acknowledge that I have the option to provide authorization to Memorial Hermann for providers and practitioners who provide care and/or interpret my tests, along with their billing services and/or collection agent and/or attorney(s) who work on their behalf, to contact me for the purposes of payment for services by home or cell phone, use of prerecorded messages, artificial voice message, automated dialing services or other computer assisted technology. **In addition to managing your preferences in MyChart, you may need to answer the call or respond directly to the caller to opt out of future calls.**

AUTHORIZATION FOR HOME/CELL TELEPHONE COMMUNICATIONS (HEALTHCARE RELATED): I acknowledge that I have the option to provide authorization to Memorial Hermann for providers, practitioners, business partners and/or vendors providing services, interpreting labs and diagnostics on their behalf, to contact me using computer assisted, automated technology or artificial intelligence. **In addition to managing your preferences in MyChart, you may need to answer the call or respond directly to the caller to opt out of future calls.**

USE AND DISCLOSURE OF HEALTH INFORMATION-TREATMENT:
Memorial Hermann participates in electronic Health Information Exchanges ("HIEs") including but not limited to Epic's Care Everywhere. HIEs allow participating healthcare providers, including Memorial Hermann, to share portions of your medical record electronically. Memorial Hermann will allow other providers to see portions of your medical record through HIEs. **You can opt-out of Memorial Hermann sharing your medical record through Epic's Care Everywhere ("Care Everywhere") by calling 713-222-CARE (2273).** By opting out of Care Everywhere, you understand that other participating Epic providers may not be able to see your medical records through Care Everywhere. Opting out will not affect your medical records that were made available through Care Everywhere prior to your request to opt-out.

☐ **By signing this form I acknowledge that my preferences may be managed as outlined above. I have had the opportunity to ask questions and acknowledge that my questions have been answered to my satisfaction.**

Translated Into _____ **By** _____

Translated copy of consent given to patient: ☐ Yes ☐ No ☐ Spanish ☐ Chinese ☐ Vietnamese

Patient / Guardian Signature	Print Name	Relationship to patient	Date	Time
				☐ AM ☐ PM

Patient unable to sign due to: _____

Guarantor/Insured Signature	Print Name	Date	Time
			☐ AM ☐ PM

Witness Signature	Print Name	Date	Time
			☐ AM ☐ PM

MEMORIAL HERMANN

Authorization for Communications/Use & Disclosures of PHI Downtime Form

18671 (3/26)

Patient Name: _____

Medical Record #: _____

Date of Birth: _____

Part 1: Chart Part 2: Patient

Memorial Hermann Health System
Ambulatory Consent to Treat Downtime Form

Patient Name: _____ Date of Birth: _____

CONSENT TO TREATMENT

Knowing that I have presented for medical treatment, I hereby voluntarily consent to such medical treatment including, but not limited to, medicines, medical procedures, telehealth/telemedicine services, E-Visits, diagnostic procedures, lab tests and medical treatment by a physician, his/her assistants or his/her consignees as may be necessary in his/her judgment. I understand that testing for infectious conditions such as Human Immunodeficiency Virus (HIV) may be included. I acknowledge that no guarantees have been made as to the result of treatments or examinations.

I understand that, as part of my treatment plan and for my safety, that the facility may use artificial intelligence, cameras, photography, recording, videography, streaming and/or other technology.

I acknowledge that Memorial Hermann staff, physicians and/or affiliated providers may need to obtain videotaping, streaming, photography, recording, and/or other imaging of me or my body parts, during treatment for use in medical treatment, and/or other health care operations purposes.

☐ AM ☐ PM

Patient / Guardian Signature	Print Name	Relationship to patient	Date	Time

USE AND DISCLOSURE OF HEALTH INFORMATION TREATMENT: I (the patient or the patient's legal representative/personal representative) understand(s) that the facility may use and disclose my (the patient's) medical information to physicians or other health care providers in order to provide treatment to me (the patient). As part of my treatment plan and for my safety, I understand the facility may use artificial intelligence, cameras, photography, recording, videography, streaming and/or other technology.

Memorial Hermann participates in electronic Health Information Exchanges ("HIEs") including but not limited to Epic's Care Everywhere. HIEs allow participating healthcare providers, including Memorial Hermann, to share portions of your medical record electronically.

Memorial Hermann will allow other providers to see portions of your medical record through HIEs. You can opt-out of Memorial Hermann sharing your medical record through Epic's Care Everywhere ("Care Everywhere") by calling 713-222-CARE (2273). By opting out of Care Everywhere, you understand that other participating Epic providers may not be able to see your medical records through Care Everywhere. Opting out will not affect your medical records that were made available through Care Everywhere prior to your request to opt-out.

PAYMENT: To the extent necessary to determine liability for payment and to obtain reimbursement, I (the patient or the patient's legal representative/personal representative) authorize(s) the facility and the patient's physicians to disclose my (the patient's) health care information, including demographic information, to any person, Social Security Administration, insurance or benefit payor, health benefit plan, or employer or worker's compensation carrier which is, or may be, liable for all or a portion of the facility's or treating physician's charges, and to complete claim forms on behalf of the patient.

HEALTH CARE OPERATIONS: I (the patient or the patient's legal representative/personal representative) understand(s) that the facility may use and disclose my health information in connection with provider operations. Examples of health care operation uses and discloses are: quality assessment and improvement activities, accreditation and certification, licensing, medical reviews, legal services, debt collection and auditing, business planning and general business management and litigation, including subpoenas and court orders. I (the patient or the patient's legal representative/personal representative) also understand that my (the patient's) health care information will be used and disclosed according to Memorial Hermann's Joint Notice of Privacy Practices. I (the patient or the patient's legal representative/ personal representative) also understand that a written authorization from me (the patient) will be required for all other uses and disclosures. I (the patient or the patient's legal representative/personal representative) understand that a special written authorization from me (the patient) will be requested by the facility prior to releasing health care information if I (the patient) am (is) receiving mental health services or care in an alcohol or drug abuse treatment program or facility. Memorial Hermann prioritizes the safety and security of its patients, employees, affiliated providers and visitors. I understand the facility may use artificial intelligence, cameras, videography or other streaming technology as part of healthcare operations. Additionally, body worn cameras and/or other technology may be used by Memorial Hermann to record events for safety and security purposes.

I (the patient or the patient's legal/personal representative) understand that Memorial Hermann will not use or disclose your protected health information for other purposes without your authorization unless required by law.

_____ _____

Translated Into **By**

Translated copy of consent given to patient: ☐ Yes ☐ No ☐ Spanish ☐ Chinese ☐ Vietnamese

☐ AM ☐ PM

Patient / Guardian Signature	Print Name	Relationship to patient	Date	Time

Patient unable to sign due to: _____

☐ AM ☐ PM

Staff Witness to Signature	Print Name	Title	Date	Time

MEMORIAL HERMANN

Ambulatory Consent to Treat Downtime Form

Patient Name: _____

Medical Record #: _____

Date of Birth: _____

Memorial Hermann Health System
Acknowledgement Of Receipt Of Joint Notice Of Privacy Practices Downtime Form

This Joint Notice of Privacy Practices applies to the privacy practices of the Affiliated Entities and the Entities participating in the Organized Healthcare Arrangement. These entities include Memorial Hermann Health System (MHHS), and each of the hospitals owned or operated by MHHS, Memorial Hermann Medical Group, and Memorial Hermann Community Benefits Corp., and Memorial Hermann Physicians of Texas. For the purpose of complying with the Texas Medical Privacy Act, Texas Health and Safety Code, Section 181, the following Memorial Hermann Entities are also subject to the practices described in the Notice: Memorial Hermann Foundation, Memorial Hermann Professional Insurance Co., Ltd., Physicians and Allied Health Professionals with privileges to practice at a Memorial Hermann Facility.

This form is used to document a patient's acknowledgement of receipt of our Joint Notice of Privacy Practices or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Section A: The Individual. (Place Patient Sticker Here)

Section B: Acknowledgement of Receipt of Joint Notice of Privacy Practices.
I acknowledge the receipt of Memorial Hermann's Joint Notice of Privacy Practices. A copy of these practices is available on MemorialHermann.org or I have been given a hard copy.

_____ _____
Translated Into **By**

Translated copy of consent given to patient: ☐ Yes ☐ No ☐ Spanish ☐ Chinese ☐ Vietnamese

_____ _____ _____ _____ _____ ☐ AM ☐ PM
Patient / Guardian Signature **Print Name** **Relationship to patient** **Date** **Time**

Patient unable to sign due to: _____

FOR OFFICE USE ONLY

Section C: Good Faith Effort to Obtain the Individual's Signature of Acknowledgement

GOOD FAITH EFFORT BY STAFF TO OBTAIN THE INDIVIDUAL'S SIGNATURE OF ACKNOWLEDGEMENT

Describe your good faith effort to obtain the individual's signature on this form:

_____

_____

Describe the reason why this individual could not/would not sign this form:

_____

_____

_____ _____ _____ _____ _____ ☐ AM ☐ PM
Staff Signature **Print Name** **Title** **Date** **Time**

MEMORIAL HERMANN

Acknowledgement Of Receipt Of Joint Notice Of Privacy Practices Downtime Form

18450 (4/24)

Patient Name: _____

Medical Record #: _____

Date of Birth: _____