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## 7. MEDICAL RECORDS REQUIREMENTS

### A. Provider and IPA Medical Record Requirements

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#### **APPLIES TO:**

- A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare—Medicaid Plan)~~ Providers and IPAs.

#### **POLICY:**

- A. All Provider offices must comply with IEHP, local, state, and federal regulatory standards for maintenance of Member medical records.

#### **PROCEDURES:**

##### **IPA Responsibilities**

- A. IPAs are responsible for monitoring contracted Providers for compliance with all applicable IEHP and Department of Health Care Services (DHCS) standards related to medical records.
1. IPA medical record policies and procedures must be consistent with IEHP ~~and DHCS~~ requirements.
  2. IPAs must ensure that contracted Providers have copies of IEHP medical record policies and procedures available at the practice site. See Policy 7B, “Information Disclosure and Confidentiality of Medical Records.”
  3. IPAs may assess medical record documentation and maintenance during the initial credentialing and recertification site review, though Facility Site Reviews (FSR) and Medical Record Review (MRR) activities are not delegated to IPAs.
  4. IPAs must provide support for Corrective Action Plans (CAPs) issued by IEHP for medical record deficiencies as appropriate.

##### **IEHP Medical Records Standards**

- A. **Individual Medical Records** – An individual medical record is created for each Member treated by an IEHP Provider. The medical record is designed to maintain a Member’s documented medical information of the care provided, as well as all ancillary services/diagnostic tests ordered by a Provider 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 within the same group to provide conformity and coordination of Member care. This unique medical record must be updated by the Provider or their office staff with each Member visit or contact. Sensitive medical information, such as detailed behavioral health and substance use records, may be filed separately to maintain confidentiality. Medical records must meet at minimum the following requirements:
1. Correct Beneficiary;
  2. Acceptable risk adjustment Provider type, source, and Provider specialty providing the face to face encounter;

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## 7. MEDICAL RECORDS REQUIREMENTS

### A. Provider and IPA Medical Record Requirements

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3. Dates of service within the data collection period under review;
  4. Valid signatures and credentials; and
  5. Coded according to the official conventions and instructions provided within ICD-CM.
- B. **Member (Patient) 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. **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 and name of parent(s)/legal guardian if Member is a minor.
- D. **Responsible Party** – Providers 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 Provider setting.
- E. **Legal Document** – The medical record is a legal document and all contents must be maintained in a confidential manner.
- F. **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 facilitates quality review.
- G. **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 a person other than the author.
- H. **Protection and Confidentiality** – Providers must limit medical records access to authorized 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. 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. Providers must educate staff regarding confidentiality and records maintenance policies and procedures and ensure that confidentiality statements are signed.
- I. **Storage, Filing and Availability** – Providers 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

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## 7. MEDICAL RECORDS REQUIREMENTS

### A. Provider and IPA Medical Record Requirements

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distribution. Providers 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. 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. Providers 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.

- K. **Record Retention** – Providers 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 19<sup>th</sup> 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.
- L. **Informed Consent for Treatment** – Providers must obtain appropriate written consent for treatment prior to actual procedure performance including the human sterilization consent procedures. 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.<sup>1</sup> See Policy 7C, “Informed Consent,” for more information.
- M. **Release of Information** – Medical records contain confidential information that is not to be released to another party without the expressed consent, written in ink, of the Member or legal representative. 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.<sup>2</sup> Members are also entitled to copies of all or any portion of his or her records upon written request.<sup>3,4</sup>

Providers must provide Members with copies within fifteen (15) days of the receipt of a written request.<sup>5</sup> Providers receiving medical records request from other Providers must submit the medical records within fifteen (15) days of receiving the written request to avoid any delay in the Member’s care.<sup>6</sup> See Policy 7B, “Information Disclosure and Confidentiality of Medical Records” for more information. As it is customary for Providers not to charge, IEHP encourages its Providers to offer this as a complimentary service to other Providers. When absolutely necessary to charge another Provider, the law allows only \$0.25 per page,<sup>7</sup> and to limit a total charge to \$20.

- N. **Exam Information** - Each medical record entry must contain all pertinent information related to the Member contact including: complaints, symptoms, examination results, medical

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<sup>1</sup> Title 22 of the California Code of Regulations (CCR), §§ 51305.1-51305.4

<sup>2</sup> California Health & Safety Code (Health & Saf. Code), § 123110

<sup>3</sup> Ibid.

<sup>4</sup> [Coordinated Care Initiative \(CCI\) Three Way Contract September 2019, Appendix B, Enrollee Rights](#)

<sup>5</sup> CA Health & Saf. Code § 123110

<sup>6</sup> Ibid.

<sup>7</sup> Ibid.

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## 7. MEDICAL RECORDS REQUIREMENTS

### A. Provider and IPA Medical Record Requirements

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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** – Providers must maintain a complete and comprehensive medical record for each Member. The record must include all Provider services rendered including all but not limited to: 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 a~~ second identifier.
  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 the Member 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 use noted for Members age 11 and older (substance use 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. Copies of signed informed consent forms.
  9. All medications prescribed include the name, dosage, frequency, and route unless medication only comes in oral form.
  10. Medications given on-site must document name, dosage, route and whether the Member had a reaction to the medication.

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## 7. MEDICAL RECORDS REQUIREMENTS

### A. Provider and IPA Medical Record Requirements

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- a. Immunizations administered on-site must document name, dosage, and route, as well as the injection site, manufacturer's name, and lot number.
  11. Laboratory and other studies are ordered and documented, as appropriate.
  12. All treatments, procedures, and tests, with results, are documented.
  13. Working diagnoses are consistent with findings.
  14. Treatment plans are consistent with diagnoses.
  15. 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.
  16. Unresolved problems from previous office visits are addressed in subsequent visits.
  17. Member education, recommendations and instructions given are included.
  18. Pediatric Members' (age 20.99 and under) records have a completed immunization record or notation of immunizations up to date.
  19. An immunization history has been noted for adults.
  20. There is no evidence that the Member is placed at inappropriate risk by a diagnosis or therapeutic procedure.
  21. Preventive screening and services are offered and documented in accordance with [DHCS](#) ~~and~~ IEHP standards.
  22. Referrals for specialty care or testing are noted, when appropriate.
  23. Consultant notes are present, as applicable.
  24. Consultation, lab, and imaging reports filed in the chart are initialed by the Provider who ordered them to signify they have been reviewed. A Provider may also designate this task to a non-physician medical practitioner under their supervision only if it is part of their practice agreement. If the reports are presented electronically or by some other method, there is also representation of review by the ordering Provider. Consultation, abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.
  25. Evidence of practitioner review of referral reports and diagnostic test results.
  26. Evidence of follow-up of specialty referrals made, and results/reports of diagnostic tests, when appropriate.
  27. Missed primary care appointments and outreach efforts/follow-up contacts are documented.
  28. For Members age 18 years and older, as well as Emancipated Minors, documentation of Advance Directives discussion or offered 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

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## 7. MEDICAL RECORDS REQUIREMENTS

### A. Provider and IPA Medical Record Requirements

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Provider or Practitioner into the Provider 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. Providers 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 record.
- S. **Language Preference** – Each medical record must include designation of primary language and documentation of request or refusal of language interpretation services. Person or entity providing medical interpretation is identified. Provider/Practitioner documentation must be in English.
- T. **Providers 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 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, if authenticated in other area of chart); and
    - c. Title.
  3. There are to be no unexplained cross-outs, erased entries or use of correction fluid or tape. 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 as needed ([PRN](#)).
- V. **Advance Directives** – Adult medical records that contain information regarding execution of advance directives such as a living will or Advance Health Care Directive, for Members 18 years or older, as well as Emancipated Minors, must be prominently noted. Refer to Policy 7D, “Advance Health Care Directive,” for more information.

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## 7. MEDICAL RECORDS REQUIREMENTS

### A. Provider and IPA Medical Record Requirements

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**W. Preventive Health Screening and Individual Health Education Behavioral Assessment -** PCPs must maintain documentation of the Individual Health Education Behavioral Assessment (IHEBA) and/or any appropriate screening tool in the Member's medical records. Please refer to Policies 10A, "Initial Health Assessment and 15F, "Individual Health Education Behavioral Assessment and Staying Healthy Assessment" for more information.

**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 must document referrals to specialists or waiver programs, treatments rendered, or recommendations made and follow-up care to be instituted.

#### Sensitive Services/ Minors Rights

~~X. AB 1184 amends the Confidentiality of Medical Information Act to require plans to take specified steps to protect the confidentiality of a subscriber's or enrollee's medical information~~

#### **Monitoring**

##### A. Facility Site Review (FSR) and Medical Record Review (MRR)

1. New and current Providers are required to undergo a full scope FSR and MRR survey initially and at a minimum of every three (3) years.
2. The MRR consists of an evaluation of a Provider's medical record system and information kept in the medical record to ensure Provider's medical record compliance with IEHP and regulatory standards. See policy 6A, "Facility Site Review and Medical Record Review Survey Requirements and Monitoring."
3. Medical record reviews for any other contracted or specialty care Providers are conducted as directed by the IEHP Chief Medical Officer, Quality Management (QM) Committee, Quality Improvement Subcommittee (QISC), Peer Review Subcommittee, or Credentialing Subcommittee.

B. Other monitoring includes Interim FSR Reviews, as well as the use of both internal quality management systems and external sources of information, as outlined in Policy 6H, "Interim FSR Monitoring for Primary Care Providers." All deficiencies require the completion of corrective action plan according to established timelines.

C. IPA medical record compliance is monitored through the Annual Delegation Oversight Audit (DOA). Please see Policy 25A2, "Delegation Oversight – Audit" for more information.

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## 7. MEDICAL RECORDS REQUIREMENTS

### A. Provider and IPA Medical Record Requirements

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INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Original Effective Date:</b>	January 1, 2007
<b>Chief Title:</b> Chief Medical Officer	<b>Revision Date:</b>	January 1, 2023 <sup>2</sup>



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## 7. MEDICAL RECORDS REQUIREMENTS

### B. Information Disclosure and Confidentiality of Medical Records

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#### **APPLIES TO:**

- A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare—Medicaid Plan)~~ Members and Providers.

#### **POLICY:**

- A. IEHP and its Delegates implement and maintain policies and procedures that ensure the Member's right to confidentiality of medical information.<sup>1</sup>
- B. IEHP, Delegates, and Providers and their staff 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 ("CMIA"); [California](#) Health and Safety Code Section 1364.5; the Insurance Information and Privacy Protection Act ("The Act"); Code 791, et. seq.; and all other applicable State, Federal and local regulations pertaining to confidentiality, privacy, and information disclosure of medical records.

#### **DEFINITIONS:**

- A. Delegate – A health plan, medical group, IPA or any contracted organization delegated to perform the activities described in this policy.
- B. Member – For the purpose of this policy, a Member is defined as a protected individual, an adult or minor Member, who can consent to a health care service without the consent of a parent or legal guardian. This definition does not include an individual that lacks the capacity to give informed consent for health care.<sup>2</sup>
- C. Sensitive Services - All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, [and minor consent services](#).<sup>3</sup> See ~~policy~~ [Policy 9E](#), "Access to Services with Special Arrangements." ~~for more information.~~
- D. "Genetic characteristics" is defined as:
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

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<sup>1</sup> ~~Coordinated Care Initiative (CCI) Three Way Contract September 2019, Appendix B, Enrollee Rights Medicare Managed Care Manual, "Benefits and Beneficiary Protections", Section 10.5.4~~

<sup>2</sup> California Civil Code (Civ. Code) § 56.05(1)

<sup>3</sup> CA Civ. Code § 56.05(n)

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## 7. MEDICAL RECORDS REQUIREMENTS

### B. Information Disclosure and Confidentiality of Medical Records

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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.

#### **PROCEDURES:**

##### **Confidentiality of Medical Records**

- A. IEHP, Delegates, and Providers are responsible for orienting all office staff, Practitioners and committee members to IEHP medical records standards including:
  1. The maintenance of confidentiality of Member medical records;
  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. IEHP, Delegates and Providers are responsible for maintaining signed confidentiality statements as follows:
  1. Provider office staff are required to sign a confidentiality statement protecting the privacy of Member medical records and information;
  2. IEHP and IPA committee members and all other attendees of committee meetings are required to sign a Member medical record confidentiality statement;<sup>4</sup> and
  3. Providers must have policies and procedures in place that require Practitioners and other subcontractors to maintain confidentiality by signing confidentiality statements.
- C. Members have the right to inspect or correct any personal or medical information held by their Provider.<sup>5</sup>
- D. 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. Providers 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.<sup>6</sup>
- E. Members have the right to request an accounting of disclosures of Protected Health

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<sup>4</sup> ~~CCI Three Way Contract September 2019, Section 2.16~~

<sup>5</sup> Title 45 Code of Federal Regulations (CFR) § 164.524

<sup>6</sup> 45 CFR § 164.526

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## 7. MEDICAL RECORDS REQUIREMENTS

### B. Information Disclosure and Confidentiality of Medical Records

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Information (PHI) made by IEHP, Delegates, and/or Providers for the prior six (6) years.<sup>7</sup>

- F. At no time shall Delegates, Providers, their staff, medical facilities, Practitioners or affiliates, obtain personal or otherwise deemed confidential information under false pretenses.
- G. Providers 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.<sup>8</sup>

#### Release of Medical Records

- A. Providers are responsible for orienting all their 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. Providers and their office staff may release medical record information only if a signed authorization of consent has been obtained from the Member, the parent or legal guardian or authorized representative who is legally responsible for making medical decisions for the Member. However, a Provider may allow for the release of medical records without authorization to health plans for the purposes of:<sup>9,10</sup>
  - 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 providers as necessary;
  - 3. Professional peer review or utilization review and quality management; and
  - 4. Conducting actuarial or research studies.
- C. Written authorization for the release of health information must meet the following criteria:<sup>11,12</sup>
  - 1. Is handwritten in plain language by the person who signs it or is in typeface no smaller than fourteen (14) point type;

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<sup>7</sup> 45 CFR § 164.528

<sup>8</sup> 45 CFR § 164.310

<sup>9</sup> 45 CFR § 164.506

<sup>10</sup> CA Civ. Code § 56.10

<sup>11</sup> CA Civ. Code § 56.11

<sup>12</sup> 45 CFR § 164.508

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## 7. MEDICAL RECORDS REQUIREMENTS

### B. Information Disclosure and Confidentiality of Medical Records

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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 uses and limitations for persons receiving the information;
  8. Specifies a 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
- D. The Member may revoke an authorization at any time if this is done in writing and the covered entity has not taken action in reliance of that authorization.<sup>13</sup>
- E. Should the requesting party need an extension to the timeframe mentioned above, they must notify the Provider in writing. This information should include:
1. The specific reason for the extension;
  2. The intended use or uses of information during the extended time; and
  3. The expected destruction date of the information.
- F. Upon request, Providers must disclose Member medical information to independent medical review organizations and their reviewers without specific authorization by the Member.<sup>14,15</sup> Independent medical review organizations may include public or private licensing or accrediting entities such as the California Department of Managed Health Care (DMHC) or its contractors.
- G. Protected 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

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<sup>13</sup> 45 CFR § 164.508

<sup>14</sup> 45 CFR § 164.506

<sup>15</sup> CA Civ. Code § 56.10

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## 7. MEDICAL RECORDS REQUIREMENTS

### B. Information Disclosure and Confidentiality of Medical Records

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Health Act (HITECH Act) as part of the American Recovery and Reinvestment Act of 2009.

- H. Any person in the Provider office staff 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.
- I. Providers and their office staff must disclose Member medical information when requested by a coroner, in the course of an investigation for the purpose of identifying the Member or locating next of kin.<sup>16</sup> 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.
- J. 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 disclosure 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.<sup>17</sup>
- K. Member questions regarding release of medical information to insurance carriers and other healthcare providers and staff must be directed to their Provider.
- L. Subpoenas are handled according to IEHP and IPA's policies and procedures and in accordance with state and federal regulatory requirements.<sup>18</sup>
- M. Upon request, all Providers are required to make available to Members the Provider's policy of Information Disclosure and Confidentiality of Medical Records.<sup>19</sup>
- N. 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 (800) 440-440-4347 or (800) 718-4347 for the speech or hearing impaired.<sup>20</sup>

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<sup>16</sup> 45 CFR § 164.512

<sup>17</sup> 45 CFR § 164.510

<sup>18</sup> 45 CFR § 164.512

<sup>19</sup> CA Health and Safety Code (~~Health & Saf.~~HSC Code) § 1364.5

<sup>20</sup> Ibid. [https://leginfo.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=1364.5.&lawCode=HSC](https://leginfo.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1364.5.&lawCode=HSC)

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## 7. MEDICAL RECORDS REQUIREMENTS

### B. Information Disclosure and Confidentiality of Medical Records

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- O. Providers must develop and implement a disclosure authorization form that is compliant with State and Federal regulations.<sup>21,22</sup> 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 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.<sup>23</sup>
- Q. Providers 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.<sup>24</sup>
- R. Delegates and Providers must monitor Provider sites for compliance with IEHP requirements for the protection of Member medical records.

#### Sensitive Services Information

- A. Medical information related to sensitive services must only be disclosed to the Member receiving care, absent an express authorization of the Member.<sup>25</sup>
- B. In special circumstances for treatment of sensitive services such as sexually transmitted infection, human immunodeficiency virus (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 these~~ Policy 10H, “Sexually Transmitted Infection Services.”

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<sup>21</sup> 45 CFR § 164.508

<sup>22</sup> CA Civ. Code § 56.11

<sup>23</sup> CA Civ. Code § 56.37

<sup>24</sup> 45 CFR § 164.502

<sup>25</sup> ~~CA Civ. Code § 56.107 Department of Managed Health Care (DMHC) All Plan Letter (APL) 22-010, “Guidance Regarding AB-1184”~~

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## 7. MEDICAL RECORDS REQUIREMENTS

### B. Information Disclosure and Confidentiality of Medical Records

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

#### Genetic Testing Information

- A. The release of information related to sensitive services must meet the same specifications as noted in the “Release of Medical Records” section above.
- 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 Provider waiving this notification.
- C. 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.<sup>26</sup>

#### Behavioral Health Information

- A. Providers, including Behavioral Health Practitioners, may not release medical information to persons or entities authorized to receive that information if the requested information specifically relates to a Member’s participation in behavioral health treatment, unless the following requirements have been met:<sup>27</sup>
1. The person or entity requesting that information submits a written request to the 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 if they notify the appropriate 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.

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<sup>26</sup> CA Civ. Code § 56.17

<sup>27</sup> CA Civ. Code § 56.104

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## 7. MEDICAL RECORDS REQUIREMENTS

### B. Information Disclosure and Confidentiality of Medical Records

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- 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 Provider waiving this notification.<sup>28</sup>
- C. This section does not apply to the disclosure or use of medical information by a law 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.<sup>29</sup>
- 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 to carry out the following treatment, payment, or health care operations:<sup>30</sup>
  - 1. Use of the originator of the psychotherapy notes for treatment;
  - 2. Use or disclosure by the covered entity for its own training programs; and
  - 3. 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 the PCP Facility Site Review and Medical Record Review Surveys. See Policy 6A, “Facility Site Review and Medical Record Review Survey Requirements and Monitoring.” [for more information.](#)
- B. IEHP monitors IPA compliance with Member medical record confidentiality 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.

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<sup>28</sup> Ibid.

<sup>29</sup> Ibid.

<sup>30</sup> 45 CFR § 164.508



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## 7. MEDICAL RECORDS REQUIREMENTS

### B. Information Disclosure and Confidentiality of Medical Records

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INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Original Effective Date:</b>	September 1, 1996
<b>Chief Title:</b> Chief Medical Officer	<b>Revision Date:</b>	January 1, 202 <del>3</del> <sup>2</sup>

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## 7. MEDICAL RECORDS REQUIREMENTS

### C. Informed Consent

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#### **APPLIES TO:**

- A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare—Medicaid Plan)~~ Members and Providers.

#### **POLICY:**

- A. Informed consent for treatment, procedures or other interventions must be obtained by IEHP Providers prior to initiation of the procedure.

#### **DEFINITIONS:**

- A. IEHP Providers - IEHP Providers, in this policy, are defined as but not limited to Primary Care Providers (PCPs), Specialists, Behavioral Health Providers, Behavioral Health Treatment Providers (BHT), Vision Providers, Urgent Care Centers, Ancillary Providers, Facilities, Pharmacies, and other Providers (e.g. Nurse Practitioners, Physician Assistants, Acupuncturists, Certified Nurse Midwives and Dentists).

#### **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<sup>1</sup> (See Attachments, “Consent for Special Procedure – English” and “Consent for Special Procedure – Spanish” in Section 7).
- B. In the event 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~~ Members with Access and Functional Needs.”
- C. In the event 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.

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<sup>1</sup> Title 45 Code of Federal Regulations (CFR) § 46.116(a)

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## 7. MEDICAL RECORDS REQUIREMENTS

### C. Informed Consent

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4. The Member's parents, spouse, registered domestic partner, or close family relatives.
- D. The consent form must include the following:<sup>2</sup>
1. Member name;
  2. ID #;
  3. Procedure;
  4. Diagnosis;
  5. Risks;
  6. Benefits;
  7. A statement signed by the Member or Agent that the procedure has been explained to the Member or Agent, and that the Member or Agent fully understands the procedure, benefits, and risks;
  8. A witness' signature; and
  9. PCP/Practitioner's signature.
- E. 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.
- F. Informed consent information must be provided with consideration of the Member's linguistic needs and literacy level.
- G. A special 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).
- H. Providers must provide informed consent forms in English and Spanish. [Special consent forms can be found in Section 10 \(See Attachments for Consent for special procedures in Section 10\) or on the IEHP Website at \[www.iehp.org/providers/provider-resources\]\(http://www.iehp.org/providers/provider-resources\). \(See Attachments, "~~PM 330 Sterilization Consent Form—English,~~" "~~PM 330 Sterilization Consent Form—Spanish,~~" "~~Contraceptive Informed Choice Form—English,~~" "~~Contraceptive Informed Choice Form—Spanish,~~" "~~Consent for HIV Test—English,~~" "~~Consent for HIV Test—Spanish,~~" "~~Auth or Refusal to Release Medical Record—Out of Network Family Planning—English,~~" and "~~Auth or Refusal to Release Medical Record—Out of Network Family Planning—Spanish~~" in Section 10\).](#)
- I. ~~An~~ informed consent procedure must be in place for Members who seek out-of-plan Sexually Transmitted Infection (STI), Family Planning and HIV testing services, and who wish to maintain medical record confidentiality but allow for transmission of information necessary for billing purposes.
- J. Providers are required to keep copies of signed informed consent forms in the Member's

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<sup>2</sup> Title 45 Code of Federal Regulations (~~CCR0-CFR~~ § 46.116(b))

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## 7. MEDICAL RECORDS REQUIREMENTS

### C. Informed Consent

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medical record as well as submit these with any claim forms.

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## 7. MEDICAL RECORDS REQUIREMENTS

### C. Informed Consent

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INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Original Effective Date:</b>	January 1, 2007
<b>Chief Title:</b> Chief Operating Officer	<b>Revision Date:</b>	January 1, 202 <del>3</del> <u>2</u>

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## 7. MEDICAL RECORDS REQUIREMENTS

### D. Advance Health Care Directive

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#### **APPLIES TO:**

- A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare—Medicaid Plan)~~ Members and Providers.

#### **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:<sup>1</sup>
1. Inform Members of their right to formulate an advance directive in writing. This policy, regarding 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.

#### **DEFINITION:**

- A. **Advance Health Care Directive**:- Written legal document that details 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): an Advance Health Care Directive form, a living will, a Durable Power of Attorney for Health Care 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:**

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<sup>1</sup> Patient Self Determination Act (PSDA) of 1990

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## 7. MEDICAL RECORDS REQUIREMENTS

### D. Advance Health Care Directive

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- A. The provisions of the PSDA that affect Health Care Providers (i.e., healthcare facilities and Practitioners) are as follows:<sup>2,3</sup>
1. Every Health Care Provider that receives payments from Medicare or Medi-Cal must give each Member a statement of rights regarding making healthcare decisions.
  2. The Health Care Provider must offer information to all Members age 18 and older, as well as Emancipated Minors, regarding advance directives. 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, "Advance Health Care Directive FAQs - English" and "Advance Health Care 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 offer information to Members 18 and older, as well as Emancipated Minors of advance directives.
  6. A Member may change, cancel and/or amend an advance directive at any time.
  7. The "Advance Health Care Directive" form can be utilized in the medical record to satisfy the advance directive requirement (See Attachments, "Advance Health Care Directive – English" and "Advance Health Care Directive – Spanish" in Section 7).
- B. Neither IEHP nor the IPA is required to provide care that conflicts with an advance directive.
- C. IEHP and/or the IPA allows a Member's representative/caregiver to facilitate care or treatment decisions for a Member who is unable to do so. IEHP and/or the 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 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 IPA must have a policy for medical record documentation of advance directives that require:

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<sup>2</sup> Patient Self Determination Act (PSDA) of 1990 [Ibid.](#)

<sup>3</sup> California Probate Code § 4670 et. Seq

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## 7. MEDICAL RECORDS REQUIREMENTS

### D. Advance Health Care Directive

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1. Documentation of whether the Member has been offered Advance Care Directives or has executed an Advance Health Care Directive.<sup>4,5,6,7</sup>
  2. The Physician Orders for Life-Sustaining Treatment (POLST) form<sup>8</sup> and Five (5) Wishes are acceptable if appropriately completed and signed by necessary parties.
  3. Advanced Health Care Directive information is reviewed with the Member at least every five (5) years and as appropriate to the Member's circumstances.
- F. IEHP shall demonstrate that it provides education for staff on issues concerning advance directives.

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<sup>4</sup> California Probate Code § 4701

<sup>5</sup> Title 42 Code of Federal Regulations (CFR) § 422.128

<sup>6</sup> 42 CFR § 489.100

<sup>7</sup> Department of Health Care Services (DHCS) APL 05-101, "Advanced Directive Form"

<sup>8</sup> California Probate Code § 4780



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## 7. MEDICAL RECORDS REQUIREMENTS

### D. Advance Health Care Directive

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INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Original Effective Date:</b>	January 1, 2007
<b>Chief Title:</b> Chief Operating Officer	<b>Revision Date:</b>	January 1, 202 <del>3</del> <sup>4</sup>

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## 7. MEDICAL RECORDS REQUIREMENTS

### Attachments

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<u>DESCRIPTION</u>	<u>POLICY CROSS REFERENCE</u>
<del>Consent for Special Procedure—English</del>	<del>7C</del>
<del>Consent for Special Procedure—Spanish</del>	<del>7C</del>
Advance Health Care Directive – English	7D
Advance Health Care Directive – Spanish	7D
Advance Health Care Directive FAQs – English	7D
Advance Health Care Directive FAQs - Spanish	7D
<u>Consent for Special Procedure - English</u>	<u>7C</u>
<u>Consent for Special Procedure - Spanish</u>	<u>7C</u>

# Advance Health Care Directive

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**NOTE:** This form should include taglines as required by the Affordable Care Act. (See [www.calhospital.org/taglines](http://www.calhospital.org/taglines), for detailed information.)

## Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

## Instructions

Part 1 of this form lets you name another person 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 a different person to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

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 your organs, tissues, and parts; 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: \_\_\_\_\_

**Part 1 – Power of Attorney for Health Care**

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.

**Designation of Agent:**

I designate the following person as my agent to make health care decisions for me:

Name of person you choose as agent: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_  
*(home phone)* *(work phone)* *(cell)*

**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 alternate agent:

Name of person you choose as alternate agent: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_  
*(home phone)* *(work phone)* *(cell)*

**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 must 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 donate my organs, tissues, and parts, authorize an autopsy and direct disposition of my remains, except as I state here or in Part 3 of this form:

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*(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 agent whom I have named.

**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:**

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. \_\_\_\_\_

*(Initial here)*

**OR**

**Choice To Prolong Life:**

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

*(Initial here)*

**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, Tissues, and Parts at Death (Optional)**

Upon my death:

I give my organs, tissues, and parts. \_\_\_\_\_  
(Initial here to indicate yes)

By initialing this line, and notwithstanding my choice in Part 2 of this form, I authorize my agent to consent to any temporary medical procedure necessary solely to evaluate and/or maintain my organs, tissues, and/or parts for purposes of donation.

**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)

My donation is for the following purposes (strike any of the following you do not want):

Transplant \_\_\_\_\_ Research \_\_\_\_\_  
(Initial here) (Initial here)

Therapy \_\_\_\_\_ Education \_\_\_\_\_  
(Initial here) (Initial here)

If you want to restrict your donation of an organ, tissue, or part in some way, please state your restriction on the following lines: \_\_\_\_\_

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 \_\_\_\_\_ No \_\_\_\_\_  
(Initial here) (Initial here)
2. My donated tissue may be used for applications outside of the United States.  
Yes \_\_\_\_\_ No \_\_\_\_\_  
(Initial here) (Initial here)
3. My donated tissue may be used by for-profit tissue processors and distributors.  
Yes \_\_\_\_\_ No \_\_\_\_\_  
(Initial here) (Initial here)

If I leave Part 3 blank, it is not a refusal to make a donation. My state-authorized donor registration should be followed, or, if none, my agent may make a donation upon my death. If no agent is named above, I acknowledge that California law permits an authorized individual to make such a decision on my behalf. (To state any limitation, preference, or instruction regarding donation, please use the lines above or on page 3 of this form.)

**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.



**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: \_\_\_\_\_

Civil Code Section 1189; Health and Safety Code Section 7158.3; Probate Code Section 4701

# Directiva por Anticipado de la Atención de la Salud

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**NOTE:** This form should include taglines as required by the Affordable Care Act. (See [www.calhospital.org/taglines](http://www.calhospital.org/taglines), for detailed information.)

## Explicación

Usted tiene el derecho de dar instrucciones sobre su propia atención médica. Usted también tiene el derecho de nombrar a otra persona para que tome decisiones sobre su atención médica. Este formulario le permite hacer cualquiera de las dos o ambas cosas. Si utiliza este formulario, puede completar o modificar todo o parte de él. Usted cuenta con la posibilidad de utilizar un formulario diferente.

## Instrucciones

La Parte 1 de este formulario le permite nombrar a otra persona como “agente” para que pueda tomar decisiones por usted sobre su atención médica en el caso de que usted resulte incapaz de tomar sus propias decisiones, o si desea que alguien más tome esas decisiones por usted en este momento aunque todavía sea capaz de tomarlas. Usted también puede nombrar a otra persona para que actúe en su nombre si su primera opción no consiente, no es capaz o no está razonablemente disponible para tomar decisiones en su nombre.

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

1. Dar o retirar el consentimiento para cualquier atención, tratamiento, servicio o procedimiento para mantener, diagnosticar o afectar de otro modo una condición física o mental.
2. Seleccionar u optar por dejar de recibir servicios de prestadores de atención médica e instituciones.
3. Aprobar o desaprobado pruebas diagnósticas, procedimientos quirúrgicos y programas de medicamentos.
4. Dirigir la prestación, el mantenimiento o el retiro de nutrición o hidratación artificial, así como cualquier otra forma de atención médica, incluyendo la resucitación cardiopulmonar.
5. Donar sus órganos, tejidos y partes del cuerpo; autorizar una autopsia y disponer de sus restos.

Sin embargo, su agente no podrá internarlo en un centro de salud mental o dar su consentimiento para tratamiento convulsivo, psicocirugía, esterilización o aborto en su nombre.

La Parte 2 de este formulario le permite dar instrucciones específicas acerca de cualquier aspecto de su atención médica, independientemente de si usted nombra a un agente. Se le brindan opciones para que usted pueda expresar sus deseos con respecto a la prestación, el mantenimiento o el retiro del tratamiento para mantenerlo vivo, así como la asistencia para alivio del dolor. También puede añadir a las decisiones que ha tomado o escribir cualquier deseo adicional. Si usted está de acuerdo en permitir que su agente determine qué es lo mejor para usted en cuanto a decisiones sobre el final de la vida, no necesita completar la Parte 2 de este formulario.

Entregue una copia del formulario relleno y firmado a su médico, a cualquier otro proveedor de atención médica que pueda tener, a cualquier institución en la cual usted recibe atención médica

y a los agentes de atención médica que ha nombrado. Usted debe hablar con la persona que ha nombrado como agente para asegurarse de que él o ella entiende sus deseos y está dispuesta a asumir la responsabilidad.

***Usted tiene el derecho de revocar esta directiva médica por adelantado o reemplazar este formulario en cualquier momento.***

Nombre de Paciente: \_\_\_\_\_

Fecha de Nacimiento: \_\_\_\_\_

### **Parte 1 – Poder notarial de atención médica**

Su agente no puede ser un operador o empleado de un centro de atención comunitaria o de una institución de cuidado residencial donde usted recibe atención, ni el médico supervisor o empleado de la institución médica donde usted recibe atención, a menos que su agente sea un pariente o compañero de trabajo.

#### **Designación de agente:**

Yo nombro a la siguiente persona como mi agente para tomar decisiones sobre mi atención médica:

Nombre de la persona que elige como agente: \_\_\_\_\_

\_\_\_\_\_

Dirección: \_\_\_\_\_

\_\_\_\_\_

Teléfono: \_\_\_\_\_

*(teléfono particular)*

*(teléfono laboral)*

*(celular)*

**OPCIONAL:** Si revoco la autoridad de mi agente o si mi agente no está dispuesto, no es capaz o no está razonablemente disponible para tomar una decisión sobre mi atención médica, nombro como mi agente alternativo:

Nombre de la persona que elige como agente alternativo: \_\_\_\_\_

\_\_\_\_\_

Dirección: \_\_\_\_\_

\_\_\_\_\_

Teléfono: \_\_\_\_\_

*(teléfono particular)*

*(teléfono laboral)*

*(celular)*

#### **La autoridad del agente:**

Mi agente está autorizado para tomar en mi nombre todas las decisiones sobre mi atención médica, incluyendo las decisiones sobre la prestación, la retención o el retiro de nutrición o hidratación artificial y cualquier otra forma de atención médica para mantenerme vivo, excepto las que consigno a continuación:

\_\_\_\_\_

*(Si es necesario, agregue hojas adicionales)*

**Momento en el que la autoridad del agente entra en vigencia:**

La autoridad de mi agente entra en vigencia cuando mi médico de cabecera determine que soy incapaz de tomar mis propias decisiones sobre mi atención médica.

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*(Inicial aquí)*

**O BIEN**

La autoridad de mi agente para tomar decisiones sobre mi atención médica entra en vigencia inmediatamente.

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*(Inicial aquí)*

**Las obligaciones del agente:**

Mi agente deberá tomar decisiones sobre mi atención médica de conformidad con este poder notarial de atención médica, las instrucciones que doy en la Parte 2 de este formulario y mis deseos en la medida en que mi agente tenga conocimiento de ellos. En la medida en que mi agente no tenga conocimiento de mis deseos, él o ella tomará decisiones sobre mi atención médica de conformidad con lo que mi agente determine es en mi mejor interés. En la determinación de lo que es en mi mejor interés, mi agente tendrá en cuenta mis valores personales en la medida en que mi agente tenga conocimiento de ellos.

**La autoridad del agente en caso de muerte:**

Mi agente está autorizado para donar mis órganos, tejidos y partes del cuerpo, autorizar una autopsia y disponer de mis restos, excepto por lo que expongo aquí o en la Parte 3 de este formulario:

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*(Si es necesario, agregue hojas adicionales)*

**Nombramiento del tutor:**

Si es necesario que un juzgado nombre un tutor para mí, yo propongo que sea el agente designado en este formulario. Si este agente no está dispuesto, no es capaz o no está razonablemente disponible para actuar como tutor, propongo al agente alternativo que he nombrado.

**Parte 2 – Instrucciones para la atención médica**

Si usted rellena esta parte del formulario, puede tachar cualquier parte del texto que no desee.

**Decisiones sobre el final de la vida:**

Deseo que mis proveedores de atención médica y otras personas involucradas en mi cuidado proporcionen, mantengan o retiren el tratamiento según la opción que he marcado a continuación:

**Elección de no prolongar la vida:**

No quiero que mi vida sea prolongada si (1) tengo una condición incurable e irreversible que provocará mi muerte dentro de un lapso relativamente corto, (2) estoy inconsciente y, con un grado razonable de certeza médica, no recuperaré la conciencia, o (3) los riesgos y las responsabilidades que probablemente conlleve el tratamiento superarían los beneficios esperados.

\_\_\_\_\_  
(Inicial aquí)

**O BIEN**

**Elección de prolongar la vida:**

Quiero que mi vida se prolongue tanto como sea posible dentro de los límites de las normas de salud generalmente aceptadas.

\_\_\_\_\_  
(Inicial aquí)

**Alivio del dolor:**

Excepto por lo consignado en el siguiente espacio, deseo que se proporcione tratamiento para aliviar el dolor o el malestar en todo momento, aunque acelere mi muerte:

\_\_\_\_\_  
\_\_\_\_\_  
*(Si es necesario, agregue hojas adicionales)*

**Otros deseos:**

(Si usted no está de acuerdo con cualquiera de las elecciones opcionales que aparecen arriba y desea añadir las suyas propias, o si desea agregar algo a las instrucciones que ha proporcionado arriba, puede hacerlo aquí). Yo deseo que:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
*(Si es necesario, agregue hojas adicionales)*

**Parte 3 – Donación de órganos, tejidos y partes del cuerpo luego de la muerte (opcional)**

Después de mi muerte:

Deseo donar mis órganos, tejidos y partes del cuerpo. \_\_\_\_\_  
(Inicial aquí)

Al escribir mis iniciales sobre esta línea e independientemente de mi elección en la Parte 2 de este formulario, autorizo a mi agente para dar su consentimiento a cualquier procedimiento médico temporal necesario exclusivamente para evaluar y mantener mis órganos, tejidos o partes del cuerpo para fines de donación.

**O BIEN**

No autorizo la donación de ninguno de mis órganos, tejidos o partes del cuerpo. \_\_\_\_\_  
(Inicial aquí)

**O BIEN**

Deseo donar solamente los siguientes órganos, tejidos o partes del cuerpo: \_\_\_\_\_  
\_\_\_\_\_  
(Inicial aquí)

Mi donación es para los siguientes propósitos (tachar cualquiera de los siguientes si NO los desea):

Trasplante \_\_\_\_\_ Investigación \_\_\_\_\_  
(Inicial aquí) (Inicial aquí)

Terapia \_\_\_\_\_ Educación \_\_\_\_\_  
(Inicial aquí) (Inicial aquí)

Si desea restringir la donación de un órgano, tejido o parte de su cuerpo de alguna manera, por favor indique su restricción en las siguientes líneas: \_\_\_\_\_

Entiendo que los bancos de tejido funcionan con procesadores y distribuidores de tejidos con fines de lucro y sin fines de lucro. Es posible que la piel donada pueda ser usada para fines de cirugía cosmética o reconstructiva. Es posible que los tejidos donados puedan ser usados para trasplantes fuera de los Estados Unidos.

1. Mi piel donada puede ser usada para fines de cirugía cosmética. Sí \_\_\_\_\_ No \_\_\_\_\_  
(Inicial aquí) (Inicial aquí)
2. Mis tejidos donados pueden ser usados para su aplicación fuera de los Estados Unidos.  
Sí \_\_\_\_\_ No \_\_\_\_\_  
(Inicial aquí) (Inicial aquí)
3. Mis tejidos donados pueden ser usados por procesadores y distribuidores de tejidos con fines de lucro. Sí \_\_\_\_\_ No \_\_\_\_\_  
(Inicial aquí) (Inicial aquí)

Si deja en blanco la Parte 3, esto no implica una negativa para realizar una donación. Se deberá seguir mi registro de donante autorizado por el Estado, o, si no hubiese ninguno, mi agente podrá hacer una donación después de mi muerte. Si no se ha nombrado ningún agente arriba, reconozco que la ley de California permite que una persona autorizada tome esa decisión en mi nombre. (Para indicar cualquier limitación, preferencia o instrucción con respecto a la donación, por favor utilice las líneas de arriba o el espacio proporcionado en la página 3 de este formulario).

**Parte 4 – Médico de cabecera (opcional)**

Yo nombro al siguiente médico como mi médico de cabecera:

Nombre del Médico: \_\_\_\_\_

Teléfono: \_\_\_\_\_

Dirección: \_\_\_\_\_

\_\_\_\_\_

**OPCIONAL:** Si el médico que he nombrado no está dispuesto, no es capaz o no está razonablemente disponible para actuar como mi médico de cabecera, nombro al siguiente médico como mi médico de cabecera:

Nombre del Médico: \_\_\_\_\_

Teléfono: \_\_\_\_\_

Dirección: \_\_\_\_\_

\_\_\_\_\_

**Parte 5 – Firmas**

El formulario deberá ser firmado por usted y por dos testigos cualificados o reconocidos ante un notario público.

**Firma:**

Firma y fecha del formulario:

Fecha: \_\_\_\_\_ Hora: \_\_\_\_\_ AM / PM

Firma: \_\_\_\_\_

*(paciente)*

Nombre en letra de imprenta: \_\_\_\_\_

*(paciente)*

Dirección: \_\_\_\_\_

\_\_\_\_\_

**Declaración de los testigos:**

Declaro, bajo pena de perjurio y en virtud de las leyes de California (1) que conozco personalmente a la persona que firmó o reconoció esta directiva médica por adelantado, o que la identidad de la persona me fue demostrada con pruebas convincentes, (2) que la persona firmó o reconoció esta directiva médica por adelantado en mi presencia, (3) que la persona parece estar en su sano juicio y no está bajo los efectos de ningún tipo de coacción, fraude o influencia indebida, (4) que no soy una persona designada como agente por esta directiva médica por adelantado y (5) que no soy el proveedor de atención médica de esta persona, ni empleado del proveedor de atención médica de esta persona, el operador de un centro de atención comunitaria, ni el empleado de un operador de un centro de atención comunitaria, el operador de una institución de cuidado residencial para ancianos, ni tampoco un empleado de un operador de una institución de cuidado residencial para ancianos.



**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 testigos:**

Al menos uno de los testigos arriba mencionados también deberá firmar la siguiente declaración:

Además declaro, bajo pena de perjurio y en virtud de las leyes de California, que no estoy emparentado con la persona que ejecuta esta directiva médica por sangre, matrimonio u adopción y, a mi leal saber y entender, no tengo derecho a recibir parte de los bienes de esta persona después de su muerte bajo un testamento ya existente o por aplicación de la ley.

Fecha: \_\_\_\_\_ Hora: \_\_\_\_\_ AM / PM

Firma: \_\_\_\_\_  
(*testigo*)

Nombre en letra de imprenta: \_\_\_\_\_  
(*testigo*)

El notario u funcionario que complete este certificado verifica solamente la identidad de la persona que firmó el documento al que se adjunta este certificado y no la veracidad, exactitud o validez del documento.

**PUEDE UTILIZAR ESTE CERTIFICADO DE RECONOCIMIENTO ANTE NOTARIO PÚBLICO EN LUGAR DE LA DECLARACIÓN DE LOS TESTIGOS.**

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)

**Parte 6 – Requerimiento de testigo especial**

Si usted es un paciente en un centro de enfermería especializada, el Defensor del paciente o Defensor del pueblo deberá firmar la siguiente declaración:

**Declaración del Defensor del paciente o Defensor del pueblo**

Declaro, bajo pena de perjurio y en virtud de las leyes de California, que soy el Defensor del paciente o Defensor del pueblo designado por el Departamento de Edad Avanzada de California (California Department of Aging) y que estoy sirviendo como testigo según lo requiere la sección 4675 del Código de Sucesiones.

Fecha: \_\_\_\_\_ Hora: \_\_\_\_\_ AM / PM

Firma: \_\_\_\_\_  
(Defensor del paciente o Defensor del pueblo)

Nombre en letra de imprenta: \_\_\_\_\_  
(Defensor del paciente o Defensor del pueblo)

Dirección: \_\_\_\_\_

Civil Code Section 1189; Health and Safety Code Section 7158.3; Probate Code Section 4701



## 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.

<p>What is advance health care directive?</p>	<p>An advance health care directive is a written legal document 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): An Advance Health Care Directive form, a living will, a Durable Power of Attorney for Health Care 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.</p>
<p>Who can fill out advance health care directive?</p>	<p>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.</p>
<p>Who decides my medical treatment?</p>	<p>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.</p>
<p>How do I know what I want?</p>	<p>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.</p> <p><i>Your doctor can tell you which treatments are available to you but cannot choose for you.</i></p>
<p>What if I am too sick to decide?</p>	<p>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.</p> <p><i>One kind of advance directive under California law is called a <u>Durable Power of Attorney for Health Care</u>. This document lets you designate someone as your “Agent” who is responsible for making your health care decisions when you are unable to.</i></p>

Patient Name: \_\_\_\_\_ DOB: \_\_\_ / \_\_\_ / \_\_\_ Member #: \_\_\_\_\_

Provider Name: \_\_\_\_\_



Inland Empire Health Plan

Whom can I name as my Agent?	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.
How does whomever I name as my Agent know what Medical treatment I would want?	<p>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</p> <p><i>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.</i></p>
What if I do not have anyone to name as my Agent?	<p>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.</p> <p><i>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.</i></p>
Are there other wills I can use?	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.
What if I change my mind?	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.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Member #: \_\_\_\_\_

Provider Name: \_\_\_\_\_



Am I required to fill out any advance directive forms?	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.
Will I still be treated if I do not fill out any of these forms?	<p><b>ABSOLUTELY.</b> 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:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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”).</li> </ul>
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 <b>NOT</b> 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 learn more about advance directives or to obtain an advance directive form, you may visit the California Office of the Attorney General website's End of Life Care Planning webpage at: <a href="https://oag.ca.gov/consumers/general/care">https://oag.ca.gov/consumers/general/care</a>

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Member #: \_\_\_\_\_

Provider Name: \_\_\_\_\_

## **Preguntas Frecuentes acerca de las Instrucciones Anticipadas sobre la Atención Médica**

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.

<p>¿Qué es una Instrucción Anticipada sobre la Atención Médica?</p>	<p>Una Instrucción Anticipada sobre la Atención Médica (también conocida como: directiva anticipada) es un documento legal por escrito que detalla las preferencias de tratamiento en el caso de que un Miembro no pueda expresarse por sí mismo cuando haya que tomar una decisión sobre su atención médica. Los ejemplos de instrucciones anticipadas incluyen (pero no se limitan a): un formulario de Instrucción Anticipada sobre la Atención Médica, un testamento vital, un formulario de Poder Legal Duradero para la Atención Médica, una carta poder para la atención médica, una Orden Médica de Tratamiento para Mantener la Vida (<i>Physician Orders of Life Sustaining Treatment, POLST</i>), Five Wishes y un encargado de tomar decisiones. Este documento debe cumplir las leyes estatales y federales.</p>
<p>¿Quién puede llenar mi Instrucción Anticipada sobre la Atención Médica?</p>	<p>Usted puede llenar su propia Instrucción Anticipada sobre la Atención Médica si tiene 18 años o más y está en pleno uso de sus facultades mentales. No necesita a un abogado para que la complete.</p>
<p>¿Quién decide mi tratamiento médico?</p>	<p>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—.</p>
<p>¿Cómo sé qué es lo que quiero?</p>	<p>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.</p> <p><i>Su doctor puede indicarle qué tratamientos están a su disposición, pero no puede elegir por usted.</i></p>

Nombre del Paciente: \_\_\_\_\_ Fecha de Nacimiento: \_\_\_ / \_\_\_ / \_\_\_ N.º de Miembro: \_\_\_\_\_

Nombre del Proveedor: \_\_\_\_\_



Entidad Pública

Inland Empire Health Plan

<p>¿Qué sucede si estoy muy grave como para decidir?</p>	<p>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 que 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 “Instrucciones anticipadas” que usted puede usar para expresar quién desea que hable en su nombre, así como qué tratamiento quisiera o no recibir.</p> <p><i>Una clase de instrucción anticipada conforme a las leyes de California se denomina <u>Poder Legal Duradero para la Atención Médica</u>. Este documento le permite designar a alguien como su “Agente” que sea responsable de tomar las decisiones sobre su atención médica cuando usted no pueda hacerlo.</i></p>
<p>¿A quién puedo nombrar como mi Agente?</p>	<p>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.</p>
<p>¿Cómo sabrá la persona a la que nombre como mi Agente, qué tratamiento deseo?</p>	<p>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 esa información se pueda transcribir 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.</p> <p><i>También debe llevar una copia con usted en caso de que sea hospitalizado o admitido en un centro de tratamiento para que dicha copia se pueda agregar a su registro médico.</i></p>

Nombre del Paciente: \_\_\_\_\_ Fecha de Nacimiento: \_\_\_/\_\_\_/\_\_\_ N.º de Miembro: \_\_\_\_\_

Nombre del Proveedor: \_\_\_\_\_



Entidad Pública

Inland Empire Health Plan

<p>¿Qué sucede si no tengo a nadie a quien nombrar como mi Agente?</p>	<p>Usted puede usar otra clase de Instrucción 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.</p> <p><i>Su doctor debe cumplir sus deseos de limitar los tratamientos o derivar su atención médica a otro doctor que los cumpla. Sus doctores también están legalmente protegidos cuando cumplen sus deseos.</i></p>
<p>¿Hay otros testamentos que pueda usar?</p>	<p>En lugar de usar la Declaración de la Ley de Muerte Natural, usted puede usar cualquiera de los formularios de “testamento vital” disponibles. 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.</p>
<p>¿Qué sucede si cambio de parecer?</p>	<p>Puede cambiar O revocar todos estos documentos de instrucciones 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 instrucción anticipada.</p>
<p>¿Tengo la obligación de llenar alguno de los formularios de instrucciones anticipadas?</p>	<p>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.</p>

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Inland Empire Health Plan

<p>¿Recibiré tratamiento incluso si no completo ninguno de estos formularios?</p>	<p><b>POR SUPUESTO.</b> 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:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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”).</li> </ul>
<p>¿Qué más debo saber acerca de cómo tomar decisiones sobre la atención médica en el futuro?</p>	<p>Le brindamos esta información sobre instrucciones 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 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 <b>NO</b> condicionará la prestación de la atención ni discriminará de otro modo a ninguna persona en función de que se haya firmado o no una instrucción anticipada. Depende estrictamente de usted decidir informar a su doctor si completó o no una instrucción anticipada y de proporcionarle una copia. Además, recuerde llevar una copia de su instrucción anticipada cuando sea admitido en un hospital u otro establecimiento de salud para que dicha copia pueda conservarse junto con su registro médico.</p>
<p>¿Cómo puedo obtener más información sobre las instrucciones anticipadas?</p>	<p>Para conocer más sobre las instrucciones anticipado u obtener un formulario de instrucciones anticipadas, puede visitar la página web de Planeación de la Atención al Final de la Vida de la Oficina del Fiscal General de California en: <a href="https://oag.ca.gov/consumers/general/care">https://oag.ca.gov/consumers/general/care</a></p>

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Nombre del Proveedor: \_\_\_\_\_



**IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan)**

Patient Name: \_\_\_\_\_ Chart #: \_\_\_\_\_

**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: \_\_\_\_\_



**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 discutirlos 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: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Member #: \_\_\_\_\_



Provider Name: \_\_\_\_\_

*Consent – Special Procedures.doc*