Consent Manual
CHA Publications

Several helpful publications are available through CHA including:

- California Health Information Privacy Manual
- California Hospital Compliance Manual
- Consent Manual
- EMTALA — A Guide to Patient Anti-Dumping Laws
- Guide to Release of Patient Information
- Healthcare Workplace Violence Prevention
- Hospital Financial Assistance Policies and Community Benefit Laws
- Mental Health Law Manual
- Managing High Profile and Patient Care Conflict Situations
- Minors and Health Care Law Manual
- Model Medical Staff Bylaws & Rules
- Principles of Consent and Advance Directives
- Record and Data Retention Schedule
- The Cal/OSHA Safe Patient Handling Regulation
- The California Guide to Preventing Sharp Injuries

Plus numerous human resource and volunteer publications.

Ordering Information
For more information, visit CHA online at www.calhospital.org/publications

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California Hospital Association

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However, hospitals that are members of the California Hospital Association may use the model forms, signs and handouts as templates in developing their own forms, signs and handouts.

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Quick Reference

INTRODUCTION

WHERE TO FIND LAWS REFERENCED IN THE MANUAL

LIST OF FORMS AND APPENDICES BY CHAPTER

SIGNAGE REQUIREMENTS

PATIENT HANDBOOKS OR OTHER INFORMATIONAL REQUIREMENTS

REPORTING REQUIREMENTS

SPECIAL CONSENT REQUIREMENTS

CHAPTERS

Chapter 1 Patients’ Rights and Interpreter Services
Chapter 2 Basic Principles of Consent
Chapter 3 Who May Consent for Adults Lacking Capacity
Chapter 4 Who May Consent for Minor Patients
Chapter 5 Treatments that Require Special Consent
Chapter 6 Refusal of Treatment and End-of-Life Issues
Chapter 7 The Medical Record
Chapter 8 Health Information Privacy Basics
Chapter 9 Medical Procedures and Interrogations Requested by Law Enforcement
Chapter 10 Research on Human Subjects
Chapter 11 Admission and Registration Documents, Arbitration and Liens
Chapter 12 Discharge Planning, Patient Transfers and Related Issues
Chapter 13 Maternity and Newborn Issues
Chapter 14 Death, Autopsies and Anatomical Gifts
Chapter 15 Voluntary Admission and Involuntary Detainment for Mental Health Treatment
Chapter 16 Mental Health Patients: Rights and Reporting
Chapter 17 Assault and Abuse Reporting Requirements
Chapter 18 Reporting Communicable Diseases and Other Patient Conditions
Chapter 19 Adverse Events and Incident Reports
Chapter 20 Other Issues

FORMS AND APPENDICES

INDEX
Introduction

Welcome to the 45th edition of the Consent Manual — the only comprehensive guide to patient consent for medical treatment and related health care law in California. The Consent Manual goes beyond the basics of consent for adults and minors, covering topics such as patients' rights, advance directives, mental health law, health information privacy law, hospital reporting requirements, and other related health care law.

The California Hospital Association publishes this manual for use by the health care community as they assist patients in making informed decisions about their medical care. The manual takes complicated laws and explains them in clear and concise language. The Consent Manual tells you exactly what the law requires and what you need to do to comply.

The manual can be used by a wide range of personnel: administrators, risk managers, health information and admissions staff, privacy officers, health care attorneys, physicians and nurses, emergency room staff, clinic managers, social workers, quality managers and others within a hospital or health care facility. It also is a useful tool for those who develop health care policy and provide counsel to health care facilities.

This edition of the Consent Manual reflects changes in state and federal legislation, regulations and judicial decisions through January 2018. Relevant regulations have been incorporated along with new state laws.

More than 100 forms and appendices, and several posters required by law, can be found at the back of the manual and online at www.calhospital.org/free-resources.

We are pleased to publish this manual as a service to our members and others. We hope you find it useful.

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Information contained in the Consent Manual should not be construed as legal advice or used to resolve legal problems by health care facilities or practitioners without consulting legal counsel. A health care facility may want to accept all or some of the Consent Manual as part of its standard operating policy. If so, the hospital or health facility's legal counsel and its board of trustees should review such policies.
Where to Find Laws Referenced in the Manual

All of the laws discussed in the Consent Manual can be found on the Internet.

I. FEDERAL LAW

A federal statute is written by a United States Senator or Representative. It is voted on by the United States Senate and the House of Representatives, and then signed by the President. A federal statute is referenced like this: 42 U.S.C. Section 1395. “U.S.C.” stands for “United States Code.” Federal statutes may be found at www.gpo.gov/fdsys or at www.law.cornell.edu.

A federal regulation is written by a federal agency such as the U.S. Department of Health and Human Services or the U.S. Food and Drug Administration. The proposed regulation is published in the Federal Register, along with an explanation (called the “preamble”) of the regulation, so that the general public and lobbyists may comment on it. The federal agency must summarize and respond to each comment it receives on the proposed regulation. The agency may or may not make changes to the proposed regulation based on the comments. The final regulation is also published in the Federal Register. A federal regulation is referenced like this: 42 C.F.R. Section 482.1 or 42 C.F.R. Part 2. “C.F.R.” stands for “Code of Federal Regulations.” Federal regulations may be found at www.gpo.gov/fdsys or at www.ecfr.gov. The preamble, however, is only published in the Federal Register and not in the Code of Federal Regulations. The Federal Register may be found at www.gpo.gov/fdsys or at www.federalregister.gov.

The Centers for Medicare & Medicaid Services (CMS) publishes its Interpretive Guidelines on the internet. The Interpretive Guidelines include information for surveyors on how CMS interprets the Conditions of Participation, and instructions for surveyors on how to assess hospitals’ compliance with the Conditions of Participation. They may be found at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html (click on Publication 100-07, “State Operations Manual, then “Appendices Table of Contents”). There are several appendices that hospitals will find useful, for example, A (hospitals), AA (psychiatric hospitals), V (EMTALA), and W (critical access hospitals).

A federal law must be obeyed throughout the United States, including in California, unless the federal law expressly states otherwise. As a general rule, if a federal law conflicts with a state law, the federal law prevails, unless the federal law expressly states otherwise.

If there is no conflict, such as when one law is stricter but they don’t actually conflict with each other, both laws generally must be followed. For example, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal law states that providers must conform to whichever provision of federal or state law provides patients with greater privacy protection or gives them greater access to their medical information.

II. STATE LAW

A state statute is written by a California Senator or Assembly Member. It is voted on by the California Senate and Assembly, and then signed by the Governor. A state statute is referenced like this: Civil Code Section 56 or Health and Safety Code Section 819. State statutes may be found at www.leginfo.legislature.ca.gov. Proposed laws (Assembly Bills and Senate Bills) may also be found at this website.

A state regulation is written by a state agency such as the California Department of Public Health or the California Department of Managed Health Care. A short description of the proposed regulation is published in the California Regulatory Notice Register, more commonly called the Z Register, so that the general public and lobbyists may request a copy of the exact text of the proposed regulation and comment on it. The state agency must summarize and respond to each comment it receives on the proposed regulation. The agency may or may not make changes to the proposed regulation based on the comments. A notice
that the final regulation has been officially adopted is also published in the Z Register. The Z Register may be found at www.oal.ca.gov/notice_register.htm.

A state regulation is referenced like this: Title 22, C.C.R., Section 70707. “C.C.R.” stands for “California Code of Regulations.” State regulations may be found at https://govt.westlaw.com/calregs/Search/Index.

A state law must be obeyed in California only. As a general rule, if a California law conflicts with a federal law, the federal law prevails, unless the federal law expressly states otherwise. (If there is no conflict, such as when one law is stricter but they don’t actually conflict with each other, both laws generally must be followed.)
List of Forms and Appendices by Chapter

These documents are provided in English in the back of the manual. All forms, including Spanish versions, when available, can be found online for CHA members at www.calhospital.org/free-resources. “S” denotes that the form is provided in English and Spanish.

1. PATIENTS’ RIGHTS AND INTERPRETER SERVICES
   1-A Patient Rights (Combines Title 22 and other California laws, The Joint Commission and Medicare Conditions of Participation requirements)

2. BASIC PRINCIPLES OF CONSENT
   1-1 Consent to Surgery or Special Procedure*
   1-2 Informed Consent to Surgery or Special Procedure*

3. WHO MAY CONSENT FOR ADULTS LACKING CAPACITY
   2-A Consent Requirements for Medical Treatment of Adults
   2-C Selection of Health Care Surrogates with the Assistance of Health Care Professionals — Sample Policy
   2-D Health Care for Unrepresented Patients*
   2-E Considerations for Revising the Hospital’s Policy & Procedure Regarding Decision Making for Unrepresented Patients
   3-1 Advance Health Care Directive

4. WHO MAY CONSENT FOR MINOR PATIENTS
   2-1 Self-Sufficient Minor Information
   2-2 Caregiver’s Authorization Affidavit
   2-3 Authorization for Third Party to Consent to Treatment of Minor Lacking Capacity to Consent
   2-B Consent Requirements for Medical Treatment of Minors

5. TREATMENTS THAT REQUIRE SPECIAL CONSENT
   4-1 Transfusion Information Form
   4-3 Authorization for and Consent to Hysterectomy
   4-4 Employee or Medical Staff Member Statement
   4-5 Release from Responsibility for Treatment of Miscarriage or Partial Abortion
   4-6 Consent to Reuse of Hemo dialysis Filters
   4-7 Consent to Receive Antipsychotic Medications
   4-8 Consent to Donation of Sperm, Ova or Embryos
   4-9 Consent to Implantation of Sperm, Ova or Embryos
   4-11 Directive Regarding Embryo Disposition
   4-A Patient’s Guide to Blood Transfusion
   4-B Be Informed (Breast Cancer)
   4-C Be Informed (Prostate Cancer)
   23-1 Consent for the HIV Test
   23-2 Refusal to Consent to Communicable Disease Testing/Refusal to Receive Results of Communicable Disease Testing

6. REFUSAL OF TREATMENT AND END-OF-LIFE ISSUES
   5-1 Refusal to Permit Medical Treatment
   5-2 Refusal of Blood Products
   5-3 Leaving Hospital Against Medical Advice
   5-4 Request Regarding Resuscitative Measures
   5-5 Request for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner
   5-6 Final Attestation for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner
   5-7 End-of-Life Option Act Attending Physician Checklist & Compliance Form
   5-8 End-of-Life Option Act Consulting Physician Compliance Form
   5-9 End-of-Life Option Act Attending Physician Follow-Up Form
   5-A Guidelines for Policies Pertaining to Withholding and Withdrawing Life-Sustaining Treatment
   5-B Physician Orders for Life-Sustaining Treatment (POLST)*
7. **THE MEDICAL RECORD**

14-1 Agreement for Facsimile Transmission of Psychiatric Records

8. **HEALTH INFORMATION PRIVACY BASICS**

16-1 Agreement for Use or Disclosure of Health Information
16-2 Request to Withhold Public Release of Information
24-3 Consent to Photograph
24-4 Consent to Photograph and Authorization for Use or Disclosure

9. **MEDICAL PROCEDURES AND INTERROGATIONS REQUESTED BY LAW ENFORCEMENT**

6-1 Blood Test Request by Peace Officer
6-2 Medical Evaluation Request by Peace Officer
6-3 Warrantless Medical Search Request by Peace Officer (When Subject Refuses to Consent)
6-A Collection and Handling of Blood Samples (Pursuant to Vehicle Code Section 23612)

10. **RESEARCH ON HUMAN SUBJECTS**

7-1 Experimental Subject’s Bill of Rights
7-2 Formal for Informed Consent Form for Participation in a Medical Research Project
7-A Research Exempted Under DHHS Regulations

11. **ADMISSION AND REGISTRATION DOCUMENTS, ARBITRATION AND LIENS**

8-1 Conditions of Admission
8-2 Notice of Lien
8-3 Assignment of Proceeds of Claim
8-4 Mutual Arbitration Agreement
8-5 Sample Arbitration Clause

12. **DISCHARGE PLANNING, PATIENT TRANSFERS AND RELATED ISSUES**

9-1 Patient Refusal of Transfer
9-2 Transfer Summary (Transfer from Acute Hospital to SNF)
9-3 Consent to Transfer for Medical Treatment
9-4 Physician Certification
9-5 Physician Authorization for Transfer
9-6 Patient Refusal of Further Medical Treatment
9-7 Patient Transfer Acknowledgment
9-8 Patient Request for Transfer or Discharge
9-9 Notice for Emergency Room
9-10 Temporary Absence Release
9-11 Consent for Participation in Patient Outing
10-1 Authorization for Release of a Minor
10-2 Acknowledgment of Release of a Minor
10-3 Release of a Child Under 8 Years of Age
13-3 Aftercare Plan

13. **MATERNITY AND NEWBORN ISSUES**

10-4 Newborn Family Medical History Questionnaire
10-5 Refusal to Permit Rho(D)-Immune Globulin Administration
10-6 Refusal to Permit Administration of an Approved Prophylactic Agent to the Eyes of Newborn
10-7 Consultation Regarding Length of Stay After Childbirth
10-A Baby Stalking Sign
10-B Safe Surrender Site Sign
10-C Obstetrical Care Notice
24-5 Request for Presence of Observer During Childbirth/Medical Procedure

14. **DEATH, AUTOPSIES AND ANATOMICAL GIFTS**

11-1 Authorization for Autopsy
11-2 Authorization for Anatomical Gift
11-3 Delivery of Personal Property of Deceased Patient

15. **VOLUNTARY ADMISSION AND INVOLUNTARY DETAINMENT FOR MENTAL HEALTH TREATMENT**

12-1 Request for Voluntary Admission and Authorization for Treatment
12-2 Statement of Professional Person Responsible for Minor’s Admission
12-3 Notice to Minors
12-4 Certificate of Admitting Physician
12-5 Application of Involuntary Admission — Inebriates
12-6 Notice of Certification for Intensive Treatment
12-7 Advisement of Rights — Involuntary Patient
12-8 Leave of Absence from Psychiatric Service
12-9 Request for Release from Involuntary Treatment
12-10 Notice of Certification to Second Involuntary 14-Day Period for Intensive Treatment — Suicidal Patient
12-11 Petition for Postcertification Treatment of Imminently Dangerous Person
12-12 Detention of Patient with Psychiatric Emergency in a Nondesignated Health Facility (Health and Safety Code Section 1799.111)
12-A Summary of the Lanterman-Petris-Short Act’s Provisions for Involuntary Evaluation and Treatment and Right of Review

16. **MENTAL HEALTH PATIENTS: RIGHTS AND REPORTING REQUIREMENTS**

13-3 Aftercare Plan
13-4 Notice to Law Enforcement Agency: Release of Person From Hospital From Whom a Firearm or Other Deadly Weapon Was Confiscated
13-5 Notice to Patient: Procedure for Return of Confiscated Weapon(s)

* Indicates forms that are new or revised in this edition.
17. ASSAULT AND ABUSE REPORTING REQUIREMENTS
   19-2 Employee Acknowledgment of Child Abuse and Neglect Reporting Obligations
   19-3 Report of Injury or Condition Resulting From Neglect or Abuse (To a Patient Received From a Licensed Health Facility)
   19-4 Employee Acknowledgment of Elder and Dependent Adult Abuse Reporting Obligations
   19-A Assault and Abuse Reporting Requirements

18. REPORTING COMMUNICABLE DISEASES AND OTHER PATIENT CONDITIONS
   No forms are associated with chapter 18.

19. ADVERSE EVENTS AND INCIDENT REPORTS
   20-1 Adverse Event Report Form — Sample
   21-1 Incident Report
   21-2 Report to Attorney
   25-A Report of a Hospital Death Associated With Restraint or Seclusion

20. OTHER ISSUES
   24-1 Release of Side Rails*
   24-2 Permit for Using Electrical Appliances

* Indicates forms that are new or revised in this edition.
Signage Requirements

California hospitals are required to post the following signs regarding patient rights and consent-related matters (see the 2018 edition of CHA’s California Hospital Compliance Manual for a complete list of hospital required signage).

**HOW TO OBTAIN SIGNS:**

These signs may also download the files from CHA at www.calhospital.org/free-resources. Many signs are available in English and Spanish.

**NOTE:** This list includes only signs regarding patient rights and consent-related matters discussed in this manual. Hospitals must also post information regarding their license, elevator permits, various employee matters, etc. (See CHA’s California Hospital Compliance Manual for a complete list of hospital signage requirements.)

<table>
<thead>
<tr>
<th>SIGN REQUIREMENTS</th>
<th>APPENDIX OR FORM</th>
<th>CHAPTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abandoned newborn or safe surrender site</td>
<td>Safe Surrender Site (CHA Appendix 10-B³)</td>
<td>13</td>
</tr>
<tr>
<td>Abortion, no provision of</td>
<td>No sign available — See chapter 5 for more information</td>
<td>5</td>
</tr>
<tr>
<td>Baby stalking (optional)</td>
<td>Baby Stalking (CHA Appendix 10-A³)</td>
<td>13</td>
</tr>
<tr>
<td>Breast cancer screening or biopsy site</td>
<td>Be Informed (Breast Cancer) (CHA Appendix 4-B³)</td>
<td>5</td>
</tr>
<tr>
<td>Chargemaster availability</td>
<td>No sign available — See chapter 11 for more information</td>
<td>11</td>
</tr>
<tr>
<td>Charity care and discount payment policy notice</td>
<td>No sign available — See chapter 11 for more information; see CHA website for sample signs</td>
<td>11</td>
</tr>
<tr>
<td>Crime against NF resident: reporting obligations and anti-retaliation</td>
<td>See chapter 17 for website where sample signs may be found</td>
<td>17</td>
</tr>
<tr>
<td>EMTALA signs</td>
<td>Notice for Emergency Room (CHA Form 9-9³)</td>
<td>12</td>
</tr>
<tr>
<td>Infant feeding policy</td>
<td>No sign available — See chapter 13 for more information</td>
<td>13</td>
</tr>
<tr>
<td>Interpreter services</td>
<td>See chapter 1 for more information and a website for where some sample signs may be found</td>
<td>1</td>
</tr>
<tr>
<td>Mental health patient complaint procedure</td>
<td>Patients’ Rights (CHA Form 13-1³)</td>
<td>16</td>
</tr>
<tr>
<td>Mental health patient’s rights poster</td>
<td>Patients’ Rights</td>
<td>16</td>
</tr>
<tr>
<td>SIGN REQUIREMENTS</td>
<td>APPENDIX OR FORM</td>
<td>CHAPTER</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Nondiscrimination and accessibility</td>
<td>See chapter 1 for website where sample signs may be found</td>
<td>1</td>
</tr>
<tr>
<td>Notice of Privacy Practices</td>
<td>Model Notice of Privacy Practices (CHA Forms 15-2(^5) and 15-3(^5)) in CHA's California Health Information Privacy Manual</td>
<td>8</td>
</tr>
<tr>
<td>Obstetrical care notice</td>
<td>Obstetrical Care Notice (CHA Appendix 10-C)</td>
<td>13</td>
</tr>
<tr>
<td>Outpatient prostate cancer screening or treatment site</td>
<td>Be Informed (Prostate Cancer) (CHA Appendix 4-C(^5))</td>
<td>5</td>
</tr>
<tr>
<td>Patient complaints/grievances</td>
<td>Patients’ Rights (CHA Appendix 1-A(^5))</td>
<td>1</td>
</tr>
<tr>
<td>Patients’ rights</td>
<td>Patients’ Rights (CHA Appendix 1-A(^5))</td>
<td>1</td>
</tr>
<tr>
<td>Pharmacy (emergency contraception)</td>
<td>No sign available — See chapter 5 for more information</td>
<td>5</td>
</tr>
<tr>
<td>Proposition 65 (chemicals known to the state to cause cancer or reproductive toxicity)</td>
<td>No sign available — See chapter 5 for more information</td>
<td>5</td>
</tr>
<tr>
<td>Smoking</td>
<td>No sign available — See chapter 20 for more information</td>
<td>20</td>
</tr>
</tbody>
</table>
## Patient Handouts or Other Informational Requirements

The following information must be given to the patient or patient’s legal representative.

<table>
<thead>
<tr>
<th>REQUIREMENT</th>
<th>FIND MORE INFO IN CHAPTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance directives — “Your Right to Make Decisions about Medical Treatment” and other advance directive information</td>
<td>1</td>
</tr>
<tr>
<td>Ancillary health service freedom of choice</td>
<td>11</td>
</tr>
<tr>
<td>Blood — receipt of infected blood or blood product</td>
<td>18</td>
</tr>
<tr>
<td>Brain death handout (for families)</td>
<td>14</td>
</tr>
<tr>
<td>Breast cancer — patients treated for</td>
<td>5</td>
</tr>
<tr>
<td>Breastfeeding information</td>
<td>13</td>
</tr>
<tr>
<td>Cancer Registry reporting information for patient</td>
<td>18</td>
</tr>
<tr>
<td>Certification review hearing — notify family of</td>
<td>15</td>
</tr>
<tr>
<td>Charity care and discount payment policy notice</td>
<td>11</td>
</tr>
<tr>
<td>Child car seat information</td>
<td>12</td>
</tr>
<tr>
<td>Community-based long-term care resources — provide this information to patients anticipated to need long-term care upon discharge</td>
<td>12</td>
</tr>
<tr>
<td>Complaint process</td>
<td>1</td>
</tr>
<tr>
<td>Confidentiality — Notice of Privacy Practices</td>
<td>8</td>
</tr>
<tr>
<td>Continuing health care requirements following discharge</td>
<td>1, 12</td>
</tr>
<tr>
<td>Dental restorative materials</td>
<td>5</td>
</tr>
<tr>
<td>End-of-life treatment options</td>
<td>6</td>
</tr>
<tr>
<td>“Experimental Subject's Bill of Rights”</td>
<td>10</td>
</tr>
<tr>
<td>Fetal ultrasound for keepsake purposes</td>
<td>13</td>
</tr>
<tr>
<td>Firearms — notify specific mental health patients of their inability to possess a firearm</td>
<td>16</td>
</tr>
<tr>
<td>Genetic disease screening program for newborns</td>
<td>13</td>
</tr>
<tr>
<td>Grievance process — notice of</td>
<td>1</td>
</tr>
<tr>
<td>Gynecological exam — patient undergoing annual exam</td>
<td>5</td>
</tr>
<tr>
<td>HIV information to prenatal care patient</td>
<td>13</td>
</tr>
<tr>
<td>HIV test information to HIV test subjects</td>
<td>5</td>
</tr>
<tr>
<td>Immunization information</td>
<td>5</td>
</tr>
<tr>
<td>Involuntary detention — advisement to persons involuntarily detained</td>
<td>15</td>
</tr>
<tr>
<td>REQUIREMENT</td>
<td>FIND MORE INFO IN CHAPTER</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Lack of in-house physician coverage</td>
<td>11</td>
</tr>
<tr>
<td>Mastectomy patients — length of stay</td>
<td>12</td>
</tr>
<tr>
<td>Maternity patients — length of stay</td>
<td>12, 13</td>
</tr>
<tr>
<td>Medical questionnaire to person abandoning a newborn (“safe surrender”)</td>
<td>13</td>
</tr>
<tr>
<td>Medication error</td>
<td>19</td>
</tr>
<tr>
<td>Medications — information to involuntarily detained patient regarding medications</td>
<td>15</td>
</tr>
<tr>
<td>Mental health patient aftercare plan</td>
<td>12, 16</td>
</tr>
<tr>
<td>Mental health patient alleges sexual contact with previous therapist — handout</td>
<td>16</td>
</tr>
<tr>
<td>Mental health patient’s rights notice and statement upon leaving</td>
<td>16</td>
</tr>
<tr>
<td>Mental health treatment of a minor — prior to admission of a minor for mental health treatment, facility must give (a) a full explanation of the facility’s treatment philosophy, (b) information about independent clinical review, and (c) Department of Mental Health booklet regarding rights of minors in mental health facilities</td>
<td>15</td>
</tr>
<tr>
<td>Midwife’s clients</td>
<td>13</td>
</tr>
<tr>
<td>Newborn genetic disease and hearing screening information</td>
<td>13</td>
</tr>
<tr>
<td>NOTICE Act (about observation status)</td>
<td>12</td>
</tr>
<tr>
<td>Notice of financial responsibility</td>
<td>11</td>
</tr>
<tr>
<td>Notice of Privacy Practices</td>
<td>8</td>
</tr>
<tr>
<td>Observation patient notices</td>
<td>12</td>
</tr>
<tr>
<td>Outcomes of care and unanticipated outcomes</td>
<td>19</td>
</tr>
<tr>
<td>Outpatient clinic — service available at another location</td>
<td>11</td>
</tr>
<tr>
<td>Patient rights and responsibilities — also, must ask patient if he/she wants next of kin or agent to be given patient rights materials</td>
<td>11</td>
</tr>
<tr>
<td>Physician ownership notice</td>
<td>11</td>
</tr>
<tr>
<td>Post-discharge providers</td>
<td>12</td>
</tr>
<tr>
<td>Prenatal ultrasound for keepsake purposes</td>
<td>13</td>
</tr>
<tr>
<td>Prostate exam — patient undergoing</td>
<td>5</td>
</tr>
<tr>
<td>Right to certification review hearing or writ of habeas corpus, right to counsel</td>
<td>15</td>
</tr>
<tr>
<td>Safe — notice of fireproof safe (optional)</td>
<td>20</td>
</tr>
<tr>
<td>Severe chronic intractable pain</td>
<td>5</td>
</tr>
<tr>
<td>Sexual assault victim rights</td>
<td>17</td>
</tr>
<tr>
<td>Shaken baby syndrome information</td>
<td>13</td>
</tr>
<tr>
<td>Sudden infant death syndrome information</td>
<td>13</td>
</tr>
<tr>
<td>Transfers — must notify patent or person legally responsible for a patient prior to transfer</td>
<td>12</td>
</tr>
<tr>
<td>Transfers — reason for a transfer or refusal to provide emergency services, right to emergency services without regard to ability to pay</td>
<td>12</td>
</tr>
<tr>
<td>Vaccine information</td>
<td>5</td>
</tr>
<tr>
<td>Visitation policy</td>
<td>1</td>
</tr>
</tbody>
</table>
# Reporting Requirements

*(Reporting Information to Parties Other Than the Patient)*

<table>
<thead>
<tr>
<th>REQUIREMENT</th>
<th>FIND MORE INFO IN CHAPTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>5</td>
</tr>
<tr>
<td>Adverse events</td>
<td>19</td>
</tr>
<tr>
<td>Animal bites</td>
<td>18</td>
</tr>
<tr>
<td>Birth certificate</td>
<td>13</td>
</tr>
<tr>
<td>Blood transfusion reactions</td>
<td>19</td>
</tr>
<tr>
<td>Burn and smoke inhalation injury</td>
<td>18</td>
</tr>
<tr>
<td>Cancer</td>
<td>18</td>
</tr>
<tr>
<td>Child abuse or neglect</td>
<td>17</td>
</tr>
<tr>
<td>Communicable diseases</td>
<td>18</td>
</tr>
<tr>
<td>Convulsive therapy — quarterly reports</td>
<td>5</td>
</tr>
<tr>
<td>Coroner</td>
<td>14</td>
</tr>
<tr>
<td>Dangerous patient — duty to warn potential victims and/or law enforcement of dangerous patient</td>
<td>16</td>
</tr>
<tr>
<td>Death certificate</td>
<td>14</td>
</tr>
<tr>
<td>Death in restraint or seclusion — report to Centers for Medicare &amp; Medicaid Services</td>
<td>19</td>
</tr>
<tr>
<td>Deaths, no next of kin — report to county public administrator</td>
<td>14</td>
</tr>
<tr>
<td>Denial of mental health patient’s rights</td>
<td>16</td>
</tr>
<tr>
<td>Discharge or escape of specified mental health patients — report to law enforcement</td>
<td>16</td>
</tr>
<tr>
<td>Elder or dependent adult abuse or neglect</td>
<td>17</td>
</tr>
<tr>
<td>Fetal death — certificate of fetal death/certificate of still birth</td>
<td>14</td>
</tr>
<tr>
<td>Hysterectomies — quarterly reports to California Department of Public Health</td>
<td>5</td>
</tr>
<tr>
<td>Infant security policy — must be sent to California Department of Public Health every two years</td>
<td>13</td>
</tr>
<tr>
<td>Injury by firearm or assaultive/abusive conduct</td>
<td>17</td>
</tr>
<tr>
<td>Injury or condition resulting from abuse or neglect in a patient transferred from another health facility</td>
<td>17</td>
</tr>
<tr>
<td>Institutional Review Board — changes in membership</td>
<td>10</td>
</tr>
<tr>
<td>Interpreter policy — must be sent to California Department of Public Health annually</td>
<td>1</td>
</tr>
<tr>
<td>Involuntarily detained minor or admission of other mental health patient — notify family</td>
<td>15, 16</td>
</tr>
<tr>
<td>Lapses of consciousness — disorders characterized by</td>
<td>18</td>
</tr>
<tr>
<td>Maternity patient transferred to hospital by midwife</td>
<td>13</td>
</tr>
<tr>
<td>Requirement</td>
<td>Find More Info In Chapter</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Medical device tracking information to device manufacturer</td>
<td>19</td>
</tr>
<tr>
<td>Medical devices — incidents involving medical devices reasonably believed to have caused or contributed to the serious injury or death of a patient</td>
<td>19</td>
</tr>
<tr>
<td>Medication error</td>
<td>19</td>
</tr>
<tr>
<td>Mental health patient escape or disappearance — notify law enforcement</td>
<td>16</td>
</tr>
<tr>
<td>Mental health patient’s release, transfer, serious illness, injury or death — notify next of kin</td>
<td>16</td>
</tr>
<tr>
<td>Mental health patients’ rights denial — quarterly report to California Department of Mental Health</td>
<td>16</td>
</tr>
<tr>
<td>Minor — release of a minor to a person other than parent, relative or other person with legal custody — report to Department of Social Services</td>
<td>12</td>
</tr>
<tr>
<td>Minors admitted for mental health treatment — annual report to California Department of Health Care Services</td>
<td>15</td>
</tr>
<tr>
<td>Newborn screening specimen not obtained</td>
<td>13</td>
</tr>
<tr>
<td>Notification of enrollee’s health plan</td>
<td>12</td>
</tr>
<tr>
<td>Occupational injury/illness</td>
<td>18</td>
</tr>
<tr>
<td>Organ procurement organization — notify of impending death</td>
<td>14</td>
</tr>
<tr>
<td>Paternity — declaration of paternity</td>
<td>13</td>
</tr>
<tr>
<td>Patient transfers — annual reports to California Department of Public Health</td>
<td>12</td>
</tr>
<tr>
<td>Pesticide poisoning</td>
<td>18</td>
</tr>
<tr>
<td>Prenatal and newborn disorders (Rhesus (Rh) hemolytic disease, neural tube defects, chromosomal defects, hereditary hemoglobinopathies, phenylketonuria, hypothyroidism, galactosemia and others)</td>
<td>13</td>
</tr>
<tr>
<td>Property of involuntarily detained patient — report to Superior Court</td>
<td>15</td>
</tr>
<tr>
<td>Psychosurgery — quarterly reports</td>
<td>5</td>
</tr>
<tr>
<td>Release of patient — notification to peace officer of release of patient</td>
<td>16</td>
</tr>
<tr>
<td>Reportable diseases and conditions (such as communicable diseases)</td>
<td>18</td>
</tr>
<tr>
<td>Research not conducted according to IRB requirements</td>
<td>10</td>
</tr>
<tr>
<td>Research with unexpected serious harm</td>
<td>10</td>
</tr>
<tr>
<td>Restraint and seclusion data — report to state</td>
<td>16</td>
</tr>
<tr>
<td>Reye’s syndrome</td>
<td>18</td>
</tr>
<tr>
<td>Rights of mental health patients — report violations</td>
<td>16</td>
</tr>
<tr>
<td>Sexual assault/rape</td>
<td>17</td>
</tr>
<tr>
<td>Specified mental health patients — report to California Department of Justice (firearms prohibition)</td>
<td>16</td>
</tr>
<tr>
<td>Sterilization — quarterly reports to the California Department of Public Health</td>
<td>5</td>
</tr>
<tr>
<td>Suspicious death — notify coroner</td>
<td>14</td>
</tr>
<tr>
<td>Transfer of patient with unstabilized emergency condition in violation of EMTALA — report to Centers for Medicare &amp; Medicaid Services</td>
<td>12</td>
</tr>
<tr>
<td>Transfusion reactions</td>
<td>19</td>
</tr>
<tr>
<td>Tubal ligations, vasectomies, hysterectomies — quarterly reports to the California Department of Public Health</td>
<td>5</td>
</tr>
<tr>
<td>REQUIREMENT</td>
<td>FIND MORE INFO IN CHAPTER</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Tuberculosis — active</td>
<td>18</td>
</tr>
<tr>
<td>Unconscious patient in ER — make reasonable efforts to contact patient’s agent, surrogate or family member upon presentation</td>
<td>1</td>
</tr>
<tr>
<td>Unusual occurrence</td>
<td>18, 19</td>
</tr>
<tr>
<td>Vaccination — adverse reaction to vaccination</td>
<td>18</td>
</tr>
<tr>
<td>Vaginal birth after C-section (VBAC), midwife</td>
<td>13</td>
</tr>
</tbody>
</table>
## Special Consent Requirements

<table>
<thead>
<tr>
<th>REQUIREMENT</th>
<th>FIND MORE INFO IN CHAPTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aid-in-dying medication</td>
<td>6</td>
</tr>
<tr>
<td>Antipsychotic medications</td>
<td>5</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>5</td>
</tr>
<tr>
<td>Body piercing, minors</td>
<td>4</td>
</tr>
<tr>
<td>Collagen injections</td>
<td>5</td>
</tr>
<tr>
<td>Convulsive therapy</td>
<td>5</td>
</tr>
<tr>
<td>Discharge medications</td>
<td>12</td>
</tr>
<tr>
<td>Fertility/infertility treatment</td>
<td>5</td>
</tr>
<tr>
<td>Fetal ultrasound for keepsake purposes</td>
<td>13</td>
</tr>
<tr>
<td>Hemodialysis filters — reuse of hemodialysis filters</td>
<td>5</td>
</tr>
<tr>
<td>HIV test</td>
<td>5, 18</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>5</td>
</tr>
<tr>
<td>Implantation of cells, tissues and organs</td>
<td>5</td>
</tr>
<tr>
<td>Medical information — release of medical information</td>
<td>8</td>
</tr>
<tr>
<td>Organs, tissue or fluids — use of organs, tissue or fluids</td>
<td>5</td>
</tr>
<tr>
<td>Outpatient medications</td>
<td>12</td>
</tr>
<tr>
<td>Pelvic exam on an anesthetized or unconscious female</td>
<td>5</td>
</tr>
<tr>
<td>Prenatal ultrasound for keepsake purposes</td>
<td>13</td>
</tr>
<tr>
<td>Psychosurgery</td>
<td>5</td>
</tr>
<tr>
<td>Research on humans</td>
<td>10</td>
</tr>
<tr>
<td>Sexual assault evidentiary exam</td>
<td>17</td>
</tr>
<tr>
<td>Silicon implants</td>
<td>5</td>
</tr>
<tr>
<td>Sperm/ova/embryos — donation of sperm/ova/embryos</td>
<td>5</td>
</tr>
<tr>
<td>Sterilization</td>
<td>5</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>5</td>
</tr>
<tr>
<td>Transplants</td>
<td>5</td>
</tr>
<tr>
<td>Vaccines</td>
<td>5</td>
</tr>
<tr>
<td>Vaginal birth after C-Section (VBAC), midwife</td>
<td>13</td>
</tr>
</tbody>
</table>
1 Patients’ Rights and Interpreter Services

I. INTRODUCTION ........................................ 1.1
   A. Required Patients’ Right Notices........... 1.1
   B. Font Size of Handouts.......................... 1.1

II. THE PATIENT SELF-DETERMINATION ACT ........................................ 1.1
   A. Who Must Comply? .............................. 1.1
   B. Provide Information to Patients ............. 1.1
   C. Who Must Be Given the Information......... 1.2
   D. Policies and Procedures...................... 1.2
   E. Documentation .................................. 1.2
   F. Education ...................................... 1.2
   G. Complaints .................................... 1.3

III. PATIENTS’ RIGHTS UNDER STATE LAW ... 1.3
   A. Notice of Patients’ Rights ................. 1.3
   B. Right to Non-Discriminatory Treatment .. 1.4
      Definitions .................................... 1.4
   C. Right to Know the Identity of Persons
      Caring for the Patient ....................... 1.5
      Exceptions .................................... 1.5
      Visiting Faculty Members .................... 1.5
      Visiting Fellows ............................. 1.5
      Individual Practitioners .................... 1.5
      Physician Assistant Trainees .............. 1.6
   D. California Right to Visitors ............... 1.6
      Interaction With Federal Law ............... 1.6
   E. Right to Be Informed of Continuing Care
      Requirements After Discharge ............. 1.6
   F. Right to Have Family Member and
      Personal Physician Notified of Admission 1.7
   G. Readable Documents ......................... 1.7

IV. PATIENTS’ RIGHTS UNDER FEDERAL LA W ...................................... 1.8
   A. Right to Nondiscriminatory Treatment:
      Section 1557 ..................................... 1.8
      Introduction .................................... 1.8
      Enforcement and Resources ................. 1.8
      Notice of Nondiscrimination ............... 1.8
      Posting the Notice ............................ 1.8
   LGBTQ Individuals .................................. 1.9
   Designation of Compliance Coordinator ....... 1.9
   Grievance Procedures ............................ 1.9
   B. Requirements of the Medicare COPs ...... 1.9
      Notice of Patients’ Rights .................... 1.10
      Exercise of Rights ............................ 1.10
      Right Regarding Restraints and Seclusion 1.10
      Federal Right to Visitors and Support
      Persons .......................................... 1.11

V. AUXILIARY AIDS FOR HEARING, VISION OR SPEECH IMPAIRMENT ........ 1.12
   A. Rehabilitation Act and Americans with
      Disabilities Act .................................. 1.13
      General Rule .................................... 1.13
      Definitions .................................... 1.13
      Effective Communication ..................... 1.14
      Interpreter Qualifications ..................... 1.14
      Friends and Family as Interpreters ........ 1.15
      Telecommunications ........................... 1.15
      TVs, Phones and Alarms in Patients Rooms 1.15
      Video Remote Interpreting Services ....... 1.15
      DOJ Settlements ............................... 1.15
   B. Section 1557: Effective Communication
      for Individuals with Disabilities ......... 1.16
      Auxiliary Aids ................................ 1.16
      Enforcement and Resources ................. 1.16
      Accessibility of Electronic Technology .... 1.16

VI. SERVICE ANIMALS ........................................ 1.16
   A. Definition of “Service Animal” .......... 1.16
      Miniature Horses .............................. 1.17
   B. Where Service Animals Are Allowed .... 1.17
      Cafeterias ...................................... 1.17
   C. When Service Animals May Be Excluded 1.18
   D. Service Animals Must Be Under Control 1.18
   E. Questions That May Be Asked About
      Service Animals ............................... 1.18
   F. Allergies and Fears ......................... 1.18
   G. Additional Policy Considerations ........ 1.18
   H. Penalties for Fraudulently Claiming to
      Have a Service Animal ....................... 1.19
VII. INTERPRETER SERVICES .............. 1.19
A. State Law Requirements ............... 1.19
   Definitions ........................................ 1.19
   Required Policy ................................ 1.19
   Required Notices ................................ 1.19
   Website Requirements ....................... 1.20
   Other Requirements ......................... 1.20
   Acute Psychiatric Hospitals .............. 1.20
B. Federal Law: Section 1557 of the ACA .... 1.20
   Required Interpreter and Translation
   Services ............................................ 1.21
   Video Remote Interpreting Services ........ 1.21
   Taglines .......................................... 1.21
   Prohibitions ..................................... 1.22
   Enforcement ..................................... 1.22
C. Limited English Proficiency Guidance .... 1.22
   Definition of LEP Persons .................... 1.22
   Compliance Factors ............................ 1.23
   Number of LEP Persons ....................... 1.23
   Frequency of Contact ........................ 1.23
   Importance of Service ....................... 1.23
   Provider’s Resources .......................... 1.23
   Elements of Effective Language Assistance
   Plan .................................................. 1.23
   Language Services .............................. 1.24
   Which Documents Should Be Translated? .... 1.24
D. CLAS Standards .............................. 1.25
E. Consent Forms ............................... 1.25
F. Payer Requirements .......................... 1.25
G. Model Hospital Policies and Procedures .. 1.25

VIII. PATIENT COMPLAINTS ........... 1.25
A. Hospital Policy Required .................. 1.25
B. Notice and Signage Required ............ 1.26
C. Complaints About Physicians or
   Podiatrists ...................................... 1.26

FORMS & APPENDICES

1-A Patient Rights

Forms and Appendices can be found at the back of the manual and
online for CHA members at www.calhospital.org/free-resources.
“S” denotes that the form is provided in English and Spanish.
Patients’ Rights and Interpreter Services

I. INTRODUCTION

An adult who is mentally competent has the fundamental right of self-determination — that is, he or she has the right to determine what happens to his or her body. Thus, patients have the right to make decisions about medical treatment that is offered or recommended. Both state and federal law require that hospitals tell patients about their rights, so they can better exercise them.

This chapter describes the rights that apply to all hospital patients. The laws granting special rights to patients receiving psychiatric care are described in chapters 15 and 16. Patient privacy rights are described in chapter 8. (For information about skilled nursing facility patient rights, see 42 C.F.R. Section 483.10; Health and Safety Code Sections 1599, 1599.1 and 123222.2; and Title 22, California Code of Regulations, Section 72527. For information about home health patient rights, see 42 C.F.R. Section 484.50)

II. THE PATIENT SELF-DETERMINATION ACT

Federal law — The Patient Self-Determination Act (PSDA) — requires that hospitals participating in the Medicare or Medicaid (Medi-Cal) program provide information to patients regarding the right, under state law, to formulate advance directives concerning health care decisions. This portion of the manual describes the requirements of the PSDA. [42 U.S.C. Sections 1395cc(f) and 1396a(w); 42 C.F.R. Sections 489.100 and 489.102; Interpretive Guidelines, Tag A-0132/C-0151]

In addition, The Joint Commission requires hospitals to adopt written policies regarding advance directives (see The Joint Commission Comprehensive Accreditation Manual for Hospitals, RI.01.05.01, EP 1).

A. Who Must Comply?

Hospitals, skilled nursing facilities, home health agencies, hospice programs, and health maintenance organizations (HMOs) must comply with the PSDA.

B. Provide Information to Patients

The PSDA requires health care providers to give adult patients written information at the time of admission about their rights under state law to make decisions about medical care, including the right to accept or refuse treatment and the right to formulate advance directives. For home health agencies and HMOs, the information must be given at the time of initial consent. A provider must update this information as soon as possible after a change in state law, and in no case later than 90 days.

The California Department of Public Health (when it was called the Department of Health Services) developed a brochure called “Your Right to Make Decisions About Medical Treatment.” This brochure may be used to fulfill this requirement. It is available in English at www.cdss.ca.gov/cdssweb/entres/forms/english/pub325.pdf or www.cdss.ca.gov/cdssweb/PG167.htm and in Spanish at www.cdss.ca.gov/cdssweb/PG177.htm. The brochure is also available in English, Spanish and many other languages from:
If a patient lacks capacity to make health care decisions at the time of admission, the hospital may give advance directive information to a family member or surrogate, but must also give the required information to the patient when the patient becomes able to understand and respond to the information. Hospitals must have procedures in place to ensure appropriate follow-up.

D. Policies and Procedures

Providers must maintain written policies to ensure that patients are given the required information, and to implement of patients’ rights. The policy must include a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience. For example, a hospital may wish to clarify that it does not implement do not resuscitate orders in the operating room, if this is the hospital’s policy. The PSDA states that it is not meant to preempt any state law that protects providers’ rights not to implement an advance directive as a matter of conscience.

The hospital’s policy must identify California’s legal authority authorizing conscience objections, and describe the range of medical conditions or procedures affected by the conscience objections. California law authorizes conscience objections pursuant to the Health Care Decisions Law (see “Declining to Comply,” page 3.12).

Providers may not condition the provision of care, or otherwise discriminate against a patient, based on whether or not he or she has completed an advance directive.

E. Documentation

Providers must document — in a prominent part of the individual’s medical record — whether or not the patient has completed an advance directive. The Joint Commission requires that employees and medical staff involved in the patient’s care be aware of whether or not the patient has an advance directive (see The Joint Commission Comprehensive Accreditation Manual for Hospitals, RL.01.05.01, EP 9, 11). Surveyors will ask hospital staff and/or medical staff if a particular patient has an advance directive, and will expect staff to know exactly where to look for it in the paper or electronic medical record.

F. Education

Providers must educate the facility’s staff about its policies and procedures on advance directives.

Providers must also provide community education about advance directives. Separate community education
Chapter 1 — Patients’ Rights and Interpreter Services

1.3

Chapter 1 — Patients’ Rights and Interpreter Services

1.3

materials may be developed and used, at the discretion of providers. The same written materials do not have to be provided in all settings, but the materials should:

1. Define what constitutes an advance directive,
2. Emphasize that an advance directive is designed to enhance an incapacitated individual’s control over medical treatment, and
3. Describe applicable state law about advance directives.

The law allows, but does not require, a provider to give advance directive forms to patients and community members. A provider must document its community education efforts.

G. Complaints

Providers must inform individuals that complaints about advance directives may be made to the California Department of Public Health (to the nearest Licensing and Certification District Office). Home health agencies must inform patients in writing of the state’s toll-free home health telephone hotline, its hours of operation, and that its purpose is to receive complaints or questions about local home health agencies [42 C.F.R. Section 484.50(c)(9)].

III. PATIENTS’ RIGHTS UNDER STATE LAW

A. Notice of Patients’ Rights

The California Department of Public Health (CDPH) has described certain patients’ rights that must be protected in general acute care hospitals [Title 22, California Code of Regulations, Section 70707]. This regulation requires hospitals and medical staffs to adopt a written policy on patients’ rights. In addition, a list of these patients’ rights must be posted in English and Spanish in appropriate places within the hospital so that they may be read by patients. The law does not specify what “appropriate places” means.

CHA has developed a sample poster included as CHA Appendix 1-A, “Patient Rights” that hospitals may use to comply with this requirement. This list may be given to patients as a handout, in addition to being posted as required. Additional rights may be added to the poster or handout, if desired.

This list must include, but need not be limited to, the patient’s right to:

1. Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, disability, medical condition, marital status, registered domestic partner status, or the source of payment for care.
2. Considerate and respectful care.
3. Knowledge of the name of the licensed health-care practitioner acting within the scope of his or her professional licensure who has primary responsibility for coordinating the care, and the names and professional relationships of physicians and nonphysicians who will see the patient.
4. Receive information about the illness, the course of the treatment and prospects for recovery in terms that the patient can understand.
5. Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information must include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or nontreatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.
6. Participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment.
7. Full consideration of privacy concerning the medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.
8. Confidential treatment of all communications and records pertaining to the care and the stay in the hospital. Written permission must be obtained before the medical records can be made available to anyone not directly concerned with the care.
9. Reasonable responses to any reasonable requests made for service.
10. Leave the hospital even against the advice of members of the medical staff.
11. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of persons providing the care.
12. Be advised if the hospital/licensed health care practitioner acting within the scope of his or her professional licensure proposes to engage in or perform human experimentation affecting care or
The patient has the right to refuse to participate in such research projects.

13. Be informed of continuing health care requirements following discharge from the hospital.

14. Examine and receive an explanation of the bill regardless of the source of payment.

15. Know which hospital rules and policies apply to the patient’s conduct while a patient.

16. Have all patients’ rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

17. Designate visitors of his/her choosing, if the patient has decision-making capacity, whether or not the visitor is related by blood, marriage, or registered domestic partner status, unless:
   a. No visitors are allowed.
   b. The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.
   c. The patient has indicated to the health facility staff that the patient no longer wants this person to visit.

18. Have the patient’s wishes considered for purposes of determining who may visit if the patient lacks decision-making capacity and to have the method of that consideration disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in the household.

19. This section may not be construed to prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

All hospital personnel must observe these patients’ rights.

NOTE: In addition to the Title 22 patients’ rights listed above, hospitals participating in the Medicare or Medicaid (Medi-Cal) program are required to inform each patient of his or her rights under federal law (see IV. “Patients’ Rights Under Federal Law,” page 1.8). The Joint Commission also requires that accredited hospitals inform patients of their rights [R.I.01.01.01]. CHA’s sample poster combines the patients’ rights requirements of Title 22 and other state laws, Medicare regulations and The Joint Commission. The text of this poster is included in this manual as CHA Appendix 1-A, “Patient Rights.” CHA members may download posters or order them through CHA’s website at www.calhospital.org/free-resources then “Forms and Posters.”

B. **Right to Non-Discriminatory Treatment**

The Unruh Civil Rights Act [Civil Code Sections 51-53] prohibits discrimination by business establishments — including those that provide medical services — on the basis of a person’s sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, or immigration status (unless required by federal law). [Civil Code Sections 51-53]

California hospital licensing regulations also prohibit discrimination. Title 22, California Code of Regulations, Section 70715 states that:

> No hospital shall discriminate against any person based on sex, race, color, religion, ancestry, national origin, sexual orientation, disability, medical condition, marital status, or registered domestic partner status, except as provided herein. This provision shall apply to the appointment of the medical staff, hiring of hospital employees, and the admission, housing, or treatment of patients.

An additional law prohibits discrimination in the provision of emergency care. Emergency services may not be based upon, or affected by, a person's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services or any other characteristic listed in the Unruh Civil Rights Act, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient. These services must be rendered without first questioning the patient or any other person regarding the patient’s ability to pay for treatment. Payment information may be obtained after the services are rendered. [Health and Safety Code Section 1317] (For more information, see “Health and Safety Code Section 1317,” page 12.21.)

**DEFINITIONS**

“Disability” means any mental disability or physical disability as defined in Government Code Sections 12926 and 12926.1.

“Medical condition” means a health impairment related to a diagnosis or history of cancer, or genetic or inherited characteristics [Government Code Section 12926].

“Sex” includes, but is not limited to, pregnancy, childbirth, or medical conditions related to pregnancy or childbirth. “Sex” also includes, but is not limited to, a person's gender.

“Gender” means sex, and includes a person's gender identity and gender expression. “Gender expression” means a person’s gender-related appearance and behavior whether or not stereotypically associated with the person’s assigned sex at birth.
C. Right to Know the Identity of Persons Caring for the Patient

The Title 22-required patients’ rights poster includes a provision stating that patients have the right to know the name of their caregivers (see A. “Notice of Patients’ Rights,” page 1.3). A different Title 22 provision requires that all employees of the hospital having patient contact, including students, interns and residents, must wear an identification tag bearing their name and vocational classification [Title 22, California Code of Regulations, Sections 70721 (general acute care hospitals) and 71521 (acute psychiatric hospitals)].

In addition, Business and Professions Code Section 680 requires each health care practitioner to disclose, while working, his or her name and license status, as granted by the state of California, on a name tag in at least 18-point type.

At one time, CDPH had required that both the first and last name must be on the employee’s name tags, but changed its interpretation of the law after a nurse was stalked by a patient. It now appears that just first or last name is satisfactory.

It is unlawful for any person to use the title “nurse” unless that person is a registered nurse or licensed vocational nurse. A certified nurse assistant may use the title of “certified nurse assistant.”

A health care facility licensed by CDPH must implement policies and procedures to ensure that health care practitioners wear identification tags.

EXCEPTIONS

A health care practitioner in a practice or office, whose license is prominently displayed, may opt to not wear a name tag. If a health care practitioner or a licensed clinical social worker is working in a psychiatric setting or in a setting that is not licensed by the state, the employer may make an exception from the name tag requirement for safety or therapeutic reasons.

VISITING FACULTY MEMBERS

A person who does not immediately qualify for a California physician and surgeon’s certificate and who is offered a full-time faculty position by a medical school may, after approval by the Medical Board of California, be granted a certificate of registration to engage in the practice of medicine to the extent that the practice is incident to and a necessary part of his or her duties connection with the faculty position. When providing clinical services, the physician must wear a visible name tag containing the title “visiting professor” or “visiting faculty member,” as appropriate. The institution at which the services are provided must obtain a signed statement from each patient to whom the registrant provides services acknowledging that the patient understands that the services are provided by a person who does not hold a physician and surgeon’s certificate but who is qualified to participate in a special program as a visiting professor or faculty member. [Business and Professions Code Section 2113]

VISITING FELLOWS

Physicians who are not citizens and who seek postgraduate study in an approved medical school may, after approval by the Medical Board of California, be permitted to participate in the professional activities of a medical school. The physician must be under the direction of the head of the department and supervised by staff from the medical school’s medical center. The physician must wear a visible name tag containing the title “visiting fellow” when he or she provides clinical services. [Business and Professions Code Section 2111]

INDIVIDUAL PRACTITIONERS

An additional requirement exists for specified types of licensed health care practitioners; however, this requirement does not apply to practitioners who work in general acute care hospitals, acute psychiatric hospitals, skilled nursing facilities, other facilities or a clinical laboratory. This requirement, in brief, requires health care practitioners to communicate to each patient his or her name, state-granted practitioner license type, and highest level of academic degree, by one or both of the following methods:

1. In writing at the patient’s initial office visit.
2. In a prominent display in an area visible to patients in his or her office. If this method is used, the sign must be in at least 24-point type in the following format:

<table>
<thead>
<tr>
<th>Health Care Practitioner Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name and license.</td>
</tr>
<tr>
<td>2. Highest level of academic degree.</td>
</tr>
<tr>
<td>(Nurses and pharmacists need not list this item)</td>
</tr>
<tr>
<td>(For physicians who are board certified)</td>
</tr>
</tbody>
</table>

In addition, a health care practitioner who has a website must prominently display the information listed above on the website. (See Business and Professions Code Section 680.5 for further information about this requirement.)
**PHYSICIAN ASSISTANT TRAINEES**

The California physician assistant examining committee prohibits trainees from providing general medical services to patients, unless the patient has been informed that the services will be rendered by that trainee.

If a trainee will provide or assist in surgical procedure, the patient on each occasion must be informed of the procedure to be performed by that trainee under the supervision of the program’s instructors or physician preceptors. The patient must consent in writing prior to the performance of the surgical procedure. These requirements do not apply in emergencies.

Because this regulation specifies that the patient must be informed of the role of the physician assistant trainee on each occasion, language in a “Conditions of Admission” form that the patient signs only once is not sufficient. [Title 16, California Code of Regulations, Section 1399.538]

**D. California Right to Visitors**

The Title 22-required patients’ rights poster states that a patient has the right to designate visitors of his or her choosing, if the patient has decision-making capacity, whether or not the visitor is related by blood, marriage, or registered domestic partner status. (See A. “Notice of Patients’ Rights,” page 1.3.)

The health facility may, however, restrict visitation in the following circumstances:

1. No visitors are allowed.
2. The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility.
3. The facility reasonably determines that a particular visitor would significantly disrupt the operations of the facility.
4. The patient has indicated to the health facility staff that the patient no longer wants this person to visit.

The patient also has the right to have his or her wishes considered for purposes of determining who may visit if the patient lacks decision-making capacity. [Title 22, California Code of Regulations, Section 70707(b)(17-19)]

The hospital must have a visitation policy that describes how a patient’s wishes will be considered for determining who may visit if the patient lacks decision-making capacity. At a minimum, the hospital policy must provide for the inclusion of any persons living in the household. In addition, the law specifically states that a patient’s registered domestic partner, the children of the domestic partner, and the domestic partner of the patient’s parent or child must be permitted to visit, unless one of the exceptions noted above applies. [Health and Safety Code Section 1261]

A health facility may establish reasonable restrictions for visitation, including the hours of visitation and number of visitors.

**INTERACTION WITH FEDERAL LAW**

Federal law also regulates a patient’s right to visitors (see “Federal Right to Visitors and Support Persons,” page 1.11). The hospital’s policy must comply with both state and federal law.

**E. Right to Be Informed of Continuing Care Requirements After Discharge**

Patients must be informed, orally or in writing, of continuing health care requirements following discharge from the hospital. If the patient lacks capacity to make health care decisions, the right to this information applies to the person who has legal responsibility to make health care decisions for the patient. In addition, a patient may request that friends or family members be given this information, even if the patient is able to make his or her own health care decisions. [Health and Safety Code Sections 1262.5 and 1262.6]

Specifically, the hospital must give each patient, upon admission or as soon thereafter as reasonably practical, written information about the patient’s right to:

1. Be informed of continuing health care requirements following discharge from the hospital.
2. Be informed that, if the patient so authorizes, a friend or family member may be given information about the patient’s continuing health care requirements after discharge.
3. Participate actively in decisions about medical care. To the extent permitted by law, this includes the right to refuse treatment.

This information may be included with other notices to the patient regarding patient rights. The form “Patient Rights” (CHA Appendix 1-A) fulfills this requirement.

The patient also has the right to designate a family caregiver who will assist in posthospital care. The hospital must permit the patient and the caregiver (if any) to participate
in the discharge planning process and receive instruction about posthospital care needs.

(See chapter 12 for a general discussion of information that must be given to patients upon discharge.)

F. Right to Have Family Member and Personal Physician Notified of Admission

If a hospital emergency department receives a patient who is unconscious or otherwise incapable of communication, the hospital must, within 24 hours, make reasonable efforts to contact the patient’s agent (appointed in a power of attorney for health care), surrogate, or a family member or other person the hospital reasonably believes has the authority to make health care decisions for the patient. HIPAA permits this notification [Probate Code Section 4717; 45 C.F.R. Section 164.510(b)].

A hospital will have fulfilled this requirement if it does all of the following:

1. Examines the personal property, if any, accompanying the patient.
2. Examines any medical records regarding the patient.
3. Reviews any verbal or written report made by emergency medical technicians or the police.
4. Contacts or attempts to contact any agent, surrogate, or a family member or other person the hospital reasonably believes has the authority to make health care decisions for the patient, that was identified during the search of the property and records noted above.
5. Contacts the California Secretary of State, directly or indirectly (including by voice mail or fax), to ask whether the patient has registered an advance health care directive, if the hospital finds or is given an Advance Health Care Directive Registry identification card. (See K. “Hospital Obligations When Receiving Unconscious Patients,” page 3.9.)

The hospital must document in the patient's medical record all efforts made to contact a potential substitute decision maker.

This law is suspended during any period in which the hospital implements its disaster and mass casualty program, or its fire and internal disaster program.

In addition, hospitals participating in the Medicare or Medicaid (Medi-Cal) program must give patients the right to have a family member or representative of his or her choice and his or her own personal physician promptly notified of the admission to the hospital [42 C.F.R. Section 482.13(b)(4)]. The hospital must document that:

1. The patient (unless incapacitated) was asked no later than the time of admission whether he or she wanted a family member or other representative notified of his or her admission;
2. The date, time and method of notification (if the patient requested that someone be notified); or
3. The patient declined to have notice provided.

If the patient was incapacitated at the time of admission, the medical record must indicate the steps taken to identify and provide notice to a family member or representative and to the patient’s physician. [Hospital Interpretive Guidelines, Tag A-0133]

Special requirements apply to notifying family members about the admission of mental health patients. (See E. “Special Requirements for a Minor,” page 15.15, and IV. “Informing Family and Others of Patient’s Admission, Release and Condition,” page 16.6, for more information.)

G. Readable Documents

Most printed materials provided to patients or residents by general acute care hospitals, skilled nursing facilities, other facilities or their agents must be printed in at least a 12-point font that is clear and legible. This requirement does not apply to psychiatric hospitals. The term “agents” is not defined.

The materials that must be in 12-point or greater type include:

1. Admission and discharge papers and forms.
2. Medical and therapeutic instructions prepared by the facility specifically for an individual upon his or her discharge.
3. Conditions of admission forms.
4. Agreement to assume financial responsibility between a patient and a facility.
5. Instructions and forms for advance health care directives.
6. Information produced by the hospital or facility regarding the rights and responsibilities of patients, and regarding grievances and appeals, forms and instructions.
7. Correspondence written, printed, or produced by facilities (not by agents).

A facility’s policies and procedures are excluded from the 12-point font requirement. [Health and Safety Code Section 123222.1]
NOTE: An authorization for the release of medical information must be in 14-point font [Civil Code Section 56.17] (see chapter 8 for information about these authorizations).

IV. PATIENTS’ RIGHTS UNDER FEDERAL LAW

Federal law requires that hospitals participating in the Medicare or Medicaid (Medi-Cal) program protect and promote each patient’s rights, as discussed below. These rights apply to all patients, not just Medicare and Medicaid patients. [42 U.S.C. Section 18116; 42 C.F.R. Sections 482.13 and 489.10; 45 C.F.R. part 92]

A. Right to Nondiscriminatory Treatment:
Section 1557

INTRODUCTION

Section 1557 of the Patient Protection and Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in any health program or activity, any part of which is receiving federal financial assistance. A hospital that participates in the Medicare or Medicaid (Medi-Cal) program receives federal financial assistance, and thus must comply with this law.

ENFORCEMENT AND RESOURCES

This law is enforced by the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services. OCR has posted educational materials about the law, sample documents, and answers to FAQs at www.hhs.gov/civil-rights/for-individuals/section-1557.

An individual or entity may also bring a civil action to challenge a violation of Section 1557 in federal court. [42 U.S.C. Section 18116; 45 C.F.R. part 92]

NOTICE OF NONDISCRIMINATION

Hospitals and other entities subject to Section 1557 (called “covered entities”) must notify beneficiaries, enrollees, applicants, and members of the public of the following:

1. The covered entity does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities;

2. The covered entity provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when necessary to ensure an equal opportunity to participate to individuals with disabilities;

3. The covered entity provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner, when necessary to provide meaningful access to individuals with limited English proficiency;

4. How to obtain the aids and services described in paragraphs (2) and (3) above;

5. Identification of, and contact information for, the employee responsible for implementing these nondiscrimination requirements and investigating complaints;

6. The availability of a grievance procedure and how to file a grievance; and


OCR has developed a sample notice and a sample nondiscrimination statement that may be used to fulfill this requirement, found in many languages at www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources.

Alternatively, a covered entity may combine the content of the Section 1557 notice with other notices given to patients. CHA Appendix 1-A does not include the Section 1557 information.

POSTING THE NOTICE

Each covered entity must:

1. Post the entire notice in a conspicuously-visible font size:

   a. In significant publications and significant communications targeted to beneficiaries, enrollees, applicants, and members of the public, except for significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures;

   b. In conspicuous physical locations where patients and the public are likely to see it; and

   c. In a conspicuous location on the covered entity’s web site accessible from the home page.

2. Post the nondiscrimination statement (not the entire notice) in a conspicuously-visible font size, in significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures.

OCR requires posting only in English, although a covered entity may post notices and nondiscrimination statements in other languages if it wishes.
**LGBTQ INDIVIDUALS**

As mentioned above, Section 1557 of the ACA requires hospitals and other covered entities to provide equal access to its health programs or activities without discrimination on the basis of sex. Federal regulations define “on the basis of sex” to include, but not be limited to, discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity.

There is ongoing litigation about whether the federal regulation improperly defined “on the basis of sex” to include gender identity and termination of pregnancy. The U.S. District Court for the Northern District of Texas issued an opinion in *Franciscan Alliance, Inc. et al v. Burwell*, enjoining the regulation’s prohibitions against discrimination on the basis of gender identity and termination of pregnancy on a nationwide basis. Accordingly, OCR may not enforce these two provisions while the injunction remains in place. However, OCR will continue to enforce the prohibitions against discrimination on the basis of race, color, national origin, age, or disability, as well as other sex discrimination provisions that are not impacted by the court’s order.

California hospitals should be aware that state law has prohibited discrimination on the basis of gender identity for many years. Hospitals should consult their legal counsel if they have questions about providing services that contradict their religious tenets.

[45 C.F.R. Section 92.206]

**Definitions**

“Gender identity” means an individual’s internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual’s sex assigned at birth. The way an individual expresses gender identity is frequently called “gender expression,” and may or may not conform to social stereotypes associated with a particular gender. A transgender individual is an individual whose gender identity is different from the sex assigned to that person at birth.

“Sex stereotypes” means stereotypical notions of masculinity or femininity, including expectations of how individuals represent or communicate their gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics. These stereotypes can include the expectation that individuals will consistently identify with only one gender and that they will act in conformity with the gender-related expressions stereotypically associated with that gender. Sex stereotypes also include gendered expectations related to the appropriate roles of a certain sex.

[45 C.F.R Section 92.4]

**DESIGNATION OF COMPLIANCE COORDINATOR**

Each covered entity that employs 15 or more persons must designate at least one employee to coordinate its efforts to comply with Section 1557, including investigating any grievances or allegations of any action that would be prohibited by Section 1557. OCR calls this person a “Civil Rights Coordinator” or “Section 1557 Coordinator” in its sample notices; however, a different job title may be used. This function can be combined with other job duties so long as there is no conflict of interest. [45 C.F.R. Section 94.7]

**GRIEVANCE PROCEDURES**

Each covered entity that employs 15 or more persons must adopt grievance procedures that incorporate appropriate due process standards and that provide for the prompt and equitable resolution of grievances alleging any action that would be prohibited by Section 1557. The law contains no specific requirements for the Section 1557 grievance procedure. However, the Medicare Conditions of Participation contain very specific requirements that hospital grievance procedures must meet (see VIII, “Patient Complaints,” page 1.25). Hospitals may wish to adopt the same procedures for both types of complaints. [45 C.F.R. Section 94.7]

OCR has developed a sample complaint procedure, which is found at www.hhs.gov/civil-rights/for-individuals/section-1557.

**B. Requirements of the Medicare COPs**

Hospitals that participate in the Medicare or Medicaid (Medi-Cal) program are required to comply with the Conditions of Participation (CoPs). The CoPs are regulations, and are found in 42 C.F.R. part 482 (for hospitals and psychiatric hospitals) and in part 485 (for critical access hospitals). The Centers for Medicare and Medicaid Services (CMS) have published *Interpretive Guidelines* that provide guidance about how hospitals and critical access hospitals will be evaluated for compliance with the CoPs. (See “Where to Find Laws Referenced in the Manual” — found at the very beginning of this manual before chapter 1 — for more information about the *Interpretive Guidelines*.)
Index

SYMBOLS

5150, 15.7 to 15.29

A

Abandoned minors—See Minor patients, abandoned, See also Safe surrender of newborn
Abandonment of newborn—See Safe surrender of newborn
Abbreviations in medical record, 7.2, 7.10
Abortion
Agent may not consent to, 3.11
Child abuse, 17.13
Consent to, 5.21 to 5.22
Partial-birth, 5.20
Refusal to participate in, 5.20
Release from responsibility for treatment of miscarriage or partial abortion, 5.22
Signage, 5.20
Absence from facility, 12.20, 12.36 to 12.37—See also Disappearance of patient, See also Leaving hospital against medical advice
Abuse—See Child abuse, See Elder and dependent adult abuse
Alcohol—See Alcohol or drug abuse
Child—See Child abuse
Dependent adult—See Elder and dependent adult abuse
Domestic, 17.31 to 17.32
Drug—See Alcohol or drug abuse
Elder—See Elder and dependent adult abuse
Forensic medical reports, 17.12, 17.26
Maternity patient abusing substances, 13.3
Partner—See Domestic abuse
Patient rights advocates, 16.10 to 16.16
Records related to abuse, 17.11 to 17.19
Refusal/withdrawal of life-sustaining treatment, 6.20
Sexual—See Child abuse; Domestic abuse; Elder and dependent adult abuse; and Sexual assault treatment
Spousal, 17.31 to 17.32
Substance—See Alcohol or drug abuse
Accounting of disclosures, 8.4
Acknowledgment of notice of lack of physician in-house coverage, 12.23
Acknowledgment of notice of physician ownership, 11.7
Acknowledgment of paternity, 13.8
Acquired Immune Deficiency Syndrome (AIDS)—See Human Immunodeficiency Virus (HIV)
Admission to facility, 11.1 to 11.16
Advance directives—See Patient Self-Determination Act
Information to be given to patient, 1.1 to 1.2, 11.6, 16.4
Involuntary admission, psychiatric patient, 15.7 to 15.34
Patient Self-Determination Act, 1.1
Voluntary admission, psychiatric patient, adult, 15.1 to 15.3
Voluntary admission, psychiatric patient, minor, 15.3 to 15.7
Adopted minors—See Minor patients, adopted
Advance directives, 1.1 to 1.26, 3.3 to 3.15, 6.10, 6.13, 11.7—See also Patient Self-Determination Act, See also Surrogate decision maker
Anatomical gift, 3.10, 3.13, 14.15
Consent for autopsy, 3.10, 14.8 to 14.9
Declining to comply, 3.12
Divorced spouse as agent, 3.8
Documentation, 1.2, 3.13
Duration, 3.8
Electronic, 3.6
Font size, 1.3
Forgoing life-sustaining treatment, 3.12, 6.12
HIV/AIDS, 5.4
Limitations, 3.11
Military, 3.7
Notarization, 3.5
Psychiatric, 3.15
Registration with Secretary of State, 3.8
Revocation, 3.8
Witnessing, 3.5
Adverse event reporting, 19.7 to 19.11
Adverse reactions to vaccines, 18.14
Aftercare plan, 12.8, 12.8 to 12.9, 16.9
Agent—See Advance directives
Aid in dying—See End of Life Option Act
AIDS—See Human Immunodeficiency Virus (HIV)
Alcohol or drug abuse, 4.15, 8.1, 9.3, 13.3, 15.2,
15.13 to 15.15
Alternative dispute resolution—See Arbitration
Ambulance companies, release of patient information to,
18.10
Amendment of medical record—See Medical record,
amendment of
Americans with Disabilities Act, 1.13, 1.16
Anatomical gift, 3.10, 3.13, 14.9 to 14.19
  Confidentiality, 14.19
  Medical marijuana, 5.51
  Minor, 4.16
  Nondiscrimination, 5.51
  Refusing to make, 14.13
  Removal of parts, 14.17
  Returning unused parts or cremated remains, 14.17
Ancillary services notice, 11.9
Animal bites, 18.8
Animals in facility, 1.16
Anti-dumping laws—See Transfer, patient
Antipsychotic medications—See Psychotropic
medications
Apology, 19.7
Arbitration, 3.10, 11.14
  Medical staff members, 11.16
  Rescission, 11.16
Area agencies on aging, 12.9
Assault
  Sexual—See Sexual assault
Assignment of insurance benefits, 11.3, 11.10
Assignment of proceeds of claim, 11.12
Assisted reproduction procedures, 5.44 to 5.46
Attorney
  Attorney-client privilege, 19.1
  Report of incident to attorney, 19.1
Audiorecording, 8.13
Audit trails, 7.14
Authorization
  For use or disclosure of health information, 8.4
Autopsy, 14.8
Auxiliary aids, 1.13
B

Baby stalking, 13.5
Balance billing, 11.5
Battery, unconsented treatment as, 2.1, 11.1
Bills, 4.2, 12.37
Birth certificate, 13.6 to 13.16, 14.7
Birth control—See Contraception
Blind individuals, 1.13
Blood—See also Human Immunodeficiency Virus (HIV)
  Donation by minors, 4.16
  Paul Gann Blood Safety Act, 5.2
  Refusal of, 6.4
  Tests requested by law enforcement officers, 5.5,
  9.3 to 9.5
Blood transfusion, reaction, 19.14
Blood transfusions/products
  Consent to, 5.1
  Lookback notification, 18.16
  Notification of recipient of infected transfusion, 18.17
  Refusal of, 6.4
Bodies
  Disposition of, 14.19 to 14.22
  Disputes concerning, 14.21
  Donated for research purposes, 14.9 to 14.19
  Fetal remains, 13.10, 14.22
Body piercing, minors, 4.16
Born-Alive Infants Protection Act, 6.18, 12.28
Brain death—See Death
Breach of privacy or security, 4.2, 4.15, 7.17, 8.2, 8.3
Breast cancer
  Consent to treatment for, 5.24
  Mastectomy patient length of stay, 12.7
Breastfeeding, 13.15

C

California Department of Health Care Services (DHCS),
15.2
California Department of Public Health (CDPH), 1.5, 8.3,
15.1, 19.3
California Department of Social Services (CDSS), 15.2
California Highway Patrol—See Law enforcement officers
Cancer registry, 18.13
Capacity, 3.1, 3.4, 4.11
Caregiver authorization affidavit, 4.5
Car seats, children, 12.5
CD4+ T-Cell results, 18.7
CDPH—See California Department of Public Health
(CDPH)
CDSS—See California Department of Social Services
(CDSS)
Cells—See Tissue
Certificate—See Birth certificate; Death, certificate of;
Fetal death
Chaplains—See Clergy
Chargemaster, 11.11
Charity care—See Financial assistance
Child abuse, 4.10, 17.7 to 17.19
  Abuse-related exams, 4.14, 8.12, 17.12
  Newborn abandonment, 13.17 to 13.19
  Refusal/withdrawal of life-sustaining treatment, 6.20
  Reporting of, 8.4, 17.7 to 17.19
Childbirth—See Maternity patient
Child passenger restraint system, 12.5
Children—See Minors
Child seats, 12.5
Chromosomal defects, 13.12
Chronic intractable pain, 5.47
Clergy
  Reporting child abuse, 17.10
  Reporting elder or dependent adult abuse, 17.20
Cloning of humans, 10.21
Collagen injections, consent to, 5.25
Common law marriage, 4.13
Communicable diseases—See Reportable diseases/conditions
Communication barriers, 1.19
Competency—See Capacity
Complaints—See Grievance procedure
Computed tomography—See CT studies (computed tomography)
Conditions of admission, 11.1 to 11.16
  Arbitration, 11.14
  Assignment of benefits, 11.3, 11.10
  Assuring payment through conditions of admission, 11.10
  Assuring payment through other methods, 11.11 to 11.14
  Consent for use of organs, tissues and fluids for research or commercial purposes, 5.1, 11.5
  Financial agreement, 11.3
  Length of time valid, 11.6
  Maternity patients, 11.2
  Mental health patients, adults (voluntary), 15.3
  Mental health patients, (involuntary), 15.15
  Procedure, 11.5
Confidentiality of Medical Information Act (CMIA), 8.1
Congenital heart disease screening, 13.13
Consent
  Abortion, 5.21 to 5.22
  Adult patient, 2.1, 3.1
  Anatomical gift—See Anatomical gift
  Assisted reproduction procedures, 5.44 to 5.46
  Autopsy, 3.10, 14.8 to 14.9
  Blood transfusion, 5.1
  Breast cancer treatment, 5.24
  Capacity to consent, 3.1, 3.4, 4.11
  Cells, organs, tissue and fluids, 5.1, 5.43 to 5.44, 11.5
  Closest available relative, 3.24
  Coerced, 2.12
  Collagen injections, 5.25
  Complicated procedures, 2.6
  Consent by telephone, email and facsimile, 2.14
  Contraception—See Contraception
  Convulsive therapy, 5.35 to 5.39
  Deafness screening, 13.12
  Developmentally disabled adult, 3.18, 5.12
  Documentation, 2.10, 3.12
  Domestic partner, 3.24
  Do not resuscitate, 6.12 to 6.13, 6.22 to 6.24
  Duration, 2.11
  Duty to obtain, 2.10 to 2.12
  Electroconvulsive therapy, 5.35 to 5.39
  Email, 2.14
  Emergency treatment exception, 2.3, 3.10
  Experimental treatment, 10.12 to 10.20
  Facsimile, 2.15
  Failure to obtain, 2.1 to 2.3
  Family members, 6.14, 6.16
  Fluids, tissue, organs, and cells, 5.1, 5.43 to 5.44, 11.5
  Font size on forms, 1.7
  Gynecological cancer, 5.24
  Gynecological exam, annual, 5.24
  Hearing loss screening, 13.12
  HIV testing, 4.14, 5.3 to 5.10, 13.2
  Hospital role, 2.10
  How to obtain, 2.12 to 2.15
  Hysterectomy, 5.17 to 5.19
  Immunizations, 5.26 to 5.28, 6.5
  Implantation of cells, tissue, organs, 5.1, 5.43 to 5.44
  Implied consent, 2.3 to 2.6, 2.12
  Incompetent patient, 3.15 to 3.18, 5.12, 6.10 to 6.11, 6.15
  Infertility procedures—See Assisted reproduction procedures
  Informed, 2.1, 2.6 to 2.12
  Insulin coma treatment, 5.35 to 5.39
  Interpreter, 1.19
  Interrogation by law enforcement officer, 9.6
  Investigational drugs and devices, 10.3 to 10.5—See also Experimental treatment, See also Research
  Mastectomy, length of stay, 12.7
  Maternity, length of stay, 12.7, 13.16
  Mental health treatment, 4.8, 4.14
  Not required, 2.3, 2.4
  Oral, 2.14
  Organs, cells, tissues and fluids, 5.1, 5.43 to 5.44, 11.5
  Pelvic exam while unconscious, 5.49
Photograph—See Photograph, consent to
Physician role, 2.9, 5.1, 6.13, 6.17, 6.20
Prisoner, 3.3, 9.1 to 9.10—See also Prisoners
Prostate cancer, 5.24
Prostate exams, 5.25
Psychosurgery, 5.33 to 5.35
Request to forgo resuscitative measures, 3.15
Research, 10.12 to 10.20
Reuse of hemodialysis filters, 5.22 to 5.24
Role of the hospital, 2.10
Role of the physician, 2.9, 5.1, 6.13, 6.17, 6.20
Silicon implants, 5.25
Simple and common procedures, 2.6, 11.1
Sterilization, 5.10 to 5.17
Telephone, email and facsimile, by, 2.14
Therapeutic privilege, 2.4
Tissue, organs, cells, and fluids, 5.1, 5.43 to 5.44, 11.5
Two-doctor consent, 2.11
Vaccines, 5.26 to 5.28, 6.5
Written, 2.12 to 2.15, 7.4, 7.8
Conservatorship—See also Guardianship
AIDS/HIV testing, 5.3 to 5.10
Anatomical gift, 14.12
Conditions of admission, 11.5
Consent to experimental treatment, 3.17, 3.22, 10.17 to 10.18
Consent to sterilization, 3.17, 3.22, 5.12
Consent to treatment, 2.1, 3.15 to 3.16, 5.12, 6.15
Developmentally disabled adult, 3.18
Disposition of remains, 14.21
Electroconvulsive therapy, 3.17, 3.22, 5.35 to 5.39
Experimental treatment, 10.17 to 10.18
Forgoing of life-sustaining treatment, 6.15
Lanterman-Petris-Short Act, 3.7, 3.16, 15.27, 15.30 to 15.31
Mental health patient, 15.2, 15.9 to 15.16, 15.27, 15.30
Convulsive treatment, 3.17, 3.22, 5.35 to 5.39
Gravely disabled patient, 15.2, 15.8, 15.16 to 15.19, 15.25 to 15.27, 15.30 to 15.31
Involuntary admission to facility, 3.17, 3.22, 15.7, 15.27, 15.30
Voluntary admission to facility (adult), 3.17, 3.22, 15.1 to 15.3
Permanent, 3.23, 15.21
Probate Code, 3.16, 15.30
Public guardian, 3.18
Relationship to agent appointed in power of attorney for health care, 3.11
Temporary, 3.23, 15.21, 15.30
Contraception
Emergency, 5.42, 17.6
Minor consent to, 4.13
Conversion therapy, 16.8
Convulsive therapy
Agent may not consent to, 3.10
Consent to, 5.35 to 5.39
Conservator may not consent to, 3.17, 3.22
Minor may not consent to, 4.15
Coroner, 14.2, 14.7 to 14.18
Court order authorizing medical treatment, 3.14, 3.20, 6.4, 6.22
Credit reports, 7.15, 11.5
Crimes, reporting, 17.1 to 17.32
CT studies (computed tomography), 7.9, 19.15
Culturally and linguistically appropriate service standards, 1.25

D

Deadly weapon
Possessed by psychiatric patient, 16.19 to 16.21
Deaf individuals, 1.13
Deafness screening, consent for, 13.12
Death, 14.1 to 14.24
Anatomical gift, 14.9 to 14.19
Autopsy, 14.8 to 14.9
Brain death, 14.1, 14.3
Burn, 18.15
Certificate of, 14.4 to 14.6
Child abuse, 17.7 to 17.19
Coroner case, 14.5
Death certificate, 14.4 to 14.6
Dependent adult abuse, 17.19 to 17.30
Disposition of personal property of decedent, 14.22
Disposition of remains, 14.6, 14.19 to 14.22
Documentation in the medical record, 14.2
Do not resuscitate, 6.12 to 6.13, 6.20 to 6.24
Elder abuse, 17.19 to 17.30
Fetal death, 13.9, 14.6, 14.22
Gift of remains, 14.9 to 14.19
Informing family, 14.3, 16.6
In restraints, 14.3, 19.9
In seclusion, 14.3, 19.9
Notifying family and others, 16.7
Pronouncement of, 14.1 to 14.2
Release of body, 14.6, 14.22
Release of information regarding, 14.4 to 14.6
Request to forgo resuscitative measures, 6.12 to 6.13, 6.20 to 6.24
Restrains, 14.3, 19.9
Seclusion, 14.3, 19.9
Sentinel event, 19.5
Time of death, 14.1
Unclaimed dead, 14.22
Uniform Anatomical Gift Act, 14.1—See Anatomical gift
Declaration of paternity, 13.8
Dental restorative materials, 5.47
Department of Health and Human Services (DHHS), 1.10, 12.35, 12.36
Dependent adult abuse, 17.19 to 17.30
Photographs of, 17.27
Dependent child of juvenile court, 4.8, 6.4, 6.8, 8.7
Detailed notice of discharge, 12.2
Detention of patient
Awaiting transfer (mental health patient), 15.33
Endangered adult, 17.29
Tuberculosis patient, 12.12, 18.4
Developmentally disabled adults, 3.3
DHCS—See California Department of Health Care Services (DHCS)
Disability Rights California—See Protection and advocacy
Disappearance of patient
Notifying law enforcement officers, 16.22
Discharge of patient—See also Detention of patient
Aftercare plan, 12.8, 16.9
Against medical advice, 6.5
Child car seat information, 12.5
Considered a transfer under EMTALA, 12.28
Family caregiver, 12.1
Homeless patient, 12.11
Infant, 12.4
Law enforcement notification, 9.8
Mastectomy patient, 12.7
Maternity patient, 12.7, 13.16
Medication information, 12.3
Mental health patient, 12.8, 16.22
Minor patient, 12.4 to 12.9
Notice of discharge rights, 12.2
Patient needing emergency services, 12.23 to 12.36
Patient refuses to leave, 12.10
Temporary release, 12.20, 12.36 to 12.37, 15.19, 15.24, 15.27
Tuberculosis patient, 12.12, 18.4
Discharge planning, 12.1 to 12.38
Disclosure of information—See Medical records, release of information from
Discount payment policy—See Financial assistance
Discrimination, 1.4, 5.11, 12.20, 12.24, 12.34, 14.11
Disposition of embryos, 5.46
Disposition of remains, 13.10, 14.19 to 14.22
DOJ—See California Department of Justice (DOJ)
Domestic abuse or violence, 17.31 to 17.32
Domestic partners, 1.4, 1.6, 1.11, 3.24, 4.3
Do not resuscitate order, 6.12 to 6.13, 6.22 to 6.24
Driver’s license, 8.2
Driving under the influence, 9.3 to 9.5
Drug abuse—See Alcohol or drug abuse
Drug orders—See also Psychotropic medications
Acute psychiatric facility, 7.6 to 7.8
Discharge medications, 12.3
Facsimile by, 7.17
General acute care hospital, 7.5 to 7.6
Severe chronic intractable pain, 5.47
Verbal orders, 7.3, 7.7
Drug substitutions, 5.42
DSS—See California Department of Social Services (DSS)
Duration of consent, 2.11
Duty to warn of dangerous psychiatric patient, 16.16 to 16.19
Dying patients—See Terminally ill patients
Elder and dependent adult abuse, 8.12, 17.19 to 17.30
Photographs of, 8.12, 17.27
Electroconvulsive therapy
Agent may not consent to, 3.10
Consent to, 5.35 to 5.39
Conservator may not consent to, 3.17, 3.22
Minor may not consent to, 4.15
Electronic advance directives, 3.6
Electronic medical records, 7.17
Elements of informed consent, 2.6
Email consent, 2.14
Emancipated minor, 4.12
Embryos—See Assisted reproduction procedures
Emergency contraception, 5.42
Emergency exception to consent requirement, 2.3 to 2.4, 3.10
Emergency Medical Treatment and Active Labor Act (EMTALA)—See Transfer, patient
Emergency Medical Treatment and Labor Act (EMTALA)—See Transfer, patient
Emergency personnel, release of communicable disease information to, 18.10
Endangered adult, 17.29
End-of-life care options, 6.17 to 6.18
End of Life Option Act, 1.2, 6.28 to 6.39
Error, 7.10, 19.8, 19.11
Escape of patient—See Disappearance of patient
Estimate of patient’s bill, 11.11
Ethics committees, 6.21
Euthanasia—See End of Life Option Act
Evidentiary exam, 4.14, 17.7, 17.12
Experimental treatment, 10.1 to 10.24
- Cloning of humans, 10.21
- Embryos, 5.46, 10.22
- Experimental Subject’s Bill of Rights, 10.13, 10.20
- Financial interest, 10.13
- Institutional Review Board, 10.6 to 10.12
- Minors, 10.9 to 10.10, 10.18
- Oocyte retrieval, 10.22
- Stem cell, 10.22
- Who may consent, 3.17, 3.22, 10.17 to 10.20

Facsimile transmission
- Of consent forms, 2.15
- Of medical records, 7.17
Fair pricing—See Financial Assistance
Family caregiver, 11.4, 12.1
Family members, 1.7, 16.6
Family notification, 1.7, 8.6, 12.1, 12.16, 15.16, 16.6
FDA—See Food and Drug Administration (FDA)
Fertility treatment—See Assisted reproduction procedures
Fetal death, 13.9, 14.6
Fetal ultrasound, 13.4
Filming patients—See Photography, consent to
Financial agreement—See Conditions of admission
Financial assistance, 11.11
Financial interest, 2.2, 2.5, 5.1, 10.13
Financial responsibility of parents, 4.2, 4.15
Firearms—See Weapons
Font size on documents, 1.3, 1.7, 11.1
Footprints of newborn, 13.8
Forensic medical reports, 17.12, 17.26
Foster parent—See Minor patients, foster parents
Freedom of choice, 12.9
Funeral director, 13.10, 14.4, 14.22—See also Coroner

Generic drugs, 5.42
Genetic information, 1.4
Genetic testing newborn, 13.10
Google Glass, 8.14
Gravely disabled, 15.1 to 15.3, 15.7 to 15.34
Grievance procedure, 1.9, 16.3
- Complaint about physician, 1.25
- Discrimination complaint, 1.9
- General patient, 1.25
- Privacy complaint, 8.2
- Requirement to have, 1.25

Guardianship—See also Conservatorship
AIDS/HIV, 5.4
Anatomical gift, 14.12
Conditions of admission, 11.5 to 11.6
Consent for minors, 4.4, 6.11, 6.15 to 6.16, 10.10, 10.18
Experimental treatment, 10.9 to 10.10, 10.17 to 10.18
Leaving against medical advice, 6.5 to 6.6
Refusal of treatment, 6.18 to 6.20
Release of records
- Minor, 4.4
- Sterilization, 5.15
Guide dogs, 1.16
Guns—See Weapons

Habeas corpus, 15.17, 15.19, 15.22
Hair dryer, 20.4
Health Insurance Portability and Accountability Act (HIPAA) of 1996, 8.1—See also Medical record
Health plan notification, 12.29
Hearing impaired individuals, 1.13
- Interpreter, 1.13
Hearing loss screening, consent for, 13.12
Heating pad, 20.4
Hemodialysis filters, consent to reuse, 5.22 to 5.24
Heritable or congenital disorders, 13.10
HIPAA—See Health Insurance Portability and Accountability Act (HIPAA) of 1996
Homeless children, 17.15
Homeless patient, discharge of, 12.11
HPV (Human papillomavirus), 5.26
Human experimentation—See Experimental treatment
Human Immunodeficiency Virus (HIV)
- Confidentiality, 8.1
- Consent to HIV test, 5.3 to 5.10, 13.2
- Deceased patients, 5.5
- Lookback notification, 18.16
- Mandatory counseling, 13.3
- Minors, 4.14, 5.4
- Notification of recipient of infected transfusion, 18.17
- Pregnant women, 13.2
- Prisoners, 5.5
- Release of test results, 5.6 to 5.8, 8.1, 18.4 to 18.5
- Reporting, 13.3, 18.4 to 18.5
- Testing by health care provider, 5.3 to 5.10, 13.2
- Without consent of patient, 5.6
- Test results, 5.6 to 5.8, 8.1, 18.4 to 18.5
Human Papillomavirus (HPV)—See HPV
Hypodermic needles, 5.49
Hysterectomy, consent to, 5.17 to 5.19
Identification of practitioners, 1.5, 2.11
Immigrations and customs enforcement, 9.7
Immune globulin, 13.14
Immunity
  Abandoned newborn, 13.17 to 13.19
  Advance directives, 3.14
  Anatomical gifts, 14.18
  Blood draw requested by law enforcement, 9.3 to 9.5
  Child abuse reports, 17.17
  Communicable disease testing after occupational exposure, 5.10
  Dependent adult abuse reports, 17.27
  Detention of mental health patient awaiting transfer, 15.32
  Do not resuscitate, 6.13, 6.21
  Elder adult abuse reports, 17.27
  Emergency treatment, 2.4
  End of Life Option Act, 6.39
  Firearms in possession of psychiatric patients, 16.21
  Health Care Decisions Law, 3.14
  Immunizations, 5.28
  Newborn abandonment, 13.17 to 13.19
  Notification of family of mental health patient, 16.8
  Photographing child abuse victim, 17.17
  Photographing elder or dependent adult abuse victim, 17.27
  POLST, 6.27
  Prehospital do not resuscitate, 6.22 to 6.24
  Providing access to abuse victim, 17.17, 17.27
  Release of involuntary mental health patients, 15.6, 15.12, 15.14, 15.19, 15.24, 15.27, 15.32
  Reporting disorders characterized by lapses of consciousness, 18.9
  Reporting neglected/abused patient transferred from a health facility, 17.31
  Reporting patient “dumping”, 12.35
  Request regarding resuscitative measures, 6.13, 6.21, 6.22 to 6.24, 6.27
  Rescue team, 2.4
  Safe surrender of newborn, 13.17 to 13.19
  Transfer-related actions, 12.35, 15.32
  Vaccines, 5.28
  Immunizations—See Vaccines
  Implantation of cells, tissues, organs—See Tissue
  Implied consent to treatment—See Consent
  Important message from Medicare, 12.2
  Incident reports, 7.10, 19.1
  Independent clinical review, 15.5
  Infant—See Minor patients
  Infant security policy, 13.4
  Infertility—See Assisted reproduction procedures
  Informed consent, 2.6 to 2.12, 5.1—See also Consent
  Injury or neglect in transferred patient, 17.30 to 17.31
  Inmates—See Prisoners
  Institutional Review Board, 10.6 to 10.12
  Insulin coma therapy—See Electroconvulsive therapy
  Interdisciplinary team consent, 3.19 to 3.20
  Interpreter, 1.19 to 1.25
    Admission of minor to mental health facility, 15.5
    Consent, 1.19
    End of Life Option Act, 6.31
    Experimental treatment, 10.12, 10.22
    Genetic testing, 13.11
    Hearing impaired individuals, 1.13
    Sign language, 1.13
    Sterilization consent, 5.15
  Interpretive Guidelines, 1.25
  Interrogation—See Law enforcement officers
  Investigational drugs and devices—See Experimental treatment, Safe Medical Devices Act
  Involuntary treatment—See Mental health patients
  Joint Commission, The
    Advance directive policy, 1.1
    Outcomes of care, 19.7
    Periodic performance review, 19.6
    Reporting outcome of care to patient, 19.7
    Smoking policy, 20.6 to 20.8
    Juvenile court—See Minor patients, Minors in custody of juvenile court
  Knives—See Weapons
  Laboratory test results, 5.6, 5.8, 7.4, 7.6, 7.8, 13.3, 18.1 to 18.5, 18.7
  Labor, inmates in, 13.5
  Language or communication barriers, 1.19
  Lanterman-Petris-Short Act, 3.16, 8.1, 8.6, 15.1, 15.7 to 15.34
  Lapses of consciousness, reporting of, 18.8
  Law enforcement officers—See also Probation officer
    Blood alcohol/drug testing, 9.3 to 9.5
    Body cameras, 8.13
    Child abuse reporting—See Child abuse
    Child safety seat information, 12.5 to 12.9
    Duty to notify of dangerous patient, 16.16 to 16.19
Elder and dependent adult abuse reporting—
   See Elder and dependent adult abuse
Immigrations and Customs Enforcement, 9.7
Interrogation, 9.6
Medical evaluation prior to incarceration, 9.5
Patient in custody of, 3.3, 9.3
Release of information to, 5.5, 9.1 to 9.10, 15.12, 15.19, 16.22, 17.1 to 17.32
Reporting crimes, 17.1 to 17.32—See also Child abuse; Elder abuse; Dependent adult abuse
Temporary custody of minor, 13.16 to 13.17
Treatment requested by, 9.1 to 9.10
Warrant—See Warrant, warrantless search
Leaving hospital against medical advice, 1.3, 6.5 to 6.6, 9.9, 12.12
Legal counsel—See Attorney
Length of stay
   Mastectomy patient, 12.7
   Maternity patient, 12.7, 13.16
Liens
   Hospital, 11.12
   Workers’ compensation, 11.13
Life support—See Refusal of treatment
Life-sustaining treatment—See Refusal of treatment
Limited English proficiency, 1.19
Living will—See Advance directives
Local health officer—See Public health officer
Lookback notification, 18.16
Los Angeles municipal code, 12.11

M

Malpractice, unconsented treatment as, 2.2
Marijuana, 5.51, 20.8 to 20.11
Marriage, common law, 4.13
Married minor—See Minor patients, married minor
Mastectomy patient, 12.7
Maternal substance abuse, 13.3
Maternity patient
   Bloodborne disease testing, 13.2
   Breastfeeding information, 13.15
   Consent for obstetric procedures, 13.5
   Discharge of, 12.7, 13.16
   Experimental treatment, 10.18
   Fetal death certificate, 14.6
   HIV counseling, mandatory, 13.3
   Immune globulin, 13.14
   Inmate in labor, 13.5
   Length of stay, 13.16
   Maternal substance abuse, 13.3 to 13.4, 17.14 to 17.15
   Maternal transmission of AIDS research, 10.21
Midwife, 13.1
Minor, 4.7, 4.13, 13.1, 17.13
Observer at childbirth, 8.16, 13.5, 20.5
Obstetrical care notice, 13.4
Research, 10.21
Stillbirth, 13.9
Substance abuse, 13.3 to 13.4, 17.14
Ultrasound, 13.4
VBAC, 13.1
Mature minor doctrine, 4.12
Mediation—See Arbitration
Medical Board of California, 1.26
Medical devices
   Experimental, 10.1 to 10.24
   Proposition 65, 5.47 to 5.49
   Reporting injuries, 19.11
   Restraints—See Restraints
   Safe Medical Devices Act, 19.11 to 19.14
   Tracking, 19.14
Medical errors, 19.6
Medical record
   Alcohol or drug abuse patient, 8.1
   Alteration of, 7.10
   Amendment of, 7.10, 8.3
   Completion of, 7.10
   Confidentiality of Medical Information Act (CMIA), 8.1
Contents
   Abuse forensic medical reports, 17.12, 17.26
   Advance directive, 1.1
   CT studies, 7.9
   Diagnostic studies, 7.9
   Emergency service, 7.8
   Failure of physician to complete, 7.10
   Family caregiver, 12.1
   General acute care hospital, inpatient, 7.2 to 7.5
   General acute care hospital, outpatient, 7.5 to 7.6
   Incident report, 19.1
   Occupational and physical therapy, 7.9
   Other services, 7.9
   Psychiatric facility, 7.6 to 7.8
   Respiratory therapy, 7.9
Correction, 7.10
Deceased patient, 14.2
Deletion of, 7.14 to 7.16
Destruction of, 7.14 to 7.16
Disposal of, 7.14 to 7.16
Electronic, 7.17
Inpatient, 7.2 to 7.5
Mental health patient, 7.6 to 7.8, 8.1
Minors—See Minor patients
<table>
<thead>
<tr>
<th>Index</th>
<th>CALIFORNIA HOSPITAL ASSOCIATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modifying, 7.10</td>
<td></td>
</tr>
<tr>
<td>Notice of Privacy Practices, 8.3</td>
<td></td>
</tr>
<tr>
<td>Organization of, 7.16</td>
<td></td>
</tr>
<tr>
<td>Outpatient, 7.5 to 7.6</td>
<td></td>
</tr>
<tr>
<td>Patient privacy rights, 8.3</td>
<td>Psychosurgery; Psychotropic medications; Restraints</td>
</tr>
<tr>
<td>Patient Self-Determination Act, 1.1 to 1.3</td>
<td>Adults, involuntary admission, 15.7 to 15.34</td>
</tr>
<tr>
<td>Psychiatric patient—See Medical record, Mental health patient</td>
<td>Adults, voluntary admission, 15.1</td>
</tr>
<tr>
<td>Psychotherapy notes, 8.2</td>
<td>Advocacy programs, 16.10 to 16.16</td>
</tr>
<tr>
<td>Radiation dose, 7.9</td>
<td>Aftercare plan, 12.8 to 12.9, 16.9</td>
</tr>
<tr>
<td>Release of—See Medical record, release of information from</td>
<td>Conservatorship</td>
</tr>
<tr>
<td>Retention, 7.11 to 7.14</td>
<td>Discharge of, 12.8, 12.30</td>
</tr>
<tr>
<td>Security, 7.17</td>
<td>Immunity for detaining—See Immunity</td>
</tr>
<tr>
<td>Storage, 7.16</td>
<td>Involuntary outpatient treatment, 15.33 to 15.34</td>
</tr>
<tr>
<td>Substance use disorder patient, 8.1</td>
<td>Medical record, release of—See Medical record, release of information from, Mental health patient</td>
</tr>
<tr>
<td>Telemedicine, 7.10</td>
<td>Minors, 4.8, 4.14, 15.3 to 15.7</td>
</tr>
<tr>
<td>Transfer patient, 12.18, 12.20, 12.29</td>
<td>Possession of weapon, 16.19 to 16.21</td>
</tr>
<tr>
<td>X-rays, 7.1</td>
<td>Psychiatric advance directives, 3.15</td>
</tr>
<tr>
<td>Medical record, release of information from, 8.1 to 8.17</td>
<td>Psychiatric emergency medical condition, 12.27, 12.30</td>
</tr>
<tr>
<td>Accounting of disclosures, 8.3</td>
<td>Restraint—See Restraints</td>
</tr>
<tr>
<td>Aftercare plan, 12.8 to 12.9, 16.9</td>
<td>Seclusion—See Restraints</td>
</tr>
<tr>
<td>Alcohol or drug abuse patient, 8.1</td>
<td>Mental health treatment, 3.10, 3.17, 3.22, 4.14, 5.28 to 5.37, 15.1 to 15.34, 16.1 to 16.25</td>
</tr>
<tr>
<td>Ambulance companies, 18.10</td>
<td>Mercury in vaccines, 5.28</td>
</tr>
<tr>
<td>Breach, 8.2</td>
<td>Midwife, 13.1, 13.6, 13.13</td>
</tr>
<tr>
<td>Child abuse—See Child abuse</td>
<td>Military advance directives, 3.7</td>
</tr>
<tr>
<td>Dependent adult abuse—See Elder and dependent adult abuse</td>
<td>Minimum necessary, 8.5</td>
</tr>
<tr>
<td>Elder abuse—See Elder and dependent adult abuse</td>
<td>Minor patients</td>
</tr>
<tr>
<td>Facsimile, via, 7.17</td>
<td>Abandoned minors, 4.8, 13.17 to 13.19—See also Safe surrender of newborns</td>
</tr>
<tr>
<td>HIV test results, 8.1</td>
<td>Abortion, 5.21 to 5.22</td>
</tr>
<tr>
<td>Law enforcement officers, to, 9.1 to 9.10, 15.12, 15.19</td>
<td>Access to medical record of, 4.2</td>
</tr>
<tr>
<td>Marketing purposes, 8.12</td>
<td>Acknowledgment of paternity, 13.8</td>
</tr>
<tr>
<td>Mental health patient, 16.6, 16.22</td>
<td>Admission to psychiatric facility, 15.3 to 15.7</td>
</tr>
<tr>
<td>Minors’ records, 4.2</td>
<td>Adopted, 4.3, 4.7</td>
</tr>
<tr>
<td>Patient, to the, 8.3</td>
<td>AIDS, 4.14, 5.4</td>
</tr>
<tr>
<td>Transfer patient, 12.18, 12.20, 12.29</td>
<td>Alcohol or drug abuse, 4.15</td>
</tr>
<tr>
<td>Medical screening exam, 12.27</td>
<td>Anatomical gift, 4.16, 14.12</td>
</tr>
<tr>
<td>Medical staff quality assurance, 19.1</td>
<td>Baby stalking, 13.5</td>
</tr>
<tr>
<td>Medicare, 11.7</td>
<td>Blood donation, 4.16</td>
</tr>
<tr>
<td>Important message from, 12.2</td>
<td>Body piercing, 4.16</td>
</tr>
<tr>
<td>Medication errors, 19.11</td>
<td>Born-Alive Infants Protection Act, 6.18, 12.28</td>
</tr>
<tr>
<td>Medications</td>
<td>Capacity to consent, 4.11</td>
</tr>
<tr>
<td>Aftercare plan, 12.8 to 12.9, 16.9</td>
<td>Caregiver authorization affidavit, 4.5</td>
</tr>
<tr>
<td>Antipsychotics—See Psychotropic medications</td>
<td>Child abuse—See Child abuse</td>
</tr>
<tr>
<td>Consultation, 5.41 to 5.43</td>
<td>Child passenger restraint system, 12.5 to 12.6</td>
</tr>
<tr>
<td>Discharge, 5.41, 12.3</td>
<td>Children of domestic partners, 4.3</td>
</tr>
<tr>
<td>Drug substitutes, 5.42</td>
<td>Children of minor parents, 4.7</td>
</tr>
<tr>
<td>Drug used as a restraint, 1.10, 5.28</td>
<td>Child seats, 12.5 to 12.6</td>
</tr>
<tr>
<td>Emergency contraception, 5.42, 17.6</td>
<td></td>
</tr>
</tbody>
</table>
Communicable disease, 4.14
Consent, 4.1 to 4.2
Contraception, 4.13, 5.42
Deafness screening, consent for, 13.12
Dependent child of juvenile court—See Dependent child of juvenile court
Disagreement with parents, 4.10
Discharge from hospital, 12.4 to 12.5, 12.4 to 12.6
Divorced minor, 4.13
Divorced parents, 4.3
Drug- or alcohol-related problems, 4.15
Emancipation, 4.12
Experimental treatment, 10.9 to 10.10, 10.18
Footprints of infant, 13.8
Foster parents, 4.9
Gravely disabled, 15.15
Guardian consent, 4.4
Hearing loss screening, consent for, 13.12
Homeless, 17.15
Infant security policy, 13.4
Married minor, 4.13
Medical record, 4.2
Mental health treatment, 4.8, 4.14, 15.3 to 15.7
Minors born out of wedlock, 4.3
Minors in custody of juvenile court, 4.8, 5.32, 6.4, 6.8
Minors in custody of law enforcement, 9.2
Minors in custody of probation officer, 4.9
Minors in custody of social worker, 4.9
Minors on active duty with U.S. armed forces, 4.13
Minors placed for adoption, 4.7
Newborn abandonment, 13.17 to 13.19
Newborn photography, 8.11
Nonabandoned minors, 4.8
Parental consent, 4.3 to 4.4
Parental financial responsibility, 4.2
Parents unavailable, 4.8
Paternity declaration, 13.8
Peace officer temporary custody, 13.16 to 13.17
Photographs of—See Photographs, consent to Piercing, 4.16
Pregnancy care, 4.13
Privacy rights, 8.7, 8.7 to 8.8
Pupils, 4.7
Rape victims, 4.14, 17.5 to 17.7
Refusal of genetic testing, 13.11
Refusal of prophylactic eye drops, 13.13
Refusal of treatment, 6.1, 6.3 to 6.4, 6.11, 6.16, 6.18 to 6.20, 12.28, 13.13 to 13.14
Release from hospital, 12.4 to 12.9
Release of infants, 12.4 to 12.9
Research, 10.9 to 10.10, 10.18
Safe surrender of newborn, 13.17 to 13.19
Self-sufficient minors, 4.12
Sexual assault victims, 4.14, 17.5 to 17.7
Sexually transmitted disease—See Sexually transmitted disease
Shaken baby syndrome, 13.14
Substance abuse—See also Alcohol or drug abuse
Substance use disorder, 4.15
Sudden Infant Death Syndrome (SIDS), 13.14
Suffering from a communicable reportable disease, 4.14
Temporary custody of infant, 13.16 to 13.17
Third-party consent, 4.5 to 4.7
Transfer, 12.5, 12.13 to 12.38
Withdrawal or withholding of life-sustaining treatment, 6.3, 6.6, 6.18, 12.28
With legal capacity to consent to medical treatment, 4.11
Moore v. Regents of the University of California, 5.1, 11.5

N

Name tags on hospital employees, 1.5
Neglect—See Child abuse; Elder and dependent adult abuse
Neural tube defects, reporting of, 13.12
Newborn—See Minor patients
Newborn abandonment—See Safe surrender of newborn
No code order—See Do not resuscitate order
Noncustodial parent, 4.3
Notary public, 3.5, 20.5
NOTICE Act, 12.9
Notice of discharge, 12.2
Notice of Financial Responsibility, 12.22
Notice of Privacy Practices, 1.10, 8.3, 11.7
Notification of family, 1.7, 12.1, 12.16, 15.16
Notification of health plan, 12.29

O

Observer of childbirth/medical procedure, 8.16, 13.5, 20.5
Obstetrical care notice, 13.4
Occupational injuries, 18.18
Exposure to blood or bodily fluids, 5.5, 5.7 to 5.10, 18.10
Pesticide injuries, 18.15
Release of records regarding, 18.15, 18.18
Office for Civil Rights (OCR), 1.8, 1.16, 8.2
Off-label drug use, 10.4
Oocyte retrieval, 10.22
Opioids, 5.39
Ophthalmic treatment, newborns, 13.13
Organ donation—See Anatomical gift
Organs—See Tissue
Outcomes, informing patients, 19.7
Outpatient and discharge medications, consent to, 5.41, 12.3
Outpatient involuntary treatment, 15.33 to 15.34
Outpatient service availability, notice of, 11.8
Ova—See Assisted reproduction procedures

PAHRA—See Patient Access to Health Records Act (PAHRA)

Pain, severe, 2.3, 5.47, 7.4, 7.8
Parkinson’s Disease registry, 18.14
Partial birth abortion, 5.20
Partner abuse, 17.19 to 17.30, 17.31 to 17.32
Paternity, acknowledgment of, 13.8
Patient-authorized disclosures, 8.3
Patient consent—See Consent
Patient death—See Death
Patient records—See Medical record
Patient rights, 1.3 to 1.26, 11.7, 16.1 to 16.25
Access to medical records, 8.2
Complaint, 1.25
Denial of, 16.4
Experimental Subject’s Bill of Rights, 10.13, 10.20
Family caregiver, 12.1
Family notification, 1.7
Font size, 1.7
Mental health patient, 16.1 to 16.25
Pain patient, 5.47
Privacy, 8.1 to 8.17
Psychiatric patient, 16.1
Research, 10.13, 10.20
Reuse of hemodialysis filters, 5.22
To refuse treatment, 1.3
Visitors, 1.4
Patient Safety Organization (PSO), 19.2
Patient safety plan, 19.4
Patient Self-Determination Act, 1.1 to 1.3, 11.7—See also Advance directives
Patient’s personal documents, 20.4
Patient’s property, 8.8, 11.2, 14.22, 20.1 to 20.11
Patient transfer—See Transfer, patient
Paul Gann Blood Safety Act, 5.2
Peace officers—See Law enforcement officers
Pelvic exam, 5.24, 5.49
Periodic performance review, 19.6
Pesticide injuries, 18.15
Pharmacy, 5.41 to 5.43, 19.11
Photograph, consent to, 8.9, 11.5
Child abuse, 17.17

Dependent or elder abuse, 17.27
Newborns, 8.11
Sexual assault suspect, 17.7

Physician
Agent of hospital, 2.10, 11.2
Complaint about, 1.25
Medical staff quality assurance, 19.1
Obligation to obtain consent, 2.1 to 2.3
Ownership notice, 11.7
Physician Orders for Life-Sustaining Treatment (POLST), 6.24 to 6.27, 12.18
Physician-patient privilege, 17.15
Psychotherapist-patient privilege, 17.15
Relationship to hospital, 2.8 to 2.12, 11.2
Transfer responsibilities, 3.12, 12.14, 12.28 to 12.31

Physician assistant, 1.6

Piercing, minors, 4.16

Police—See Law enforcement officers

POLST, 6.24 to 6.27, 12.18
Post-hospital caregiver, 12.1, 12.9
Post-hospital providers, 12.9
Freedom of choice of, 12.9

Power of attorney—See Advance directives

Prefrontal sonic treatment, 5.33, 5.35

Pregnancy—See Maternity patient

Prehospital do not resuscitate, 6.22

Prenatal care patient—See Maternity patient

Prisoners, 3.3, 9.1 to 9.10, 9.2, 10.18—See also Law enforcement officers

Blood test for alcohol or drugs, 9.3 to 9.5
Consent for prisoners who lack capacity, 3.3, 9.2
Discharge information and movement information to law enforcement officers, 9.8, 15.12, 15.19
Inmates in labor, 13.5
Interrogation by law enforcement officer, 9.6
Medical evaluation prior to incarceration, 9.5
Pregnant inmates, 13.5
Release of information, 9.1 to 9.10, 15.12, 15.19
Reporting crimes, 17.1 to 17.32
Shackles, 13.5
Sterilization, 5.17

Privacy breach—See Breach of privacy or security

Privacy officer, 8.4

Privacy right, 1.3, 1.10, 4.2, 4.15, 8.1 to 8.17, 17.1—See also Health Insurance Portability and Accountability Act (HIPAA) of 1996

Privacy rights of minors, 4.2, 4.15

Privilege
Attorney-client, 19.1 to 19.3
Evidence Code 1157
Medical staff quality assurance, 19.1
Physician-patient, 17.15
Psychotherapist-patient, 17.15
Probation officer, 4.9
Pronouncement of death, 14.1
Property of patient
  Conditions of admission form, 11.2
  Deceased patient, 14.22 to 14.23
  Disposition of, 14.22 to 14.23, 20.3
  Electrical appliances, 20.4
  Searching, 8.8
  Valuables, 20.2
Proposition 65, 5.47 to 5.49, 20.8
Prostate cancer, 5.24 to 5.25
Prostate exam, 5.24 to 5.25
Protected health information—See Health Insurance Portability and Accountability Act (HIPAA) of 1996
Protected health information (PHI)
  Use and disclosure
    CMIA—See Confidentiality of Medical Information Act (CMIA)
    LPS—See Lanterman-Petris-Short Act
Protection and advocacy, 16.10 to 16.16
Psychiatric advance directives, 3.15 to 3.26
Psychosurgery, consent to, 5.33 to 5.35
  Agent may not consent to, 3.11
  Minor may not consent to, 4.15, 5.33
Psychotherapeutic drugs—See Psychotropic medications
Psychotherapist
  Duty to warn, 16.17 to 16.19
  Psychotherapist-patient privilege, 17.15
Psychotherapy notes, 8.2
Psychotropic medications, 4.8, 4.15, 5.28 to 5.33, 15.11
  Involuntary outpatient treatment, 15.33 to 15.34
  Involuntary patient, 5.30, 15.11
  Minor, 4.8, 4.15, 5.32
  Skilled nursing facility patient, 5.28 to 5.33
  Voluntary patient, 5.29
Public administrator, 14.2
Public health officer, 12.12, 18.1, 19.17
Q
  Quality assurance, 19.1
R
  Rabies, 18.8
  Radiation, 7.9, 19.15
  Rape—See Sexual assault
  Records, medical—See Medical record
  Refusal of treatment, 6.1 to 6.40
    Administration of approved prophylactic agent to eyes of newborn, 13.13
    Administration of immune globulin, 13.14
  Antipsychotic medication—See Psychotropic medications
    Blood products, 6.4 to 6.5
    Convulsive treatment, 5.35
    Court authorization of treatment, 3.14, 3.20, 6.22
    Documentation, 6.3, 6.20
    Effects of anticipated refusal on admission policy, 6.27
    Electroconvulsive treatment, 5.35
    Ethics committees, 6.21
    Forms, 6.2
    Incident report, 6.3
    Incompetent patient, 6.10 to 6.11, 6.15 to 6.16
    Infant, 6.18, 12.28
    Leaving hospital against medical advice, 6.5 to 6.6, 12.12
    Life-sustaining treatment, adults, 6.1 to 6.40
    Life-sustaining treatment, infants, 6.18 to 6.20, 12.28, 13.9
    Minor, 6.1, 6.3 to 6.4, 6.11, 6.16, 6.18 to 6.20, 12.28, 13.13
    Patient’s right, 6.1
    Prophylactic eye drops, 13.13
    Psychosurgery, 5.35
    Psychotropic medications—See Psychotropic medications
      Recommended procedure, 6.5
      Right to, 6.1
      Transfer, 12.15, 12.31
      Vaccines, 5.27, 6.5
      Withholding or withdrawing life-sustaining treatment, 6.6 to 6.22
  Registry for advance directives, 3.8
  Registry for anatomical gifts, 14.9, 14.12
  Registry for cancer cases, 18.13
  Registry for Parkinson’s Disease cases, 18.14
  Release of a minor from hospital, 12.4, 12.4 to 12.6
  Release of information—See Medical record, release of information from
    Release of side rails, 20.3
    Religious beliefs, 2.13, 6.4, 14.7, 14.9
    Reparation therapy, 16.8
    Reportable diseases, disclosure of, 18.1 to 18.5
  Reporting
    Adverse events, 19.7 to 19.11
    Animal bites, 18.8
    Assault and abuse, 17.1 to 17.32
    Blood transfusion reactions, 19.14
    Burn and smoke inhalation injuries, 18.15
    Child abuse, 17.7 to 17.19
    Chromosomal defects, 13.12
    Communicable disease, 18.1 to 18.8
Convulsive therapy, 5.39
Crimes, 17.1 to 17.32
Death after restraint or seclusion, 14.3
Dependent adult abuse, 17.19 to 17.30
Discharge of minor, 12.4
Disclosure of medical information, 8.4
Disclosure of reportable diseases, 18.1 to 18.5
Diseases/conditions, 17.1 to 17.32, 18.1 to 18.18
Elder abuse, 17.19 to 17.30
HIV/AIDS, 13.3, 18.11
Lapse of consciousness, 18.8
Medical errors, 19.4, 19.11
Medication errors, 19.11
Minor discharge—See Reporting, Discharge of minor
Minor with sexually-related condition, 17.13
Neural tube defects, 13.12
Newborn genetic disorder, 13.10
Parkinson’s disease, 18.14
Psychosurgery, 5.35
Release of information, 18.1
Reyes syndrome, 18.14
Rhesus (Rh) hemolytic disease, 13.12
Ryan White CARE Act, 18.11
Safe Medical Devices Act, 19.11 to 19.14
Sexual assault/rape, 17.5, 17.9, 17.22
Smoke inhalation injuries, 18.15
Sterilization, 5.19
Transfer reports, 12.35
Transfer violations, 12.35
Transfusion reactions, 19.14
Tuberculosis, 18.4
Unusual occurrences, 19.17
Vaccines, adverse reactions, 18.14
Report to attorney, 19.1
Request for observer at childbirth/medical procedure,
8.16, 13.5, 20.5
Request regarding resuscitative measures, 6.12 to 6.13,
6.20 to 6.22, 6.22 to 6.24
Rescue team immunity, 2.4
Research—See Experimental treatment
Residential shelter services, 4.14
Responsibilities—See Patient responsibilities
Restraints, 16.5, 20.3
Acute psychiatric facility, 1.10, 7.8
Death after, 14.3, 19.16
Drug as a restraint, 1.10
General acute care hospital, 1.10, 5.28
Reporting death after restraint or seclusion, 14.3,
19.16
Seclusion, 1.10, 7.5, 7.8
Reyes syndrome, 18.14
Rhesus (Rh) hemolytic disease, 13.12
Stillbirth, 13.9, 14.6
Strike, 19.17
Student, 4.7, 5.49, 11.5
Substance abuse records—See Alcohol or drug abuse
Substance use disorder patient—See Alcohol or drug abuse
Substance use disorder records—See Alcohol or drug abuse
Sudden Infant Death Syndrome (SIDS), 13.14
Suicide, assisted—See End of Life Option Act
Support person, 1.11, 17.6
Surrendered newborn, 13.17 to 13.19
Surrogate decision maker, 3.4, 6.13 to 6.16
Sympathy, statements of, 19.7
Syringes, 5.49

T
Tarasoff v. Regents of the University of California, 16.16
Telehealth—See Telemedicine
Telemedicine, 5.46
Consent, 5.46
Documentation, 7.10
Telephone Consumer Protection Act, 11.4
Telephone, e-mail, facsimile
Consent by, 2.14
Temporary absence, 12.20, 12.36 to 12.37
 Terminally ill patients, 3.13, 6.6 to 6.40
Therapeutic privilege, 2.4
Third-party consent, 4.5 to 4.7
Tissue
Anatomical gift, 3.13, 14.9 to 14.19
Consent for transplant, 5.50, 14.13
Consent from living donor, 5.50, 14.11
Use for research or commercial purposes, 2.2, 2.9, 5.1, 5.43 to 5.44, 10.1, 11.5
Transfer, patient, 12.13 to 12.38
Agreements, 12.18
Discrimination, 12.20, 12.24, 12.34
Emergency declared by DHHS, 12.36
Emergency patient, 12.23 to 12.36
Injury in, 17.30 to 17.31
Insurance status, 12.13, 12.21, 12.22, 12.29
Medical records, 12.18, 12.20, 12.29
Medical screening exam, 12.27
Neglect in, 17.30 to 17.31
Notifying family, 12.16
Obligations of receiving facility and physician, 12.18
Obligations of transferring facility and physician, 12.14 to 12.18
Patient request, 12.13, 12.29
Psychiatric emergency medical condition, 12.27
Reporting violation to DHHS, 12.35
Specialized capabilities or facilities, 12.31
Summary, 12.18, 12.29
Temporary absence, 12.36 to 12.37
Transportation method, 12.16
Tuberculosis patient, 12.12
Transfusion—See Blood transfusions/products
Transfusion reaction, 19.14
Translator—See Interpreter
Transplant
Medical marijuana, 5.51
Transplantation—See Tissue
Treatment, consent for—See Consent
Truth in Lending Act, 11.3
Tubal ligation—See Sterilization
Tuberculosis
Detention of patients, 12.12, 18.4
Immunity for detention, 18.4
Reporting by laboratories, 18.4
Reporting to emergency personnel, 18.10
Reporting to local health officer, 18.4
Two-doctor consent, 2.11

U
Ultrasound, fetal, 13.4
Umbilical cord blood banking, 13.4
Unanticipated outcomes, 19.7
Unclaimed dead, 14.22
Unconscious patient, 1.7, 2.4, 5.49
Uniform Anatomical Gift Act, 14.2, 14.9 to 14.19
Uniform Determination of Death Act, 14.1
Unrepresented patient, 3.20
Unusual occurrences, 19.17

V
Vaccines
Consent to, 5.26 to 5.28
Mercury in, 5.28
Refusal of, 5.27, 6.5
Reporting adverse reactions to, 18.14
Valuables belonging to patient
Conditions of admission form, 11.2
Deceased patient, 14.22
Live patient, 20.2
Vasectomy—See Sterilization
Vehicle code violations, 9.3 to 9.5
Verbal drug orders, 7.3, 7.7
Verification of identity, 8.5
Victims of crime, 9.6—See also Child abuse, See also Domestic abuse, See also Elder and dependent adult abuse
Videotaping patient—See Photography, consent to
Vision impaired individuals, 1.13
Visitors, 1.4, 1.6, 1.10, 1.11
Volunteers, 3.6
W

Ward of the court, 4.8
Warrant, 9.5, 13.16
Warrantless search, 9.5
Weapons
  Psychiatric patients, prohibition against possession,
    16.19 to 16.21
Will and testament of patient, 14.12, 14.13, 14.20,
  20.4 to 20.5
Withholding or withdrawing life-sustaining treatment, 6.6
  to 6.22, 12.28—See also Refusal of treatment
Witnessing of patient signature, 2.13, 3.5, 20.4 to 20.5
Workers’ compensation—See also Occupational injuries
  Lien, 11.13

X

X-rays
  Consent to, 2.2, 4.10, 11.1, 17.12
  Copies requested by patient, 7.1