7. MEDICAL RECORDS REQUIREMENTS

A. PCP and IPA Medical Record Requirements

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP is responsible for establishing medical record standards in the IEHP Provider Policy and Procedure Manual and promulgating these to Providers and Primary Care Physicians (PCPs).

B. All Providers and Practitioner offices must maintain policies and procedures consistent with IEHP standards, state and federal laws and regulations for maintenance of Member medical records.

C. Providers are responsible for monitoring contracted Practitioners for compliance with IEHP medical record standards.

D. IEHP performs PCP Facility Site Review (FSR) and Medical Record Review (MRR) Surveys prior to site participation.

E. A Medical Record Review is performed at the time of the Facility Site Review if medical records are available; otherwise, Medical Record Review is performed within ninety (90) to one hundred eighty (180) days of the Provider’s effective date with IEHP.

PROCEDURES:

IPA Responsibilities

A. IPAs are responsible for monitoring contracted Providers for compliance with all applicable IEHP standards related to medical records.

1. IPA medical record policies and procedures must be consistent with IEHP requirements.

2. IPAs must ensure that contracted Providers have copies of IEHP medical record policies and procedures available at the practice site.

3. IPAs must assess medical record documentation and maintenance during the initial credentialing site review.

4. IPAs must implement Corrective Action Plans (CAPs) for medical record deficiencies.

IEHP Medical Records Standards

A. Individual Medical Records – An individual medical record is created for each Member treated by an IEHP Provider or a Practitioner. The medical record is designed to maintain a Member’s documented medical information of the care provided, as well as all
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ancillary services/diagnostic tests ordered by a Provider or a Practitioner and all referred
diagnostic and therapeutic services in a consistent, logical, and uniform manner. The
same medical record may be used by other treating Providers or Practitioners within the
same group in order to provide conformity and coordination of Member care. This
unique medical record must be updated by the Provider, Practitioner or office staff with
each Member visit or contact. Detailed behavioral health and substance abuse records
may be filed separately to maintain confidentiality.

B. Member Identification – Members should be linked to their individual medical records
through an assigned unique identifier for filing purposes and to distinguish that record
from any other Member record. Each page, test result, letter, and item of correspondence
regarding that individual Member must contain the unique identifier, and Member
(patient) name as a means of Member identification.

C. Audit Score – Medical Record Review score results are as follows, in accordance with
Department of Health Care Services (DHCS) requirements:

Medical Record Review Survey: Total points will vary based on the type of charts
reviewed, i.e., Peds vs. Adult vs. OB, and the overall number of charts. The following
compliance level categories will apply:

1. Exempted Pass 90% and above with all individual section scores at 80% or
above.

2. Conditional Pass 80-89% or 90% and above with one or more individual
section score below 80%.

3. Fail Below 80%.

Full points are given if the scored element meets the applicable criteria. Partial points are
not given for any scored element that is considered only “partially” met. Zero (0) points
are given if an element does not meet criteria. Refer to Policy 6A, “Facility Site Review
and Medical Records Review Survey Requirement and Monitoring.”

D. Member Demographics – Each medical record must contain a section for Member
identification that includes name, age, employer, occupation, work and home telephone
numbers, address, insurance information, marital status and emergency contact person
information.

E. Responsible Party – Physicians designate individuals responsible for record
maintenance. Responsible parties must follow established protocols for the daily
collection, research, retrieval, securing, maintaining, and transporting of medical records
within the physician setting.

F. Legal Document – The medical record is a legal document and all contents must be
maintained in a confidential manner.

G. Medical Record Maintenance – The Member medical record must be maintained in a
current and detailed organized manner that reflects effective care of the Member and also
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facilitates quality review.

H. Protection and Confidentiality – Physicians must limit medical records access to authorized practitioners and associated staff. Records must be maintained in a protective and confidential manner and are not readily accessible to unauthorized persons or visible to the general public. Practitioners and Providers must maintain policies and procedures to ensure appropriate record processing to prevent breach of protection or confidentiality or the unauthorized release of Member information to any internal or external person. Practitioners and Providers must educate staff regarding confidentiality and records maintenance policies and procedures and ensure that confidentiality statements are signed. A copy of the IEHP medical record policies must be available at each physician office. See Policy 7B, “Information Disclosure and Confidentiality of Medical Records.”

I. Storage, Filing and Availability – Physicians must maintain an organized record-keeping system to make the individual medical record available for each Member visit or contact including: collection, processing, maintenance, storage, retrieval, identification, and distribution. Records must be stored in a secured location either in the Physician’s office or in a central file area that is inaccessible to unauthorized persons. Physicians must maintain procedures to assign the unique identifier to each individual record and ensure that the appropriate record is pulled for each Member. Filing of records must be done in a consistent manner either alphabetically or by Member identifier number. Physicians must have written procedures for the disposition of medical records including designation of a person or persons responsible for record maintenance. In addition, procedures must outline the methodology for pulling requested records, methodology for tracking, the amount of notification time required, and system of distribution and collection. Physicians must have provisions for obtaining medical records on an emergency basis. Medical records are to be kept in a clean, secure environment and in good condition.

J. Record Retention – Physicians must retain medical records pertaining to Members for a period of ten (10) years from the end of the fiscal year in which IEHP’s contract expires or is terminated. Pediatric medical records must be maintained for a minimum of ten (10) years or until the Member’s 19th birthday, but in no event for less than ten (10) years. All medical records, medical charts and prescription files, and other documentation pertaining to medical and non-medical services rendered to Members are subject to this requirement.

K. Informed Consent for Treatment – Providers and Practitioners must obtain appropriate written consent for treatment prior to actual procedure performance including the human sterilization consent procedures required by Title 22 of the California Code of Regulations, Section 51305.1 through 51305.6. Consent forms must be completely filled out to include risk, benefits and alternative treatments, signed in ink, and retained in the Member’s medical records. If someone other than the Member signs the consent, the legal relationship should be noted on the consent form. Provider/Practitioner staff must witness, sign, and date consent forms. Practitioners must not require a Member, as a
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condition of receiving health care services, to sign a consent that would permit the disclosure of medical information. Refer to Policy 7C, “Informed Consent,” for more information.

L. Release of Information – Medical records contain confidential information that is not to be released to another party without the expressed written consent, written in ink, of the Member or legal representative. Providers must maintain procedures for obtaining written consent prior to release of copied records. The consent should be filed in the Member’s medical record and include: the purpose for the request, the information being requested, name of receiving or requesting party, the date when copies were released, a list of the copied portion of the medical record and the length of time the information is kept (for behavioral health services only). Member medical records must be made available to authorized reviewers per applicable state laws and regulations. Section 123110 of the California Health & Safety Code states that any adult patient, or any minor patient who by law can consent to medical treatment is entitled to inspect patient records upon written request within five (5) working days after receipt of the written request. Members are also entitled to copies of all or any portion of his or her records upon written request. Physicians must provide Members with copies within fifteen (15) days of the receipt of a written request. Physicians receiving medical records request from other Medical Providers must submit the medical records within fifteen (15) days of receiving the written request to avoid any delay in the Member’s care. Refer to Policy 7B, “Information Disclosure and Confidentiality of Medical Records,” for more information.

The State has determined that a managed Medi-Cal Member can never be charged for any covered services, as outlined in Policy 18L, “Providers Charging Members.” As it is customary for physicians not to charge, IEHP encourages its Practitioners to offer this as a complimentary service to other physicians. When absolutely necessary to charge another physician, the law allows only $0.25 per page and to limit a total charge to $20.

M. Legibility and Maintenance – Providers must establish a uniform format to organize medical records and maintain all medical records in a consistent and comprehensive manner. Medical record entries are to be legible, made in a timely manner, dated, and signed by the appropriate Provider/Practitioner or staff. Records may be maintained in hard copy format or electronically as long as they are easily accessible, have sufficient backup to prevent loss of information and have a unique electronic identifier for the author. The medical record must be legible to someone other than the author.

N. Exam Information - Each medical record entry must contain all pertinent information related to the Member contact including all: complaints, symptoms, examination results, medical impressions, treatments, Member conditions, test results, and proposed follow-up. A subjective complaints, objective findings, assessment, and plan (SOAP) format may be used to satisfy this requirement.

O. Medical Record Contents – Physicians must maintain a complete and comprehensive
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medical record for each Member. The record must include all Provider services rendered including all: examinations, Member contacts, health maintenance or preventive services, laboratory and radiology test results or reports, procedures, ancillary services, off-site treatments, Emergency Room records, and hospital admission and discharge information. Correspondence regarding the Member’s medical condition, such as consultation records, specialist reports, and referrals, must also be included in the Member record. Pathology and laboratory/radiology reports must be included in the record with a special notation for all abnormal findings. Each page, insert, test, and lab entry must be identified by Member name and/or Member identifier. The medical record must include Member identification, biographical data, emergency contact information, and informed consents.

P. Documentation Standards – The IEHP documentation standards and goals for medical record maintenance are as follows:

1. Each page in the record contains the Member’s name and/or identification number.

2. Medication allergies and adverse reactions are noted in a consistent, prominent place; otherwise, no known allergies or history of adverse reactions is noted.

3. Past medical history for Members seen more than three (3) times is documented. This documentation includes serious accidents, operations and childhood illnesses. For children and adolescents (20.99 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.

4. The use of cigarettes, alcohol and history of substance abuse noted for Members age 12 and older (substance abuse history is queried for Members seen three (3) or more times).

5. Problem lists are maintained for Members with significant illnesses and/or conditions that are monitored. A chief complaint and diagnosis or probable diagnosis is included.

6. The history and physical examination records must include appropriate subjective and objective information pertinent to the Member’s presenting complaints.

7. Documentation of exams is appropriate for the medical condition.

8. All medications prescribed include the name, dosage, frequency, and route unless medication only comes in oral form.

9. Medications given on-site list name, dosage, and route as well as the site given, manufacturer’s name and lot number and whether the Member had a reaction to the medication.

10. Laboratory and other studies are ordered and documented, as appropriate.

11. All treatments, procedures, and tests, with results, are documented.

12. Working diagnoses are consistent with findings.
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13. Treatment plans are consistent with diagnoses.
14. Notes have a notation, when indicated, regarding needed follow-up care, calls or visits. The specific time of return is noted in weeks, months, or as needed.
15. Unresolved problems from previous office visits are addressed in subsequent visits.
16. Member education, recommendations and instructions given are included.
17. Pediatric Members’ (age 20.99 and under) records have a completed immunization record or notation of immunizations up to date.
18. An immunization history has been noted for adults.
19. There is no evidence that the Member is placed at inappropriate risk by a diagnosis or therapeutic procedure.
20. Preventive screening and services are offered and documented in accordance with IEHP standards.
21. Referrals for specialty care or testing are noted, when appropriate.
22. Consultant notes are present, as applicable.
23. Consultation, lab and imaging reports filed in the chart are initialed by the Provider or Practitioner who ordered them to signify they have been reviewed. Review and signature by professionals other than the ordering Provider or Practitioner do not meet this requirement. If the reports are presented electronically or by some other method, there is also representation of review by the ordering Provider or Practitioner. Consultation, abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.
24. For Members age 18 years and older, as well as Emancipated Minors, documentation of Advance Directives discussion is present.

Q. Completeness of the Medical Record – The medical record must be checked to assure that all ordered procedure and referral notes are returned and filed in the chart within three (3) working days of the visit, procedure, or receipt of the report/progress notes from any outside Provider or Practitioner into the physician office. The Provider/Practitioner must review and initial all test results and consultations and document follow-up treatment for abnormal lab results.

R. Laboratory and Radiology Results – Providers must maintain procedures for filing laboratory and radiology results in the Member’s medical record. STAT tests are to be performed and reported within twenty-four (24) hours. Physicians must have procedures for review of test results, notation of normal and abnormal results in the medical record, and documentation of instructions for follow-up. Providers must have guidelines identifying which staff member is authorized to notify Members of test results. Tests performed by the Provider or Practitioner must have results documented in the medical
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record.

S. **Language Preference** - Each medical record must include designation of primary language and documentation of request or refusal of language interpretation services. Provider/Practitioner documentation must be in English.

T. **Physicians, Practitioners and Staff Entries and Signatures** - Each entry including chief complaint and vital signs or Member contact, including telephone conversation/advice noted in a Member’s medical record must be dated and signed by the Provider/Practitioner and/or staff, if applicable, including the title of the person making the chart entry. This includes all therapies, procedures, and medications administered to a Member. When documentation errors occur, the person that makes the error must correct the error in the following manner:

1. A single line is drawn through the error;
2. The corrected information is written as a separate entry and includes the following:
   a. Date of the entry;
   b. Signature (or initials); and
   c. Title.
3. There are to be no unexplained cross-outs, erased entries or use of correction fluid. Both the original entry and corrected entry are to be clearly preserved. One method used for correcting documentation errors is the S.L.I.D.E Rule: Single Line, Initial, Date and Error.

U. **Follow-Up Care Documentation** - Specific follow-up care instructions and a definite time for return visit or other follow-up care is appropriately documented in the Member’s medical record. The time period for return visit or other follow-up care is definitively stated in number of days, weeks, months or PRN.

V. **Advance Directives** - Adult medical records that contain information regarding execution of advance directives such as a living will or Durable Power of Attorney for Health Care, for Members 18 years or older, as well as Emancipated Minors, must be prominently noted. Refer to Policy 7D, “Durable Power of Attorney for Healthcare,” for more information.

W. **Preventive Health Screening and Individual Health Education Behavioral Assessment** - Providers must have a system to notify Members of the need for an initial health assessment within one hundred twenty (120) days of enrollment to assess current medical conditions, institute any necessary treatments, and outline preventive health care programs and within sixty (60) days of enrollment for Members under the age of 18 months. This offers the Member and Provider/Practitioner an opportunity to discuss medical concerns and establish a baseline for future care. The initial preventive health screening includes a comprehensive history and physical exam, documentation of an
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Individual Health Education Behavioral Assessment (IHEBA) and any referrals to health education services. Specific notations must be made concerning use of cigarettes, alcohol, and substance abuse for Members age 12 or older. Included with the notation should be health education or counseling regarding such use.

X. Follow-up Care for Referrals, Emergency Treatment, Hospitalization, Home Health Care, Skilled Nursing Facility (SNF) or Surgical Treatment Rendered at Surgical Center – The medical record must reflect continuity of care for any treatment, emergency or otherwise, rendered in a hospital, emergency room, urgent care, home health, SNF, or surgical center setting. Documentation must include the provisions for follow-up or continued treatment. Providers and Practitioners must document referrals to specialists or waiver programs, treatments rendered or recommendations made and follow-up care to be instituted.

Monitoring

A. Audit Scope – The Medical Record Review Survey process is focused on Primary Care Providers. Medical record reviews for any other contracted physicians and specialty care practitioners are conducted as directed by the IEHP Chief Medical Officer or Quality Management (QM) Committee.

B. Audit Frequency - IEHP conducts a Medical Record Review Survey for Providers at the time of the Initial Facility Site Review Survey, if medical records are available or within ninety (90) days of the Provider’s effective date after the initial review. An additional extension of ninety (90) calendar days may be allowed only if the new Provider does not have sufficient Member assignment to complete a review of ten (10) medical records. If there are still fewer than ten (10) assigned Members at the end of six (6) months, a medical record review is completed on the total number of records available or on a sample chart and the scoring adjusted according to the number of records received. The Medical Record Review Survey evaluates compliance with IEHP Policies and Procedures and is conducted every three (3) years. Refer to Policy 6A, “Facility Site Review and Medical Records Review Survey Requirements and Monitoring,” for more information.

C. Medical Record Information – The information in the medical record is evaluated and performance improvement actions required as necessary to ensure that the documentation is current, detailed, and organized and that it shows sound professional practice and appropriate preventive health education and referral.

D. Medical Records Systems – Medical record systems for Providers are evaluated for adequacy and appropriateness by IEHP during the Site Review Surveys. The Medical Record Review Survey is utilized to gather information necessary to evaluate Provider and organization-wide compliance with IEHP approved medical record standards.

E. Maintenance of Medical Record Policy - Each contracted Provider is responsible for maintaining medical record policies and procedures in compliance with IEHP, regulatory, and National Committee for Quality Assurance (NCQA) requirements.
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F. Audit Tool Requirements - The audit tool for Medical Record Review Survey used by IEHP includes elements consistent with Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS), and other regulatory agencies under the direction and approval of the IEHP Chief Medical Officer (CMO). Provider compliance with medical record standards must meet IEHP and regulatory requirements.

G. Medical Record Review Survey – The number of medical records reviewed depends on the type and status of the Provider. This information is detailed in the following table:

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Number of Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice (FP), General Practitioner (GP), Internal Medicine (IM) seeing all ages</td>
<td>Five (5) Pediatric Records, Five (5) Adult Records</td>
</tr>
<tr>
<td>FP, GP, IM seeing Members ages 14+ or 18+</td>
<td>Five (5) Pediatric Records, Five (5) Adult Records</td>
</tr>
<tr>
<td>GP, IM seeing Members ages 21+</td>
<td>Ten (10) Adult Records</td>
</tr>
<tr>
<td>Pediatric, GP, FP seeing Members ages 0-20.99</td>
<td>Ten (10) Pediatric Records</td>
</tr>
<tr>
<td>Clinic/Staff Model Setting and Residency Teaching Clinics (Patient care by multiple Providers)</td>
<td>Ten (10) Records, Twenty (20) Records, Thirty (30) Records</td>
</tr>
<tr>
<td>One (1) to Three (3) Providers</td>
<td></td>
</tr>
<tr>
<td>Four (4) to Six (6) Providers</td>
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<tr>
<td>Seven (7) or More Providers</td>
<td></td>
</tr>
<tr>
<td>PCP/OB Provider</td>
<td>Five (5) Peds Records, Five (5) Medical Records (mix of Adult and OB)</td>
</tr>
<tr>
<td>CAP Verification</td>
<td>Five (5) Medical Records</td>
</tr>
</tbody>
</table>

Medical Record Review Surveys are used to assess the following (when applicable):

All Records:
1. Format;
2. Documentation; and
3. Coordination /Continuity of Care.

Adults:
1. Initial Health Assessment (IHA);
2. Individual Health Education Behavioral Assessments (IHEBA);
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3. Periodic Health Evaluation;
4. Tuberculosis Screening;
5. Blood Pressure;
6. Obesity screening;
7. Cholesterol;
8. Chlamydia Screening;
9. Mammogram;
10. Cervical Cancer Screening;
11. Colorectal Cancer screening; and
12. Adult Immunizations.

Pediatrics:
1. Initial Health Assessment (IHA);
2. Individual Health Education Behavioral Assessment (IHEBA);
3. Age-appropriate physical Exams according to most recent American Academy of Pediatrics (AAP) schedule;
4. Anthropometric measurements;
5. Body Mass Index (BMI) percentile;
6. Developmental screening;
7. Anticipatory Guidance;
8. Sexually Transmitted Infection (STI) screening on all sexually active adolescents including Chlamydia;
9. Vision Screening;
10. Hearing Screening;
11. Nutritional Assessment;
12. Dental Assessment;
13. Blood Lead Screening Test;
14. Tuberculosis Screening; and
15. Childhood Immunizations.

OB/Comprehensive Perinatal Services Program (CPSP)-Like Services:
1. Initial Comprehensive Prenatal Assessment (ICA) to include;
a. Obstetrical and Medical history;
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b. Physical exam;
c. Lab tests;
   1) Screening for Hepatitis B Virus; and
   2) Screening for Chlamydia infection and syphilis;
d. Nutrition;
e. Psychosocial Screening; and
f. Health education;

2. Screening for Gestational Diabetes;
3. Subsequent Comprehensive Prenatal Trimester Re-assessments;
4. Third Trimester screening for Group B Strep;
5. Prenatal Care Visits according to most recent American College of Obstetricians and Gynecologists (ACOG) standards;
6. Individualized Care Plan;
7. Referral to Women, Infants, and Children (WIC) Program and Assessment of Infant Feeding Status;
8. Human Immunodeficiency Virus (HIV)-related services offered;
9. Alpha-fetoprotein (AFP)/Genetic Screening offered;
10. Domestic Violence/Abuse Screening;
11. Family Planning Evaluation;
12. Perinatal Depression Screening; and
13. Postpartum Comprehensive Counseling.

H. Monitoring - IEHP systematically monitors all Provider sites between each regularly scheduled Facility Site Review and Medical Record Review Survey. Monitoring sites between audits includes the use of both internal quality management systems and external sources of information. This is done through review of Grievance Data, Potential Quality Incident (PQI) referrals, and focused reviews when necessary. All deficiencies identified by the monitoring process require the completion of corrective actions according to CAP timelines.

I. Other monitoring includes Interim FSR Mid-Cycle Review (See Attachment, “Interim FSR Facility Site Review - (Self-Review” in Section 6), as well as the use of both internal quality management systems and external sources of information, as outlined in Policy 6A, “Facility Site Review and Medical Record Review Survey Requirements and Monitoring.”
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J. IEHP reviews and monitors the Provider’s referral process and/or referral log during the Facility Site Review (FSR) and Interim Audit.

1. If the Provider is deficient in the FSR section, Office Management E1 or E2 a Focused audit/training is sent to the nurse educator for further follow-up. Should the Provider miss the same questions during an Interim audit the same process is repeated.

2. The IEHP Nurse Educators conduct training at the office and verify if changes were made to their referral process since the audit was performed.

3. If the referral log/process is complete at the training, a copy of the referral log or new process is attached to the focused audit. The findings are sent to the QM Nurse Manager for sign off.

4. Should the Provider fail two (2) referral audits, they are forwarded to the Peer Review Subcommittee for further action.

K. Provider sites that are removed from participation in the IEHP network due to failure of a site review and medical record review survey may appeal to IEHP for reconsideration in accordance with Policy 6C, “PCP Sites Denied Participation or Removed from the IEHP Network.”

L. IPA medical record compliance is monitored through the Annual Delegation Oversight Audit (DOA).

**REFERENCES:**

A. Title 22, California Code of Regulations §§ 51305.1-51305.6.

B. California Health & Safety Code § 123110.

C. Department of Health Care Services (DHCS) Policy Letter (PL) 14-004 Supersedes PL 02-002, “Site Reviews: Facility Site Review and Medical Record Review.”

D. Coordinated Care Initiative (CCI) Three-Way Contract, Section 2.16, eff January 1, 2018.
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B. Information Disclosure and Confidentiality of Medical Records

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. Providers must fully comply with all applicable sections of the Health Insurance Portability and Accountability Act (“HIPAA”), the California Civil Code, Section 56 et seq., the Confidentiality of Medical Information Act; Health and Safety Code Section 1364.5; the Insurance Information and Privacy Protection Act, Code 791, et. seq.; and all other applicable State, Federal and local regulations pertaining to confidentiality, privacy and information disclosure of medical records.

B. Providers and Behavioral Health Practitioners must fully comply with Sections of the Civil Code and Sections of HIPAA that prohibit health care Practitioners from releasing specified medical information unless the person or treating entity requesting the information submits a written request signed by the Member or his/her legal representative/guardian.

1. California Civil Code, Section 56.35 and 56.104 - Prohibits the release of specified medical information created regarding an individual as a result of that person’s participation in outpatient behavioral health.

2. California Civil Code, Section 56.17 - Prohibits the release of specified medical information created regarding genetic testing of an individual.

3. Title 45, Code of Federal Regulations (CFR) Section 164.508 – Prohibits a covered entity from disclosing a Member’s Protected Health Information (PHI) without a Member’s authorization unless the disclosure is for treatment, payment, or health care operations.

C. IEHP is responsible for establishing standards for the protection and maintenance of Member medical records. IEHP medical record standards and any updates are distributed at least annually to contracted Providers and Primary Care Physicians (PCPs).

D. Providers and network Practitioners are required to maintain Member medical records in a manner that is compliant with IEHP standards.

E. IPAs are responsible for monitoring network Practitioners for compliance with IEHP medical record standards. Physician offices are required to maintain policies and procedures consistent with IEHP requirements.

F. Providers and Behavioral Health Practitioners are responsible for ensuring that network Practitioners do not release specified medical information regarding the Member’s participation in outpatient behavioral health programs without appropriate Member
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consent and without a written request signed by the requestor as specified in California Civil Code Section 56.104 and Title 45, CFR Section 164.508. For more information on release of behavioral health information, please see the ‘Behavioral Health Information’ section in this Policy.

G. Contracted Providers and Practitioners must disclose medical information when the information is requested by a coroner in the course of an investigation.

H. Contracted Providers and Practitioners who create, maintain, preserve, store, transmit or destroy medical records must do so in a manner that preserves the confidentiality of the information contained in the records.

PROCEDURES:

Confidentiality of Medical Records

A. Providers are responsible for orienting all Practitioner’s office staff, Practitioners and committee members to IEHP policies and procedures regarding confidentiality of Member medical records including:

1. The maintenance of confidentiality of Member medical records used comprehensively by the Practitioner;
2. The protection of medical record information including the documentation used in utilization and case management processes; and
3. The protection of medical record information used in the claims process.

B. Providers are responsible for maintaining signed confidentiality statements as follows:

1. Providers and office staff are required to sign a confidentiality statement protecting the privacy of Member medical records and information;
2. IPA committee members and all other attendees of IPA committee meetings are required to sign a Member medical record confidentiality statement; and
3. Providers must have policies and procedures in place that require Practitioners and other subcontractors to maintain confidentiality that includes signed confidentiality statements as applicable.

C. Upon request, Providers and Practitioners must disclose Members’ confidential medical information to governmental regulators, or other legal authorities for purposes of:

1. Administering benefits under the Medicare program, including determination of responsibility for payment, Member’s eligibility for benefits, provision of services to eligible recipients and payment of claims;
2. Coordination of care between Practitioners as necessary;
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3. Professional peer review or utilization review and quality management (as established by Congress in Public Law 97-248 in 1982);
4. Conducting actuarial or research studies; and
5. Providers and Practitioners may not disclose medical information related to a Member’s participation in behavioral health treatment unless the requirements delineated in the ‘Behavioral Health Information’ section of this Policy have been met.

D. Upon request, Providers and Practitioners must disclose Member medical information to independent medical review organizations and their reviewers without specific authorization by the Member. Independent medical review organizations may include public or private licensing or accrediting entities such as the DMHC or its contractors.

E. Members have the right to inspect or correct any personal or medical information held by their medical Practitioner.

F. Members have the right to develop a written addendum for inclusion in their medical record if they believe that the records are incomplete or inaccurate. Practitioners must include this addendum as a permanent part of the Member’s medical record and must disclose it to other parties when records are requested.

G. Members have the right to request an accounting of disclosures of protected health information made by the covered entity for the prior six (6) years.

H. Private Health Information (PHI) that is electronically transmitted to another entity must be sent in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule, as required by the Health Information Technology for Economic and Clinical Health Act (HITECH Act) as part of the American Recovery and Reinvestment Act of 2009.

I. At no time shall the Providers, its staff, medical facilities, Practitioners or affiliates, obtain personal or otherwise deemed confidential information under a false pretense.

Release of Medical Records

A. Providers are responsible for orienting all Practitioners office staff, Practitioners, and committee members to IEHP Policies and Procedures regarding the release of Member medical records including:

1. The release of medical record information at the request of the Member and in response to legal requests for information;
2. The release of a Member’s behavioral health records without the Member’s written consent, in ink; and
3. The release of a Member’s genetic testing records without the Member’s written consent in ink.
B. Members (or their legal guardians/representatives) must be given the opportunity to approve or deny the release of identifiable personal medical record information, including behavioral health and genetic testing, by the Practitioner and Practitioner’s staff, except to the extent that the law allows release of information.

C. Member medical records are kept confidential and information must be released only according to approved IEHP policy and procedure.

D. Practitioners and office staff may release medical record information only if a signed consent has been obtained from the Member, the parent or legal guardian or the person legally responsible for making medical decisions for the Member. However, Title 45, CFR Section 164.506 and the California Civil Code, Section 56.10, allows for the release of medical records to health plans for the purposes of:

1. Administering benefits under IEHP programs, including determination of responsibility for payment, Member’s eligibility for benefits, provision of services to eligible recipients and payment of claims;
2. Coordination of care between Practitioners as necessary;
3. Professional peer review or utilization review and quality management (as established by Congress in Public Law 97-248 in 1982);
4. Conducting actuarial or research studies; and
5. Medical information regarding a Member’s participation in behavioral health treatment may not be released unless the requirements delineated in the ‘Behavioral Health Information’ section of this Policy have been met.

E. Practitioners and office staff must disclose Member medical information when the request is from a coroner, in the course of an investigation for the purpose of identifying the Member or locating next of kin. Disclosure must also be provided when the coroner’s office is investigating deaths that may involve public health concerns, organ or tissue donation, child abuse, elder abuse, suicides, poisonings, accidents, sudden infant death, suspicious deaths, unknown deaths, or criminal deaths, or when otherwise authorized by the Member’s representative. Medical information shall be limited to information regarding the patient who is the Member and who is the subject of the investigation. This information must be given to the coroner without delay.

F. Except to the extent permitted by law, and notwithstanding a Member’s legal or court appointed representative, confidential information pertaining to a Member’s medical records must not be released to family members, unless written authorization is on file. The authorization must allow for release of information to family members, or a court document must be presented that substantiates the family member’s right to obtain confidential medical record information on the Member.
7. MEDICAL RECORDS REQUIREMENTS

B. Information Disclosure and Confidentiality of Medical Records

G. Questions regarding release of medical information to insurance carriers and other healthcare Practitioners and staff must be directed to the Practitioner.

H. Subpoenas are handled according to the IPA’s policies and procedures and in accordance with state and federal regulatory requirements.

I. Any person making copies of Member medical record information must note the release in the departmental, medical, or computer record, sign and date the entry, and document what information was copied.

J. Written authorization for the release of health information must meet the following criteria, as delineated in California Civil Code Section 56.11 and Title 45, CFR Section 164.508:

1. Is hand written in plain language by the person who signs it or is in typeface no smaller than fourteen (14) point type;

2. Is clearly separate from any other language on the same page and is executed by a signature which serves no other purpose than to execute the authorization;

3. Is dated and signed by the Member, the Member’s legal representative, the Member’s spouse or person financially responsible for the Member, or the beneficiary or personal representative of a deceased Member;

4. Specifies the uses and limitations on the types of medical information to be disclosed;

5. Specifies the names or functions of persons authorized to disclose the information about the Member;

6. Specifies the names or functions of persons authorized to receive the disclosed information;

7. Specifies the specific uses and limitations for persons receiving the information;

8. Specifies a specific date after which the authorization is no longer valid;

9. If a covered entity seeks an authorization, the covered entity must provide the Member with a copy of the authorization they signed;

10. The authorization must include the Member’s individual right to revoke the authorization in writing; and

11. An authorization revocation is allowed at any time as long as the covered entity has not taken action in reliance of that authorization.

K. Should the requesting party need an extension to the timeframe mentioned above, they must notify the Practitioner in writing. This information should include:

1. The specific reason for the extension;
7. MEDICAL RECORDS REQUIREMENTS

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2. The intended use or uses of information during the extended time; and

3. The expected destruction date of the information.

L. Upon request, all Providers are required to make available to Members the Provider’s policy of Information Disclosure and Confidentiality of Medical Records.

M. IEHP makes available to its Members its policies and procedures for preserving the confidentiality of medical records. Any request for IEHP’s policy of Information Disclosure and Confidentiality of Medical Records must be directed to IEHP Member Services at (877) 273-4347 or (800) 718-4347 for the speech or hearing impaired.

N. Providers must fully comply with all applicable sections of the “HIPAA” Insurance Information and Privacy Protection Act (“The Act”), Insurance Code 791 et seq.; The Confidentiality of Medical Information Act (“CMIA”), California Civil Code 56, et seq.; the HITECH Act; and all other applicable State, Federal and local regulations pertaining to confidentiality, privacy and information disclosure of medical records.

O. Providers must develop and implement a disclosure authorization form that is compliant with California Civil Code Section 56.11, HIPAA and Title 45, CFR Section 164.508. An example of acceptable language is as follows:

“I, the undersigned, hereby authorize (Releasing Entity) to release to (Receiving Entity), any and all medical records pertaining to (Patient’s Name) specifically relating to (Type of Information/Date Parameters). This authorization of the medical information specified herein is to be used solely for the purpose of (Uses/Limitations) and will expire after (Date). I also understand that I have the right to receive a copy of this authorization. I also understand that I have the right to revoke this authorization in writing.”

Signed: ____________________ Date: _____________________

Print Name: _______________

Relationship to Patient: _______________

P. Providers/Practitioners must not require a Member, as a condition of receiving health care services, to sign a release or consent that would permit the disclosure of medical information per Section 56.10 of the California Civil Code.

Q. Providers/Practitioners are prohibited from intentional sharing, selling or using medical information for any purpose not necessary to provide health care services to the Member, except as otherwise authorized.
7. MEDICAL RECORDS REQUIREMENTS

B. Information Disclosure and Confidentiality of Medical Records

R. All Providers must maintain information disclosure policies that are in full compliance with the Federal Regulations of HIPAA and Section 56.10 of the California Civil Code.

S. IPAs monitor Provider sites for compliance with IEHP requirements for the protection of Member medical records.

T. This section does not apply to the disclosure or use of medical record information when IEHP is the payer and IEHP requests clinical information, records for coordination of care, quality studies or risk adjustment activities.

Sensitive Services Information

A. The release of information related to sensitive services must meet the same specifications as noted in section J of “Release of Medical Records” above.

B. In special circumstances for treatment of sensitive services such as sexually transmitted disease, HIV, and family planning, Members have the right to sign a Limited Release of Information Form that prohibits the release of medical records, but does allow release of sufficient information for billing purposes, as outlined in the Policy 10G, “Sexually Transmitted Infection (STI) Services.”

C. Except in cases where direct health care Practitioners are disclosing the results of HIV tests for purposes directly related to the health care of the Member, all IEHP network Practitioners must obtain written consent from the Member to disclose results of an HIV test.

Genetic Testing Information

A. “Genetic characteristics” as used in this section, shall be defined as follows:

1. Any scientifically or medically identifiable gene or chromosome, or combination or alteration thereof, that is known to be the cause of a disease or disorder in a person or his or her offspring, or that is determined to be associated with a statistically increased risk of development of a disease or disorder and presently not associated with any symptoms of any disease or disorder; or

2. Inherited characteristics that may derive from the individual or family member, that are known to be a cause of a disease or disorder in a person or his or her offspring, or that are determined to be associated with a statistically increased risk of development of a disease or disorder and presently not associated with any symptoms of any disease or disorder.

B. The release of information related to genetic testing must meet the same specifications as noted in section J of “Release of Medical Records” above.

C. In addition, the person or entity requesting the medical record information must submit a copy of the written request to the Member within thirty (30) days of receipt of the requested information, unless the Member has signed a written waiver in the form of a
7. MEDICAL RECORDS REQUIREMENTS

B. Information Disclosure and Confidentiality of Medical Records

letter that is submitted by the Member to the health care Practitioner of IEHP waiving this notification.

D. A person who negligently or willfully discloses the results of a test for genetic characteristics to any third party is subject to those penalties described in Section 56.17 of the California Civil Code that prohibits health care Practitioners from releasing specified medical information created regarding genetic testing of an individual unless the person or treating entity requesting the information submits a written request signed by the Member.

Behavioral Health Information

A. Providers and Practitioners may not release medical information to persons or entities authorized to receive that information pursuant to Federal Regulations under HIPAA and California Civil Code, Section 56.104, if the requested information specifically relates to a Member’s participation in behavioral health treatment, unless the following requirements have been met:

1. The person or entity requesting that information (“requestor”) submits a written request to the Practitioner or Provider, whichever is applicable, signed by the requestor. The request must include:
   a. The specific information relating to a Member’s participation in behavioral health treatment and its specific use(s);
   b. A statement that the information is not to be used for any purpose other than its intended use;
   c. The length of time that the information will be kept before being destroyed or disposed of. A requestor may extend the timeframe provided that they notify the appropriate Practitioner or Provider of the extension. An extension notice must include the specific reason for the extension, the intended use of the information during the extension, and the expected date that the information is to be destroyed; and
   d. A statement that the requestor will destroy the information and all copies in their possession or control, will cause it to be destroyed, or will return the information and all copies of it before or immediately after the length of time specified in paragraph (c.) has expired.

B. In addition, the person or entity requesting the medical record information must submit a copy of the written request to the Member within thirty (30) days of receipt of the requested information, unless the Member has signed a written waiver in the form of a letter that is submitted by the Member to the health care Practitioner of IEHP waiving this notification.

C. This section does not apply to the disclosure or use of medical information by a law
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enforcement agency or a regulatory agency when required for an investigation of unlawful activity or for licensing, certification, or regulatory purposes, unless otherwise prohibited by law.

D. This section does not apply to the disclosure or use of behavioral health information when IEHP is the payer and IEHP requests clinical information, records for coordination of care, quality studies or risk adjustment activities.

E. A covered entity must obtain an authorization for any use or disclosure of psychotherapy notes except in the following situations under Title 45, CFR Section 164.508(a)(2):

1. To carry out the following treatment, payment, or health care operations:
   a. Use of the originator of the psychotherapy notes for treatment;
   b. Use or disclosure by the covered entity for its own training programs; and
   c. To defend itself in a lawsuit.

IEHP Oversight and Monitoring:

A. IEHP monitors the confidentiality of Member medical records and the appropriate release of confidential information through initial PCP Facility Site Review and Medical Record Review Surveys.

B. IEHP monitors IPA compliance with Member medical record confidentiality (HIPAA) policies and procedures through annual IPA Delegation Oversight Audits.

C. IEHP monitors IPA compliance with medical record confidentiality by ensuring that committee members have signed a confidentiality statement protecting Member information.

REFERENCES:

B. Health Insurance Portability and Accountability Act.
C. Health Information Technology for Economic and Clinical Health Act (HITECH).
D. Confidentiality of Medical Information Act. (CMIA)
E. Insurance Information and Privacy Protection Act.
F. Title 45, Code of Federal Regulations § 164.506, 164.508.
G. California Civil Code § 56.17, 56.35-56.104.
H. California Health and Safety Code § 1364.5.
I. California Insurance Code § 791 et seq.
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B. Information Disclosure and Confidentiality of Medical Records
7. MEDICAL RECORDS REQUIREMENTS

C. Informed Consent

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP Providers are defined as Primary Care Physician (PCP) includes PCPs PCP-OB/GYNs, Specialists, Behavioral Health Providers, Qualified Autism Services Providers (QASPs), Vision Providers, Urgent Care Centers, Ancillary Providers, Facilities, Pharmacies, and other Providers (e.g. Nurse Practitioners, Physician Assistants, Acupuncturists, Certified Nurse Midwives and Dentists).

B. Informed consent for treatment, procedures or other interventions must be obtained by the Provider prior to initiation of the procedure.

C. Informed consent information must be provided with consideration of the Member’s linguistic needs and literacy level.

D. Informed consent is required whenever any surgical or invasive diagnostic procedure is to be performed or when general, local or regional anesthesia is to be used.

PROCEDURES:

A. IEHP Providers must obtain appropriate written consent from Members before the actual performance of any diagnostic or treatment procedure of an intrusive nature (See Attachments, “Consent for Special Procedure – English” and “Consent for Special Procedure – Spanish” in Section 7).

B. In the event that the appropriate consent form is unavailable in the Member’s primary language, Members have the right to request an interpreter at no charge. See Policies 9H1, “Cultural and Linguistic Services – Foreign Language Capabilities” and 9C1, “Access to Care for People with Disabilities - Members Who Are Deaf or Hard-of-Hearing.”

1. Interpretation Services - All Providers must provide services to limited English proficient Members in the Member’s primary language.
   a. These linguistic capabilities must be available to Members twenty-four (24) hours a day, seven (7) days a week.
   b. Providers are encouraged to have bilingual Practitioners and staff.
   c. Providers may use face-to-face interpreters or telephonic interpretation services to meet the requirement of providing linguistic services to Members.
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C. Informed Consent

d. IEHP contracts with Pacific Interpreters to provide telephone interpretation services to Members. Providers access these services by contacting IEHP Dualchoice Member Services at (877) 273-IEHP. Pacific Interpreters offers interpretation services twenty-four (24) hours a day, seven (7) days a week.

e. Members or Providers must contact IEHP Member Services at least five (5) working days before the medical appointment to arrange for face-to-face interpreter service.

f. Providers should not require or suggest the use of family members or friends as interpreters. However, a family member or friend may be used as an interpreter if this is requested by the Member after being informed he/she has the right to use free interpreter services. The use of such an interpreter should not compromise the effectiveness of services or violate the Member’s confidentiality. Minors should not be used as interpreters except for extraordinary circumstances such as medical emergencies.

g. Providers must document all Member requests for and refusal of interpreter services in the Member’s medical record.

C. In the event that a Member lacks legal authority to sign the consent due to either the Member’s legal status as a minor or because of mental incapacitation, an agent may sign the consent on behalf of the Member. The signing agent must document their relationship to the Member on the consent form. A copy of any authorizing document or court order should be maintained in the Member’s file. Examples of authorized agents include:

1. A person appointed pursuant to a valid advance health care directive.

2. A conservator, guardian, or interested person with a court order authorizing the particular treatment of the Member.

3. A conservator or guardian authorized by a court to make health care decisions for the Member.

4. The Member’s parents, spouse, registered domestic partner, or close family relatives.

D. The consent form must include the following:

1. Member name;

2. ID #;

3. Procedure;

4. Diagnosis;
7. MEDICAL RECORDS REQUIREMENTS

C. Informed Consent

5. Risks;
6. Benefits;
7. A statement signed by the Member that the procedure has been explained to the Member and that the Member fully understands the procedure, benefits, and risks;
8. A witness’ signature; and
9. PCP/Practitioner’s signature.

E. An informed consent procedure must be followed in the case of sterilization for Members enrolled in IEHP DualChoice (See Attachments, “PM 330 Sterilization Consent Form – English” and “PM 330 Sterilization Consent Form – Spanish” in Section 10).


G. An informed consent procedure must be in place for Members who seek out of plan STD, Family Planning and HIV testing services, and who wish to maintain medical record confidentiality but allow for transmission of information necessary for billing purposes.

H. Providers are required to keep copies of signed informed consent forms in the Member’s medical record as well as submit these with any claims forms.

REFERENCES:
A. 45 CFR § 46.116, “General Requirements for Informed Consent”.
B. 45 CFR § 46.117, “Documentation of Informed Consent”.

INLAND EMPIRE HEALTH PLAN

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<th>Original Effective Date:</th>
<th>January 1, 2007</th>
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<tr>
<td>Chief Title: Chief Network Officer</td>
<td>Revision Date:</td>
<td>January 1, 2018</td>
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7. MEDICAL RECORDS

D. Advance Health Care Directive

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP requires that all Health Care Providers (i.e., healthcare facilities and Practitioners) comply with the Patient Self Determination Act (PSDA) of 1990, which states that all Health Care Providers must:

1. Inform Members of their right to formulate an advance directive in writing. This policy, in regards to PSDA, applies to all Health Care Providers and Members age 18 and older, as well as Emancipated Minors.

2. Periodically inquire as to whether a Member executed an advanced directive and document the Member wishes regarding their medical care;

3. Not to condition the provision of care or otherwise discriminate against persons who have or have not executed an advanced directive;

4. Ensure that legally valid advance directives and documented medical care wishes are implemented to the extent permitted by State law; and

5. Provide education to staff, Members and the community on ethical issues concerning patient self-determination and advance directives.

B. IEHP and/or the delegated IPA allows a Member’s representative/caregiver to facilitate care or treatment decisions for a Member who is unable to do so.

DEFINITION:

A. Advanced Directive: Written instructions that detail treatment preferences for any health care decisions when a Member is unable to speak for his or herself. Examples of advance directives include (but are not limited to): a living will, a Durable Power of Attorney form, a health care proxy, a Physician Orders of Life Sustaining Treatment (POLST), Five Wishes, and surrogate decision maker. This document must comply with State and Federal law.

PROCEDURES:

A. The provisions of the Patient Self Determination Act (PSDA) that affect Health Care Providers (i.e., healthcare facilities and practitioners) are as follows:

1. Every Health Care Provider that receives payments from Medicare must give each Member a statement of rights in regard to making healthcare decisions.
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D. Advance Health Care Directive

2. The Health Care Provider must ask all Members age 18 and older, as well as Emancipated Minors, if they have an advance directive. A response must be documented in the Member’s medical record. Healthcare may not be withheld or delayed for lack of an advance directive.

3. If the Member has an advance directive, the Health Care Provider must request that the Member bring the Provider a copy to be placed in the Member’s medical record.

4. If the Member does not have an advance directive and requests further information, the Health Care Provider must have written educational materials on hand regarding the PSDA (See Attachments, “Health Care Advance Directive FAQs - English” and “Health Care Advance Directive FAQs - Spanish” in Section 7).

5. Health Care Providers are not required to assist Members with formulating advance directives. They are only required to notify Members 18 and older, as well as Emancipated Minors of their advance directive rights.

6. A Member may change, cancel and/or amend an advance directive at any time.


B. Neither IEHP nor the delegated IPA is required to provide care that conflicts with an advance directive.

C. IEHP and/or the delegated IPA will allow the Member or the Member's representative/caregiver to be involved in decisions about withholding resuscitative services or declining/withdrawing life-sustaining treatment.

D. Through its written Member materials, IEHP must:
   1. Periodically inform Members of their right to accept or refuse treatment and to complete an advance directive and inform the Member how to implement that right.

E. IEHP and/or the delegated IPA must have a policy for medical record documentation of advance directives that require:
   1. Documentation of advance directives to be in a prominent part of the Member's medical record. This documentation should include whether or not a Member has executed an advance directive.

F. IEHP shall demonstrate that it provides education for staff on issues concerning advance directives.
7. MEDICAL RECORDS

D. Advance Health Care Directive

REFERENCES:

B. California Probate Code Section 4670 et seq.
### 7. MEDICAL RECORDS REQUIREMENTS

**Attachments**

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<tr>
<th>DESCRIPTION</th>
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<td>Consent for Special Procedure - Spanish</td>
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<td>Advance Health Care Directive FAQs - Spanish</td>
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ADVANCE HEALTH CARE DIRECTIVE

INSTRUCTIONS

Part 1 of this form lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Unless you state otherwise in this form, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
2. Select or discharge health care providers and institutions.
3. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
5. Donate organs or tissues, authorize an autopsy, and direct disposition of remains.

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment, psychosurgery, sterilization or abortion for you.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You also can add to the choices you have made or write down any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end of life decisions, you need not fill out Part 2 of this form.

Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

Name of Patient: 

Date of Birth: 

(03/17)
**PART 1 – POWER OF ATTORNEY FOR HEALTH CARE**

**DESIGNATION OF AGENT:**
I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent: ________________________________
Address: ____________________________________________________________
_________________________________________________________________

Telephone: __________________________________________________________
  (home phone)  (work phone)  (cell/pager)

OPTIONAL: If I revoke my agent’s authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as first alternate agent: _________________________
Address: ____________________________________________________________
_________________________________________________________________

Telephone: __________________________________________________________
  (home phone)  (work phone)  (cell/pager)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent: _________________________
Address: ____________________________________________________________
_________________________________________________________________

Telephone: __________________________________________________________
  (home phone)  (work phone)  (cell/pager)

**AGENT’S AUTHORITY:**
My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

(Add additional sheets if needed.)
WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE:
My agent’s authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

(Initial here)

OR

My agent’s authority to make health care decisions for me takes effect immediately.

(Initial here)

AGENT’S OBLIGATION:
My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

AGENT’S POSTDEATH AUTHORITY:
My agent is authorized to make anatomical gifts, authorize an autopsy and direct disposition of my remains, except as I state here or in Part 3 of this form:

(Add additional sheets if needed.)

NOMINATION OF CONSERVATOR:
If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.
PART 2 – INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

END OF LIFE DECISIONS:
I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

Choice Not To Prolong Life:

(Initial here)

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits,

OR

Choice To Prolong Life:

(Initial here)

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

RELIEF FROM PAIN:
Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

(Add additional sheets if needed.)

OTHER WISHES:
(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

(Add additional sheets if needed.)
PART 3 – DONATION OF ORGANS AT DEATH (OPTIONAL)

I. Upon my death:
I give any needed organs, tissues, or parts. (Initial here)

OR
I do not authorize the donation of any organs, tissues or parts. (Initial here)

OR
I give the following organs, tissues, or parts only: ______________________________

(Initial here)

II. If you wish to donate organs, tissues, or parts, you must complete II. and III.
My gift is for the following purposes:
Transplant (Initial here) Research (Initial here)
Therapy (Initial here) Education (Initial here)

III. I understand that tissue banks work with both nonprofit and for-profit tissue processors and distributors. It is possible that donated skin may be used for cosmetic or reconstructive surgery purposes. It is possible that donated tissue may be used for transplants outside of the United States.

1. My donated skin may be used for cosmetic surgery purposes.
Yes (Initial here) No (Initial here)

2. My donated tissue may be used for applications outside of the United States.
Yes (Initial here) No (Initial here)

3. My donated tissue may be used by for-profit tissue processors and distributors.
Yes (Initial here) No (Initial here)

(Health and Safety Code Section 7158.3)
PART 4 – PRIMARY PHYSICIAN (OPTIONAL)

I designate the following physician as my primary physician:

Name of Physician: __________________________________________________________
Telephone: __________________________________________________________________
Address: ___________________________________________________________________

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

Name of Physician: __________________________________________________________
Telephone: __________________________________________________________________
Address: ___________________________________________________________________

PART 5 – SIGNATURE

The form must be signed by you and by two qualified witnesses, or acknowledged before a notary public.

SIGNATURE:

Sign and date the form here:

Date: _________________________________ Time: _________________________________ AM / PM

Signature: __________________________________________ (patient)

Print name: __________________________________________________________________ (patient)

Address: ___________________________________________________________________

STATEMENT OF WITNESSES:

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual’s identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual’s health care provider, an employee of the individual’s health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

(03/17)  
Page 6 of 8  
California Hospital Association
FIRST WITNESS

Name: __________________________ Telephone: __________________________
Address: ______________________________________________________________

Date: __________________________ Time: __________________________ AM / PM
Signature: ______________________________________________________________
(witness)
Print name: __________________________________________________________
(witness)

SECOND WITNESS

Name: __________________________ Telephone: __________________________
Address: ______________________________________________________________

Date: __________________________ Time: __________________________ AM / PM
Signature: ______________________________________________________________
(witness)
Print name: __________________________________________________________
(witness)

ADDITIONAL STATEMENT OF WITNESSES:

At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual’s estate upon his or her death under a will now existing or by operation of law.

Date: __________________________ Time: __________________________ AM / PM
Signature: ______________________________________________________________
(witness)
Print name: __________________________________________________________
(witness)
A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of the document.

YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.

State of California  
County of ________________________________  

On (date) ________________ before me, (name and title of the officer) ________________________________, personally appeared (name(s) of signer(s)) ________________________________, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature: ___________________________ [Seal]  
(notary)

PART 6—SPECIAL WITNESS REQUIREMENT

If you are a patient in a skilled nursing facility, the patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

Date: ________________________________ Time: ________________________________ AM / PM

Signature: ________________________________  
(patient advocate or ombudsman)

Print name: ________________________________  
(patient advocate or ombudsman)

Address: ________________________________

(03/17)  
Page 8 of 8  
California Hospital Association
DIRECTIVA POR ANTICIPADO DE LA ATENCIÓN DE LA SALUD

INSTRUCCIONES

La Sección 1 de este formulario le permite nombrar a otro individuo como representante para que tome las decisiones de atención de la salud por usted en caso que llegue a ser incapaz de tomar sus propias decisiones o si usted quiere que alguien más tome esas decisiones por usted ahora aunque todavía siga siendo capaz. También puede nombrar a un representante suplente que actúe por usted si su primera elección no está dispuesta, no es capaz o no está razonablemente accesible para tomar decisiones por usted.

Su representante no puede ser un operador o empleado de un establecimiento de atención comunitaria y un establecimiento de atención residencial donde lo estén atendiendo, ni su proveedor de atención de la salud encargado de la supervisión o un empleado de la institución de atención de la salud donde usted esté recibiendo la misma, a menos que su representante esté emparentado con usted o sea compañero de trabajo.

A menos que indique lo contrario en este formulario, su representante tendrá el derecho de:

1. Prestar o negar el consentimiento a cualquier atención, tratamiento, servicio o procedimiento para mantener, diagnosticar o afectar de otro modo una enfermedad física o mental.
2. Seleccionar o rechazar proveedores e instituciones de atención de la salud.
3. Aprobar o desaprobear pruebas diagnósticas, procedimientos quirúrgicos y programas de medicamentos.
4. Dirigir el proveimiento, la negación o la retirada de nutrición e hidratación artificial y todas las demás formas de atención de la salud, incluyendo resucitación cardiopulmonar.
5. Donar órganos o tejidos, autorizar una autopsia y ordenar la disposición final de los restos.

Sin embargo, su representante no podrá internarlo en un establecimiento psiquiátrico ni dar su consentimiento para que usted sea sometido a tratamiento convulsivo, psicocirugía, esterilización o aborto.

La Sección 2 de este formulario le permite dar instrucciones específicas acerca de cualquier aspecto de su atención de la salud, ya sea que usted nombre un representante o no. Se proporcionan opciones para que usted exprese sus deseos acerca del proveimiento, la negación o la retirada del tratamiento para mantenerlo vivo, así como el proveimiento de alivio del dolor. También se proporciona espacio para que usted aumente las opciones que haya hecho o que anote cualesquiera deseos adicionales. Si está conforme con dejar que su representante determine lo que sea mejor para usted al tomar decisiones relacionadas con el final de la vida, no es necesario que llene la Parte 2 de este formulario.

Entrégameles copias del formulario firmado y debidamente llenado a su médico, a cualesquiera otros proveedores de atención de la salud que pueda tener, a cualquier institución de atención de la salud en la que lo estén atendiendo y a todos los representantes de atención de la salud que haya nombrado. Deberá hablar con la persona que haya nombrado como representante para asegurar que él o ella entienda sus deseos y está dispuesta a asumir la responsabilidad.
**Usted tiene derecho a revocar esta directiva por anticipado de la atención de la salud o a reemplazar este formulario en cualquier momento.**

Nombre de Paciente: ________________________________________________________________

Fecha de Nacimiento: _____________________________________________________________

**PARTE 1 – PODER NOTARIAL PARA ATENCIÓN DE LA SALUD**

**DESIGNACIÓN DEL REPRESENTANTE:**

Designo al siguiente individuo como mi representante para que tome las decisiones de atención de la salud por mí:

Nombre del individuo que usted elija como representante: __________________________________

Dirección: _______________________________________________________________________

Teléfono: ________________________________________________________________________
    (en casa)       (teléfono en el trabajo)       (teléfono celular/localizador)

OPCIONAL: Si revoco la autoridad de mi representante o si mi representante no está dispuesto, no es capaz o no está razonablemente accesible para tomar una decisión de atención de la salud por mí, designo como mi primer representante suplente a:

Nombre de la persona que usted elige como primera alternativa: ____________________________

Dirección: _______________________________________________________________________

Teléfono: ________________________________________________________________________
    (en casa)       (teléfono en el trabajo)       (teléfono celular/localizador)

OPCIONAL: Si revoco la autoridad de mi representante y mi primer representante suplente o si ninguno de los dos está dispuesto, es capaz o está razonablemente accesible para tomar una decisión de atención de la salud por mí, designo como mi segundo representante suplente a:

Nombre del individuo que usted elija como su segundo representante suplente: ________________

Dirección: _______________________________________________________________________

Teléfono: ________________________________________________________________________
    (en casa)       (teléfono en el trabajo)       (teléfono celular/localizador)
AUTORIDAD DEL REPRESENTANTE:
Mi representante está autorizado para tomar todas las decisiones de atención de la salud por mí, incluyendo las decisiones para proveer, negar o retirar la nutrición e hidratación artificial y todas las demás formas de atención de la salud para mantenerme vivo, excepto como lo consigno aquí:

(Si es necesario, agregue hojas adicionales.)

CUÁNDO ENTRA EN VIGENCIA LA AUTORIDAD DEL REPRESENTANTE:
La autoridad de mi representante entra en vigencia cuando mi médico de atención primaria determine que soy incapaz de tomar mis propias decisiones de atención de la salud.

(Inicial aquí)
La autoridad de mi representante para tomar las decisiones de atención de la salud por mí entra en vigor inmediatamente.

(Inicial aquí)

OBLIGACIÓN DEL REPRESENTANTE:
Mi representante tomará decisiones de atención de la salud por mí de acuerdo con este poder notarial para atención de la salud, todas las instrucciones que yo proporcione en la Parte 2 de este formulario y mis demás deseos en la medida conocida para mi representante. En la medida que mis deseos sean desconocidos, mi representante tomará decisiones de atención de la salud por mí de acuerdo con lo que mi representante determine que es en mi mejor interés. Para determinar mi mejor interés, mi representante deberá considerar mis valores personales en la medida conocida por el mismo.

AUTORIDAD DEL REPRESENTANTE DESPUÉS DE LA MUERTE:
Mi representante está autorizado para hacer donaciones anatómicas, autorizar una autopsia y ordenar la disposición final de mis restos, excepto como yo lo consigno aquí o en la Parte 3 de este formulario:

(Si es necesario, agregue hojas adicionales.)

NOMBRAMIENTO DE CURADOR:
Si algún tribunal necesita nombrar a un curador de mi persona, propongo al representante designado en este formulario. Si dicho representante no está dispuesto, no es capaz o no está razonablemente disponible para actuar como curador, propongo a los representantes suplentes que he nombrado, en el orden designado.
PARTE 2 – INSTRUCCIONES PARA LA ATENCIÓN DE LA SALUD

Si usted llena esta parte del formulario, podrá tachar cualquier texto que no quiera.

DECISIONES DEL FINAL DE LA VIDA:

Ordeno que mis proveedores de atención de la salud y otros que participen en mi atención provean, nieguen o retiren el tratamiento de acuerdo con la elección que yo haya marcado abajo:

Elección de no prolongar la vida

(Inicial aquí)

No quiero que mi vida sea prolongada si (1) tengo una enfermedad incurable e irreversible que resulte en mi muerte dentro de un periodo relativamente corto, (2) pierdo el conocimiento y, con un grado razonable de certidumbre médica, no lo recuperaré o (3) los riesgos y cargas probables del tratamiento serían más mayores que los beneficios previstos,

O

Elección de prolongar la vida

(Inicial aquí)

Quiero que mi vida sea prolongada tanto como sea posible dentro de los límites de las normas de atención de la salud generalmente aceptadas.

ALIVIO DEL DOLOR:

Excepto como lo consigno en el siguiente espacio, ordeno que se me proporcione en todo momento tratamiento para el alivio del dolor o las molestias, aunque acelere mi muerte:

(Si es necesario, agregue hojas adicionales.)

OTROS DESEOS:

(Si usted no está de acuerdo con alguna de las elecciones opcionales que aparecen arriba y desea anotar las suyas propias, o si desea aumentar las instrucciones que ha proporcionado arriba, puede hacerlo aquí). Ordeno que:

(Si es necesario, agregue hojas adicionales.)
PARTE 3 – DONACIÓN DE ÓRGANOS DESPUÉS DE LA MUERTE (OPCIONAL)

I. Después de mi muerte

Dono todos los órganos, tejidos o partes necesarios. _________________

(Inicial aquí)

O

No autorizo la donación de ningún órgano, tejido u otra parte del cuerpo. _________________

(Inicial aquí)

O

Dono solamente los siguientes órganos, tejidos o partes: _________________

____________________________________

____________________________________

____________________________________

(Inicial aquí)

II. Si usted desea donar a órganos, tejidos o partes, usted debe completar II. y III.

Mi donación es para los siguientes propósitos (tache cualquiera de los siguientes que usted no desee):

Trasplante _________________

(Inicial aquí)

Investigación _________________

(Inicial aquí)

Terapia _________________

(Inicial aquí)

Educación _________________

(Inicial aquí)

III. Entiendo que los bancos de tejidos trabajan con procesadores y distribuidores de tejidos tanto con fines de lucro como sin fines de lucro. Es posible que la donación de piel se use para fines cosméticos o de cirugía reconstructiva. Es posible que la donación de tejido se use para trasplantes fuera de los Estados Unidos.

1. Mi donación de piel puede usarse con fines de cirugía cosmética.

Si _________________

(Inicial aquí)

No _________________

(Inicial aquí)

2. Mi donación de tejido puede usarse para aplicaciones fuera de los Estados Unidos.

Si _________________

(Inicial aquí)

No _________________

(Inicial aquí)

3. Mi donación de tejido puede ser usada por procesadores y distribuidores de tejidos con fines lucrativos.

Si _________________

(Inicial aquí)

No _________________

(Inicial aquí)

(Health and Safety Code Section 7158.3)
PARTE 4 – MÉDICO DE ATENCIÓN PRIMARIA (OPCIONAL)

Designo al siguiente como mi médico de atención primaria:
Nombre del Médico: 
Teléfono: 
Dirección: 

OPCIONAL: Si el médico que he designado no está dispuesto, no es capaz o no está razonablemente accesible para actuar como mi médico de atención primaria, designo al siguiente para que desempeñe este papel:
Nombre del Médico: 
Teléfono: 
Dirección: 

PARTE 5 – FIRMA

El formulario debe ser firmado por usted y dos testigos calificados o certificado ante un notario público.

FIRMA:
Firme y ponga aquí la fecha en el formulario:
Fecha: Hora: AM / PM

DECLARACIÓN DE LOS TESTIGOS:
Declaro bajo pena de perjurio conforme a las leyes de California (1) que el individuo que firmó o certificó esta directiva por anticipado de la atención de la salud es conocido personalmente para mí, o que la identidad del individuo me fue demostrada con evidencia convincente, (2) que el individuo firmó o certificó esta directiva por anticipado en mi presencia, (3) que el individuo parece encontrarse en buen estado mental y bajo ninguna presión, fraude o influencia indebida, (4) que no soy la persona designada como representante en esta directiva por anticipado y (5) que no soy el proveedor de atención de la salud del individuo, un empleado del proveedor de atención de la salud del individuo, el operador de un establecimiento de atención comunitaria, el operador de un establecimiento de atención residencial para ancianos, ni un empleado de un operador de un establecimiento de atención residencial para personas de edad avanzada.
**PRIMERO TESTIGO**

Nombre: ___________________________ Teléfono: ___________________________

Dirección: ________________________________________________________________

_______________________________________________________________

Fecha: ___________________________ Hora: ___________________________ AM / PM

Firma: ___________________________

(testigo)

Nombre en letra de imprenta: __________________________________________

(testigo)

**SEGUNDO TESTIGO**

Nombre: ___________________________ Teléfono: ___________________________

Dirección: ________________________________________________________________

_______________________________________________________________

Fecha: ___________________________ Hora: ___________________________ AM / PM

Firma: ___________________________

(testigo)

Nombre en letra de imprenta: __________________________________________

(testigo)

**DECLARACIÓN ADICIONAL DE LOS TESTIGOS:**

Por lo menos uno de los testigos mencionados arriba también debe firmar la siguiente declaración:

Declaro además bajo pena de perjurio conforme a las leyes de California que no estoy emparentado por lazos sanguíneos, matrimonio o adopción con el individuo que formaliza esta directiva por anticipado de la atención de la salud, y que a mi leal saber y entender, no tengo derecho a parte alguna del caudal hereditario del individuo después de su muerte bajo un testamento actualmente existente o por ministerio de ley.

Fecha: ___________________________ Hora: ___________________________ AM / PM

Firma: ___________________________

(testigo)

Nombre en letra de imprenta: __________________________________________

(testigo)
A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of the document.

USTED PUEDE USAR ESTE CERTIFICADO DE CONFIRMACIÓN ANTE NOTARIO PÚBLICO EN VEZ DE LA DECLARACIÓN DE TESTIGOS.

State of California  
County of__________________________

On ______________________________ before me, (name and title of the officer) ___________________________ personally appeared (name(s) of signer(s)) ___________________________, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature: ______________________________ [Seal]  
(notary)

PARTE 6 – REQUERIMIENTO DE TESTIGO ESPECIAL

Si usted es paciente en un establecimiento con servicio de enfermería especializada, el abogado o defensor cívico del paciente debe firmar la siguiente declaración:

DECLARACIÓN DEL ABOGADO O DEFENSOR CÍVICO DEL PACIENTE

Declaro bajo pena de perjurio conforme a las leyes de California que soy abogado o defensor cívico del paciente designado por el Departamento de la Senectud del Estado y que estoy sirviendo como testigo como lo estipula la Sección 4675 del Código Testamentario.

Fecha: ______________________________ Hora: ______________________________ AM / PM
Firma: ______________________________

(abogado o defensor cívico del paciente)

Nombre en letra de imprenta: ______________________________

(abogado o defensor cívico del paciente)

Dirección: ______________________________
Advance Health Care Directive FAQs

You have the right to make decisions about your medical treatment

This document explains your rights to make health care decisions and how you can plan what should be done when you cannot speak for yourself. The Patient Self Determination Act (PDSA) requires us to provide you with this helpful information that aims to increase your control over your medical treatment.

<table>
<thead>
<tr>
<th>What is advance health care directive?</th>
<th>A health care advance directive is a legal document that details treatment preferences for any health care decision in the event that you cannot speak for yourself. It is a document you complete while competent concerning your future health wishes. This could include a living will, a health care power of attorney, or a Physician Order for Life Sustaining Treatment (POLST).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who can fill out advance health care directive?</td>
<td>You can fill out your own advance directive if you are 18 years of age or older and of sound mind. You do not need a lawyer to fill it out.</td>
</tr>
<tr>
<td>Who decides my medical treatment?</td>
<td>Your doctors will give you information about treatments and options. You have the right to choose your treatment. You can say “YES” to the treatment(s) you want or you can say “NO” to any treatment you do not want – even if the treatment might prolong your life.</td>
</tr>
</tbody>
</table>
| How do I know what I want? | Your doctor must tell you about your medical condition and about what different treatments can do for you. Many treatments have “side effects.” Your doctor must offer you information about serious problems that medical treatment is likely to cause you.  

*Your doctor can tell you which treatments are available to you but cannot choose for you.* |
| What if I am too sick to decide? | If you cannot make treatment decisions, your doctor will ask for your closest available relative or friend to help decide what is best for you. It is helpful if you say to someone in advance what medical treatment you desire in the event that something should happen and you cannot speak for yourself. There are several kinds of “advance directives” that you can use to express who you want to speak on your behalf as well as what treatment you do and/or do not want.  

*One kind of advance directive under California law is called a Durable Power of Attorney for Healthcare. This document lets you designate someone as your “Agent” who is responsible for making your health care.* |
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whom can I name as my Agent?</td>
<td>You can select an adult relative or friend who you trust as your Agent. This individual will speak on your behalf when you are too ill to make your own healthcare decisions.</td>
</tr>
<tr>
<td>How does whomever I name as my Agent know what Medical treatment I would want?</td>
<td>You can talk to your designated Agent and doctor about your requested medical treatment in the event you are unable to make the decision on your own and that information can be transcribed in your medical records. Also, you can write down in the Durable Power of Attorney for Healthcare document when you would and would not want medical treatment. Give your doctor and Agent a copy of the Durable Power of Attorney form. You should also carry a copy with you in the event that you are hospitalized or enter a treatment center so that it may be placed into your medical record.</td>
</tr>
<tr>
<td>What if I do not have anyone to name as my Agent?</td>
<td>You can use another kind of advance directive called a “living will” to write down your wishes about medical treatment. It takes effect while you are still alive but have become unable to speak for yourself. The California Natural Death Act lets you sign a “living will” called a Declaration. Anyone 18 years of age or older and of sound mind may sign one. When you sign a Declaration, it tells your doctors that you do not want any treatment that would only prolong your life. All life-sustaining treatment would be stopped if you were terminally ill and your death was expected soon, or if you were permanently unconscious or “brain dead.” In addition, you would still receive treatment to keep you comfortable and pain-free. Your doctor must follow your wishes about limiting treatment or turn your care over to another doctor who will. Your doctors are also legally protected when they follow your wishes.</td>
</tr>
<tr>
<td>Are there other wills I can use?</td>
<td>Instead of using the Declaration in the Natural Death Act, you can use any of the available “living will” forms. You can also use a Durable Power of Attorney for Healthcare form without naming an Agent. Or, you can simply write down your wishes on a piece of paper. Your doctors and family can use what you write in deciding about your treatment. However, “living wills” that do not meet the requirements of the Natural Death Act do not give as much protection for your doctors if a disagreement arises about following your wishes.</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>What if I change my mind?</td>
<td>You can change OR revoke any of these advance directive documents at any time as long as you can communicate your wishes. Be sure to let your doctors, family, friends and any Agent you may have appointed know if you decide to change or revoke your advance directive.</td>
</tr>
<tr>
<td>Am I required to fill out any advance directive forms?</td>
<td>No, you are not required to fill out any of these forms if you do not want to. You can just talk with your doctor(s) and ask them to write down what you’ve said in your medical chart or you could talk with your family. However, writing down your medical treatment wishes is encouraged as it will give people a clearer understanding of your wishes and is more likely to be followed in the manner you would like.</td>
</tr>
</tbody>
</table>
| Will I still be treated if I do not fill out any of these forms?       | ABSOLUTELY. You will still get full medical treatment. We just want you to know that if you should become too sick to make decisions, someone else will have to make them for you. Remember that:  
  - A Durable Power of Attorney for Healthcare lets you name someone to make treatment decisions for you. That person can make most medical decisions—not just those about life-sustaining treatment—when you cannot speak for yourself. Besides naming an Agent, you can also use this form to say when you would and would not want particular kinds of treatment.  
  - If you do not have someone you want to name to make your decisions when you cannot, you can sign a Natural Death Act Declaration. This Declaration says that you do not want life-prolonging treatment if you are terminally ill or permanently unconscious (“brain dead”). |
| What else do I need to know about making future health care decisions? | We have provided you with this information concerning advance directives so that you can fully participate in planning your future health care decisions. Unfortunately, every family must face the possibility of serious illness in which important decisions must be made. We believe that it is never too early to think about these important decisions and to discuss these topics with your family, friends, and other interested persons. Finally, rest assured your medical provider does NOT condition the provision of care or otherwise discriminate against anyone based on whether or not the person has executed an advance directive. It is strictly up to you to decide and to inform your doctor of whether or not you have completed an advance directive and then provide them a copy of it. Also, remember to bring a copy of your advance directive when you check into a hospital or other health facility so that it can be kept with your medical records. |
| How can I get more information about advance health care directives? | To obtain an advance directive form, attend a workshop, or to receive free assistance in completing an advance directive, you may call the California Health Decisions at:  
(714) 347-7921  
For more information on advance directives, you may also visit:  
Preguntas Frecuentes acerca de la Directiva por Anticipado de la Atención de la Salud

Usted tiene derecho a tomar decisiones sobre su tratamiento médico

Este documento explica sus derechos a tomar decisiones sobre su atención médica y de qué manera puede planificar lo que debería hacerse cuando no pueda expresarse por usted mismo. La Ley de Autodeterminación del Paciente (Patient Self Determination Act, PDSA) requiere que le brindemos esta información útil con el objetivo de que usted tenga un mayor control sobre su tratamiento médico.

<table>
<thead>
<tr>
<th>¿Qué es una Directiva por Anticipado de la Atención de la Salud?</th>
<th>Una Directiva por Anticipado de la Atención de la Salud es un documento legal que detalla sus preferencias de tratamiento en el caso de que no pueda expresarse por usted mismo cuando haya que tomar una decisión sobre su atención médica. Es un documento que usted completa, mientras aún es capaz de hacerlo, para dejar constancia de sus deseos sobre su atención médica futura. Este documento podría incluir un testamento vital, un poder legal para la atención médica o una Orden Médica de Tratamiento para Mantener la Vida (Physician Order for Life Sustaining Treatment, POLST).</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Quién puede llenar mi Directiva por Anticipado de la Atención de la Salud?</td>
<td>Usted puede llenar su propia Directiva por Anticipado de la Atención de la Salud si tiene 18 años o más y está en pleno uso de sus facultades mentales. No necesita a un abogado para que la complete.</td>
</tr>
<tr>
<td>¿Quién decide mi tratamiento médico?</td>
<td>Sus doctores le darán información sobre los tratamientos y las opciones. Usted tiene derecho a elegir su tratamiento. Puede decir “SÍ” a los tratamientos que desee recibir o puede decir “NO” a cualquier tratamiento que no desee recibir —incluso si el tratamiento pueda prolongarle la vida—.</td>
</tr>
<tr>
<td>¿Cómo sé lo que quiero?</td>
<td>Su doctor debe hablarle de su condición médica y la finalidad de los distintos tratamientos. Muchos tratamientos tienen “efectos secundarios”. Su doctor debe brindarle información sobre los problemas graves que un tratamiento médico podría causarle. Su doctor puede indicarle qué tratamientos están a su disposición, pero no puede elegir por usted.</td>
</tr>
<tr>
<td>¿Qué sucede si estoy muy grave como para decidir?</td>
<td>Si usted no puede tomar decisiones sobre el tratamiento, su doctor le pedirá a su pariente o amigo más cercano que le ayude a decidir lo qué es mejor para su caso. Es de gran ayuda que usted le diga a alguien por anticipado qué tratamiento médico desea en caso de que le suceda algo y no pueda expresarse por usted mismo. Hay varias clases de “directivas anticipadas”</td>
</tr>
</tbody>
</table>

Nombre del Paciente: ____________________ Fecha de Nacimiento: __/__/___ N.º de Miembro: _______

Nombre del Proveedor: ____________________________
<table>
<thead>
<tr>
<th>¿A quién puedo nombrar como mi Agente?</th>
<th>Puede elegir a un pariente o un amigo adulto en el que confíe para que actúe como su Agente. Esta persona hablará en su nombre cuando usted esté muy enfermo y no pueda tomar sus propias decisiones de atención médica.</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Cómo sabrá la persona a la que nombre como mi Agente, qué tratamiento deseo?</td>
<td>Usted puede hablar con su doctor y su Agente designado sobre el tratamiento médico que usted solicite en caso de que no sea capaz de tomar la decisión por su cuenta y que esa información se transcriba en su registro médico. Además, puede expresar por escrito en el documento Poder Legal Duradero para la Atención Médica en qué momento desea o no recibir tratamiento médico. Entregue una copia del formulario de Poder Legal Duradero a su doctor y a su Agente.</td>
</tr>
<tr>
<td>¿Qué sucede si no tengo a nadie a quien nombrar como mi Agente?</td>
<td>Usted puede usar otra clase de directiva anticipada llamada “Testamento Vital” para expresar sus deseos sobre el tratamiento médico. Este documento entra en efecto mientras usted aún está vivo, pero que ha perdido la capacidad de expresarse por usted mismo. La Ley de Muerte Natural de California le permite firmar un “testamento vital” llamado Declaración. Cualquier persona de 18 años o más, en pleno uso de sus facultades mentales, puede firmar este documento. Cuando usted firma una Declaración, les informa a sus doctores que no desea ningún tratamiento que sólo le prolongaría la vida. Todo tratamiento de sostén de la vida cesará si usted padeciera una enfermedad terminal y su fallecimiento fuera a ocurrir en poco tiempo, o si quedara inconsciente de manera permanente o con “muerte cerebral”. No obstante, usted seguirá recibiendo tratamientos que le permitan estar cómodo y sin dolor.</td>
</tr>
<tr>
<td>¿Hay otros testamentos que En lugar de usar la Declaración de la Ley de Muerte Natural, usted puede usar cualquiera de los formularios de “testamento vital” disponibles.</td>
<td></td>
</tr>
</tbody>
</table>
### ¿Puedo usar un formulario de Poder Legal Duradero para la Atención Médica sin nombrar a un Agente?

También puede usar un formulario de Poder Legal Duradero para la Atención Médica sin nombrar a un Agente. O simplemente puede escribir sus deseos en un papel. Sus doctores y familiares pueden usar lo que usted escriba para decidir su tratamiento. Sin embargo, los “testamentos vitales” que no satisfagan los requisitos de la Ley de Muerte Natural no otorgan la misma protección a sus doctores en caso de haber un desacuerdo en lo que respecta al cumplimiento de sus deseos.

### ¿Qué sucede si cambio de parecer?

Puede cambiar O revocar todos estos documentos de directivas anticipadas en cualquier momento siempre y cuando pueda comunicar sus deseos. Informe a sus doctores, familiares, amigos y a cualquier Agente que pueda haber designado si decide cambiar o revocar su directiva anticipada.

### ¿Tengo la obligación de llenar un formulario de directiva anticipada?

No, no tiene la obligación de llenar ninguno de estos formularios si no lo desea. Simplemente puede hablar con sus doctores y pedirles que escriban lo que usted les ha dicho en su registro médico o podría hablar con sus familiares. No obstante, se recomienda dejar por escrito sus deseos sobre tratamientos médicos, ya que dará a la gente una comprensión más clara y mejores probabilidades de que se cumplan de la manera en que usted desea.

### ¿Recibiré tratamiento incluso si no completo ninguno de estos formularios?

POR SUPUESTO. Aun cuando no llene ningún formulario, recibirá tratamiento médico completo. Sólo queremos que sepa que, si se enferma de gravedad y no puede tomar decisiones, alguien más tendrá que tomarlas por usted. Recuerde que:

- Un Poder Legal Duradero para la Atención Médica le permite nombrar a alguien que tome decisiones sobre tratamientos en su nombre. Esa persona podrá tomar la mayoría de las decisiones médicas (no sólo las relacionadas con tratamientos para mantener la vida) cuando usted no pueda expresarse. Además de nombrar a un Agente, usted puede usar este formulario para indicar en qué momento desea o no una clase de tratamiento en particular.

- Si no tiene a alguien a quien nombrar para que tome decisiones en su nombre cuando usted no pueda hacerlo, puede firmar una Declaración de la Ley de Muerte Natural. Esta Declaración dice que usted no quiere tratamiento que le prolongue la vida si padece una enfermedad terminal o si queda inconsciente de manera permanente (“muerte cerebral”).

### ¿Qué más debo saber o acerca de cómo tomar decisiones sobre

Le brindamos esta información sobre directivas anticipadas para que pueda participar plenamente en la planificación de sus decisiones sobre su atención médica en el futuro. Lamentablemente, todas las familias deben enfrentar la posibilidad de una enfermedad grave en la que se deben tomar decisiones.
| ¿Cómo puedo obtener más información sobre directivas anticipadas? | Para obtener un formulario de directivas anticipadas, asistir a un taller o recibir ayuda gratuita para llenar el formulario, puede llamar a California Health Decisions al: (714) 347-7921  
<table>
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</thead>
<tbody>
<tr>
<td>la atención médica en el futuro?</td>
<td>importantes. Creemos que nunca es demasiado temprano para pensar en estas decisiones importantes y analizar estos temas con sus familiares, amigos y otras personas interesadas. Por último, tenga la certeza de que su proveedor médico NO condicionará la prestación de la atención ni discriminará de otro modo a ninguna persona en función de que se haya firmado o no una directiva anticipada. Depende estrictamente de usted decidir informar a su doctor si completó o no una directiva anticipada y de proporcionarle una copia. Además, recuerde llevar una copia de su directiva anticipada cuando sea admitido en un hospital u otro establecimiento de salud para que dicha copia pueda conservarse junto con su registro médico.</td>
</tr>
</tbody>
</table>
CONSENT FOR SPECIAL PROCEDURE

Surgical and diagnostic procedures all may involve calculated risks of complications from both known and unknown causes and no guarantee has been made as to result or cure. Except in a case of emergency or exceptional circumstances, these procedures are therefore not performed upon patients unless and until the patient has had an opportunity to discuss them with his physician. Each patient has the right to consent to, or refuse any proposed procedure based upon the description or explanation received.

Your physician has determined that the special procedure listed below may be beneficial in the diagnosis and treatment of your condition. Upon your authorization and consent, a physician selected by your attending physician will perform these special procedures for you.

Your signature opposite the procedures listed below constitutes your acknowledgment that you have read and agreed to the foregoing and that the procedure has been adequately explained to you and that you have all the information that you desire and that you authorize and consent to the performance of these procedures.

Diagnosis:   
Procedure:   

Date and Time:   
Physician/Provider:   

Patient’s Signature:   
Parent, Legal Guardian or Representative:   
Witness Signature:   

Patient Name:   DOB:   Member #:   
Provider Name:   Consent – Special Procedures.doc
IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan)

Nombre del(a) Paciente: ________________________ Expediente Clínico #: _______________

CONSENTIMIENTO PARA PROCEDIMIENTO ESPECIAL

Estos procesos quirúrgicos y diagnósticos podrían involucrar riesgos calculados de complicaciones de ambas causas tanto conocidas como desconocidas y no se hace garantía en cuanto a los resultados ó la cura. Salvo en casos de emergencia ó circunstancias excepcionales, estos procesos no serán efectuados en los pacientes a no ser y hasta que el(la) paciente haya tenido oportunidad de discutirlas con su médico. Cada paciente tiene todo el derecho a dar consentimiento ó rechazar cualquier proceso que se proponga basado en la descripción ó explicación que haya recibido.

Su médico ha determinado que el proceso especial mencionado abajo puede ser beneficioso en el diagnóstico y tratamiento de la condición que le afecta. Una vez que se haya recibido su autorización y consentimiento, estos procesos especiales se efectuarán en usted por un médico seleccionado por su médico de cabecera.

Su firma al lado opuesto de los procesos mencionados abajo constituye su reconocimiento que usted ha leído y concuerda con lo precedente y que el proceso le ha sido explicado totalmente y que usted tiene toda la información que desea y que usted da su autorización y consentimiento para que se efectúen estos procedimientos.

Diagnóstico: _______________________________________________________________________

Procedimiento: ___________________________________________________________________

Fecha y Horario: ___________________________________________________________________

Médico/Proveedor: __________________________________________________________________

Firma del(a) Paciente: __________________________________________________________________

Padre/Madre o Tutor(a) Legal: __________________________________________________________________

Firma del(a) Testigo: __________________________________________________________________

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Patient Name: ________________________ DOB: ______________ Member #: ______________

Provider Name: ________________________ Consent – Special Procedures.doc