The End Stage Renal Disease Network Of Texas, Inc.
4040 McEwen Rd. Suite 350. Dallas. TX 75244
972-503-3215 * fax 972-503-3219 * info@nw14.esrd.net * www.esrdnetwork.org

Permission for Public Acknowledgement

It is the distinct honor of the ESRD Network of Texas, Inc. (NW 14) to recognize those facilities in the state that rank as "High Performers" in various indicator categories. These facilities receive certificates to acknowledge their outstanding performance. The ESRD Network of Texas, Inc. would like permission from all facilities to publish and recognize publically the success demonstrated by those facilities. NW 14 is required to comply with all Centers for Medicare & Medicaid Services (CMS) confidentiality rules and regulations described in the CROWN memo received on June 3, 2009, which states, "All identifiable data provided to Network by CMS and all materials prepared by the Network for CMS are considered confidential and cannot be disclosed to anyone other than the Network staff except as provided by 42 CFR 480.130 – 480.142. Confidential information is defined as any information that explicitly or implicitly identifies an individual patient, practitioner, or reviewer; sanction reports and recommendations; or quality review studies that identify patients, practitioners, or institutions (defined at 42 CFR 480.101(b)." Therefore, NW 14 is contacting all facilities in the state to obtain permission to release the facility name and CMS Certification Number (CCN), or Medicare Provider Number, for areas of outstanding performance.

☐ **NO**, I do not want my facility publically acknowledged for outstanding performance.
If no, please check box, complete facility information and fax to NW 14 at 972-331-3659.

☐ **YES**, please recognize the hard work invested by this facility to achieve excellence.
If yes, please check box, complete information below and fax to NW 14 at 972-331-3659.

I hereby grant to the NW 14 and its agents, the right to use, publish, reproduce in any form, the facility name and provider number at their direction for the purpose of publically acknowledging the facility's outstanding achievements in various areas of performance measurement. Permission is granted to use the facility name and CCN for publicity, advertising purposes, or in any other legitimate way. My consent and agreement herein is given with the knowledge that the ESRD Network of Texas, Inc. will incur the expense in connection with such advertisement/promotion/announcements, and I hereby waive any claims now or hereafter for any compensation for the right granted under this release.

Signed: ____ Date: _____/_____/_____

Printed Name: __________________________________Position:______________________

Witness Signature: _______________________________________ Date: _____/_____/_____

Printed Witness Name: ____________________________Position:______________________

Facility Name:________________________________CCN# 45-_________ or 67-__________

City: ____, TX Zip: ________

NOTE:

- **ONLY** signatures from Clinical Managers, Medical Directors or Administrators will be considered valid.
- This form will be valid from **July 2011** through and including **July 2016**. Should the facility wish to amend or change this form a signed formal letter on facility letterhead will need to be submitted to the ESRD Network of Texas, Inc.

Fax to: 972-331-3659

Due: Friday, August 12, 2011

Supporting Quality Care