**Welcome to Women's Healthcare Group of Illinois and The Women's Wellness Group**. We want to thank you for choosing us for your healthcare needs. We ask that all registration paperwork be completed in its entirety before your visit. We also require that you ***bring your insurance card, a valid form of photo ID and your co-pay (if required)***. Should you have any questions or if you need additional information, please do not hesitate to contact our office.

## Appointment Policy Agreement

Due to the high demand for appointments, we have created a "no show" or same day cancellation policy. Included in this policy is the requirement that ALL cancellations must be made at least 24 hours in advance of a scheduled appointment. Any cancellation made less than 24 hours prior to an appointment will be considered a "no-show". ***If you have three or more "no show" appointments within a 24-month period, we reserve the right to refuse you future appointments***. For every "no show", there is also a ***$35 no show fee*** that you will be billed.

We ask that all patients arrive for their appointments at least 10 minutes before their appointment time. This allows enough time for patients to be checked in, to complete any needed paperwork and for them to complete their in-take with the nurse before their scheduled appointment time arrives. It is our goal to accommodate as many patients as we can while ensuring that we see them in a timely and efficient manner. ***Anyone who is more than 10 late for their appointment may be required to reschedule their appointment for a later time and/or date***. If you have any questions or concerns, please contact our office.

## Patient Notification Preference

If our office needs to contact you for any reason, including to share test results (both normal and abnormal), how would you prefer to be contacted?

◯ Home Phone  Home Number _____

- ◯ Leave Message with details (no test results are left on voicemail)
- ◯ Leave brief message to call office back.
- ◯ Do not leave a message.

◯ Cell Phone  Cell Number _____

- ◯ Leave Message with details (no test results are left on voicemail)
- ◯ Leave brief message to call office back.
- ◯ Do not leave a message.

◯ Mail Notification  Mailing Address _____

I hereby acknowledge that, as a patient of Women's Healthcare Group of Illinois and/or The Women's Wellness Group, I have read and agree to the above.

_____  _____

Patient Name  Patient and/or Guardian Signature

_____  _____

Patient Date of Birth  Relationship to Patient

## Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

I have been provided the Electronic Prescribing Notice.

| | | | | | |
|---|---|---|---|---|---|
| Parent, Patient's Signature or Legal Representative | | | | Date | Time |
| Relationship to Patient | | | Interpreter, if Utilized | Date | Time |
| Witness Signature | Date | Time | If Telephone Consent, Second Witness Signature | Date | Time |



Patient Label

| Patient's Name | Date of Birth | Medical Record Number | |
|---|---|---|---|
| Patient Street Address | City | State | Zip |
| Home Telephone Number | Work Telephone Number | | |

**I give permission to VERBALLY discuss the following medical information about me *(check all boxes that apply):***

❑ Medical information, including my symptoms, diagnosis, medications and treatment plan
❑ Lab/test results
❑ Other (describe):_____
❑ Other (describe):_____

**The physician practice has my permission to discuss the above information with:**

1. _____
Name/Relationship to Patient

_____ _____ _____ _____
Street Address City State Zip

_____ _____ _____ _____
Home Telephone Number Work Telephone Number

2. _____
Name/Relationship to Patient

_____ _____ _____ _____
Street Address City State Zip

_____ _____ _____ _____
Home Telephone Number Work Telephone Number

I understand that I have the right to revoke my permission at any time, except where the physician practice has already made disclosures in reliance upon this request. **I understand that I must notify the physician practice in writing if I want to revoke my permission.**

| Patient's or Authorized Personal Representative's Signature | | | |
|---|---|---|---|
| Relationship to Patient / Authority to Act on Patient's Behalf | Interpreter, if Utilized | Date | Time |
| Witness Signature | Expiration Date or Event | Date | Time |

If authorized representative, please sign and attach copies of supporting legal documentation.

Reason patient unable to sign: _____

_____

_____

Permission to Verbally Discuss
Protected Health Information
PPSI-1404 07/11 Page 1 of 2
WHITE - Medical Record CANARY - Recipient

Patient Label

Patient Name _____
Patient Number _____
Date of Birth _____ Date _____
Facility Name _____

The physician practice knows that privacy regulations have an impact on our customer services to you, especially when it comes to discussing information about you with family, friends and others you designate who are involved in your care. We have established a process that allows you to tell us who we may talk with about your medical care.

**How can I give others permission to get verbal information about me?**
Complete the Permission to Verbally Discuss Protected Health Information form on the 1st page to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss.

**How is the information on the form used?**
Anytime your designated person calls or makes a request on your behalf, **we will verify the individual has your permission to receive the information and then we will share the information.**

**What are some examples of when this might be useful?**
- If an elderly parent wants an adult child to help understand medical treatment instructions
- If a friend is helping an elderly patient with health issues
- If a college student wants information shared with a parent

**Can the person I designate also get copies of my medical records?**
No they can only receive verbal information. To get copies of medical records, you must complete a separate Authorization form available at our Physician Practice(s).

**What if I change my mind?**
You can change or revoke (stop) this process at any time by writing to us at the address shown below. Forms are available at your Physician Practice(s), or you can obtain a new form from the Physician Practice(s).

**What happens if I don't complete this form?**
We will continue to protect your private health information as required by law.

Physician Practice Name

Street Address | City | State | Zip

Telephone Number | Fax Number



Patient Label

Patient Name
Patient Number
Date of Birth Date
Facilty Name

# Patient Registration Form

Patient Last Name_____ Patient First Name_____Gender □M □F

Date of Birth_____Social Security Number_____Occupation_____

Address_____City_____State_____Zip_____

Home Phone Number_____Cell_____Work_____

Marital Status: □Single □Married □Domestic Partnership □Divorced □Separated □Widowed

Employer_____Employer Address_____

_____

***About the Patient's Guardian and/or Spouse:***

Guardian/Spouse Last Name_____Guardian/Spouse First Name_____

Date of Birth_____Social Security Number_____Occupation_____

Address_____City_____State_____Zip_____

Home Phone Number_____Cell_____Relationship to Patient_____

Marital Status: □Single □Married □Domestic Partnership □Divorced □Separated □Widowed

Employer_____Work Phone_____Employer Address_____

***Billing Information:***

Bills should be sent to: □Patient □Spouse □Guardian

Mailing Address for Bill is: □Same as above □Other_____

***Emergency Contacts:***

Name_____Phone_____Relationship to Patient_____

Name_____Phone_____Relationship to Patient_____

***Insurance Information:***

**Primary Insurance**_____Policy ID Number_____

Policy Holder's Name_____Group Number_____Policy Holder SSN_____

Employer (that Insurance is through)_____Effective Date_____

Claims Address_____Insurance Phone Number_____

Policy Holder's Date of Birth_____Policy Holder's Relationship to Patient_____

**Secondary Insurance**_____Policy ID Number_____

Policy Holder's Name_____Group Number_____Policy Holder SSN_____

Employer (that Insurance is through)_____Effective Date_____

Claims Address_____Insurance Phone Number_____

Policy Holder's Date of Birth_____Policy Holder's Relationship to Patient_____

**I authorize the release of any medical information necessary to coordinate care with other physicians and to process insurance claims. I understand that I am financially responsible for all charges whether or not paid by my insurance company and authorize my insurance company to pay directly to Women's Healthcare Group of Illinois.**

Patient/Guardian Signature _____ Date_____

# Patient Self History (Please complete BOTH pages completely)

Date:_____

Patient Name:_____

Address:_____

Birth Date:_____

Have you ever been in the hospital or had surgery? If yes, for what and when?

---

---

---

Pregnancies: Number _____ Living Children_____ Miscarriages_____ Abortions_____

**Medical History**: Please circle all past or present medical problems and/or symptoms.

| | | |
|---|---|---|
| Anemia | Heart Disease | Any Other Bleeding |
| Arthritis | Chest Pain | Easy Bruising |
| Asthma | High Blood Pressure | Abnormal Vaginal Discharge |
| Cancer | Kidney Disease | Abnormal Penile Discharge |
| Diabetes | Prostate Disease | Psychiatric Problems |
| Fibroids | Urinary Incontinence | Seizures |
| Gout | Difficulty Urinating | Stroke |
| Alcoholism | Liver Disease | Thyroid Disease |
| Glaucoma | Lung Disease | Tuberculosis |
| Hearing Loss | Shortness of Breath | HIV |
| Visual Loss | Ulcers | Sexually Transmitted Disease |
| Heart Attack | Gastrointestinal Bleeding | Drug/Substance Abuse |

**Medication History**: Please list medications you are currently taking:

| **Medication** | **How Often?** | **For What Problem?** |
|---|---|---|

---

---

---

**Allergies**: List any medications or other substances that you are Allergic to:

---

**Social History**: Do you smoke? If yes, how much and how often? _____

Do you drink alcohol? If yes, how much and how often?_____

Do you use illicit drugs? If yes, what kind and how often?_____

What is your occupation?_____

Is there any exposure to dust, fumes, smoke or noise?_____

Are you watching your diet or following any strict dietary guidelines?_____

Do you exercise regularly?_____

Do you take any non-prescription medications, health foods or vitamins?_____

Advance Directives: Do you have someone named as Power of Attorney for Healthcare?_____

If yes, whom?_____Do you have a Living Will Declaration?_____
(If you would like information regarding these Advance Directives, ask front desk for information)

**Family History**: (Immediate only: father, mother, brothers, sisters and grandparents)

| | **Alive?** | **Age** | **Medical Problems or Cause of Death** |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Siblings | | | |
| Grandparents | | | |
| Other | | | |

**Health Screenings/Immunizations**: Please specify if you had any of the following.

| | **Date & Results:** |
|---|---|
| Pap Smear | |
| Mammogram | |
| Chest x-ray | |
| Physical Exam | |
| Digital Rectal Exam | |
| Prostate Exam/PSA | |
| Stool Hemoccult | |
| Flexible Sigmoidoscopy | |
| Colonoscopy | |
| Cholesterol | |
| Blood Sugar | |
| B.M.I. | |
| PPD | |
| Influenza Vaccine | |
| Tetanus/TD | |
| Hepatitis B Vaccine | |
| Chicken Pox or Vaccine | |

***This has been reviewed by Doctor (Drs Initials)_____ Updated (yearly) _____

## NOTICE OF PRIVACY PRACTICES

**This Notice Describes How Medical Information about You May Be Used and Disclosed and How You Can Get Access to This Information**
***PLEASE REVIEW CAREFULLY.***
If you have any questions about this notice, please contact the Facility Privacy Officer.

**Who Will Follow This Notice:** This notice describes the facility's practices and how the facility shares your information with others for treatment, payment and health care operations purposes.

- Any health care professional authorized to enter information into your facility chart.
- All departments and units of the facility.
- Any member of a volunteer group allowed to help you while you are in the facility.
- All employees, staff, agents and other facility personnel.
- Health care providers and their authorized representatives who are members of the facility's organized health care arrangement, or "OHCA." These health care providers and their authorized representatives will be operationally and/or clinically integrated with the facility, or will otherwise be permitted by law to receive your information. For example, to the extent permitted by law and in accordance with our policies, the facility will share your medical information with physicians who are members of the facility's medical staff, even if the physician is not employed by the facility.
- All entities, sites and locations within this facility's system will follow the terms of this notice. They also may share medical information with each other for treatment, payment and health care operations purposes.

**Our Pledge Regarding Medical Information:** We understand that medical information about you and your healthcare is personal. We are committed to protecting medical information about you. A record is created of the care and services you receive at this facility. This record is needed to provide the necessary care and to comply with legal requirements. This notice applies to all of the records of your care generated by the facility. Your personal physician may have different policies or notices regarding the physicians use and disclosure of your medical information in the physician's office or clinic.

This notice will tell about the ways in which the facility may use and disclose medical information about you. Also described are your rights and certain obligations we have regarding the use and disclosure of medical information.

The law requires the facility to:

- Make sure that medical information that identifies you is kept private;
- Inform you of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect. This notice is effective as of September 23, 2013.

**HOW THE FACILITY MAY USE and DISCLOSE YOUR MEDICAL INFORMATION:**

Except with respect to Highly Confidential Information (described below), we are permitted to use your health information for the following purposes:

- **Treatment.** Your medical information may be used to provide you with medical treatment or services. This medical information may be disclosed to physicians, nurses, technicians, and others involved in your care at the facility, including employees, volunteers, students and interns at the facility. This includes using and disclosing your information to treat your illness or injury, to contact you to provide appointment reminders or to give you information about treatment options or other health related benefits and services that may interest you.



Patient Label

For example: A physician treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. The physician may need to tell the dietitian about the diabetes so appropriate meals can be arranged. Different departments of the facility may also share medical information about you in order to coordinate your different needs, such as prescriptions, lab work and X-Rays. The facility also may disclose medical information about you to people outside the facility who may be involved in your medical care after you leave the facility, such as family members, home health agencies, and others who provide services that are part of your care.

- **Payment.** Your medical information may be used and disclosed so that the treatment and services received at the facility may be billed and payment may be collected from you, your insurance company and/or a third party. Please note, we will comply with your request not to disclose your health information to your insurance company if the information relates solely to a healthcare item or service for which you have paid out of pocket and in full to us. This restriction does not apply to the use or disclosure of your health information for your medical treatment.

  For example: To the extent insurance will be responsible for reimbursing the facility for your care, the health plan or insurance company may need information about surgery you received at the facility so they can provide payment for the surgery. Information may also be given to someone who helps pay for your care. Your health plan or insurance company may also need information about a treatment you are going to receive to obtain prior approval or to determine whether they will cover the treatment.

- **Health Care Operations.** Your medical information may be used and disclosed for purposes of furthering day-to-day facility operations. These uses and disclosures are necessary to run the facility and to monitor the quality of care our patients receive.

  For example: Subject to any limitations described in this notice, your medical information may be:

  1. Reviewed to evaluate the treatment and services performed by our staff in caring for you.
  2. Combined with that of other facility patients to decide what additional services the facility should offer, what services are not needed, and whether certain new treatments are effective.
  3. Disclosed to physicians, nurses, technicians, and other agents of the facility for review and learning purposes.
  4. Disclosed to healthcare students, interns and residents.
  5. Combined with information from other facilities to compare how we are doing and see where we can improve the care and services offered. Information that identifies you in this set of medical information may be removed so others may use it to study health care and health care delivery without knowing who the specific patients are.

- **Individuals Involved in Your Care.** With your permission, your medical information may be released to a family member, guardian or other individuals involved in your care. They may also be told about your condition unless you have requested additional restrictions. In addition, your medical information may be disclosed to an entity assisting in a disaster relief effort so your family can be notified about your condition, status, and location.

- **Research.** Under certain circumstances, your medical information may be used and disclosed for research purposes.

  For example: A research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same conditions. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, balancing the research needs with the patients' need for privacy of their medical information. Your medical information may be disclosed to people preparing to conduct a research project; for example, helping them look for patients with specific medical needs, so long as the medical information they review does not leave the facility. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the facility.



Patient Label

- **Marketing Activities.** We may, without obtaining your authorization and so long as we do not receive payment from a third party for doing so, 1) provide you with marketing materials in a face-to-face encounter, 2) give you a promotional gift of nominal value, or 3) tell you about our own health care products and services. We will ask your permission to use your health information for any other marketing activities.

- **Appointment Reminders.** Your medical information may be used to contact you as a reminder of an appointment you have for treatment or medical care at the facility.

- **Treatment Alternatives.** Your medical information may be used to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services.** Your medical information may be used to tell you about health-related benefits or services that may be of interest to you.

- **Participation in Health Information Exchanges.** We may participate in one or more health information exchanges (HIEs) and may electronically share your health information for treatment, payment and permitted healthcare operations purposes with other participants in the HIE – including entities that may not be listed under "**Who Will Follow This Notice**" on the first page of this notice. Depending on State law requirements, you may be asked to "opt-in" in order to share your information with HIEs, or you may be provided the opportunity to "opt-out" of HIE participation. HIEs allow your health care providers to efficiently access and use your pertinent medical information necessary for treatment and other lawful purposes. We will not share your information with an HIE unless both the HIE and its participants are subject to HIPAA's privacy and security requirements.

- **As Required by Law.** Your medical information will be disclosed when required to do so by federal, state, or local authorities, laws, rules and/or regulations.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, your medical information will be disclosed in response to a court or administration order, subpoena, discovery request, or other lawful process by someone else involved in the dispute when we are legally required to respond.

- **Law Enforcement.** Your medical information will be released if requested by a law enforcement official:
    1. In response to a court order, subpoena, warrant, summons or similar process;
    2. To identify or locate a suspect, fugitive, material witness, or missing person;
    3. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
    4. About a death we believe may be the result of criminal conduct;
    5. In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **National Security and Intelligence Activities.** Your medical information will be released to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Protective Services for the President and Others.** Your medical information may be disclosed to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

- **To Alert a Serious Threat to Health or Safety.** Your medical information may be used and disclosed when necessary to prevent a serious threat to your health and safety and that of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **Health Oversight Activities.** Your medical information may be disclosed to a health oversight facility for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**SPECIAL SITUATIONS:**

- **Organ and Tissue Donation.** If you are an organ or tissue donor, your medical information may be released to organizations that handle organ procurement or organ, eye and tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, your medical information may be released as required by military command authorities. If you are a member of the foreign military personnel, your medical information may be released to the appropriate foreign military authority.

- **Workers' Compensation.** If you seek treatment for a work-related illness or injury, we must provide full information in accordance with state-specific laws regarding workers' compensation claims. Once state-specific requirements are met and an appropriate written request is received, only the records pertaining to the work-related illness or injury may be disclosed.

- **Public Health Risk.** Your medical information may be used and disclosed for public health activities. These activities generally include the following:
  1. To prevent or control disease, injury or disability;
  2. To report births and deaths;
  3. To report child abuse or neglect;
  4. To report reactions to medications or problems with products;
  5. To notify people of recalls of products they may be using;
  6. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  7. To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **Coroners, Medical Examiners, and Funeral Directors.** Your medical information may be released to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the facility to funeral directors as necessary to carry out their duties.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the following reasons:
  1. For the institution to provide you with health care;
  2. To protect the health and safety of you and others;
  3. For the safety and security of the correctional institution.

**HIGHLY CONFIDENTIAL INFORMATION:**

Federal and/or State law require special privacy protections for certain highly confidential information about you, including your health information that is maintained in psychotherapy notes. Similarly, Federal and/or State law may provide greater protections for the following types of information than HIPAA, in which case we will comply with the law that provides your information with the greatest protection and you with the greatest privacy rights: (1) mental health and developmental disabilities; (2) alcohol and drug abuse prevention, treatment and referral; (3) HIV/AIDS testing, diagnosis or treatment; (4) communicable diseases; (5) genetic testing; (6) child abuse and neglect; (7) domestic or elder abuse; and/or (8) sexual assault. In order for your highly confidential information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

**YOUR WRITTEN AUTHORIZATION**

We will first obtain your written authorization before using or disclosing your protected health information for any purpose not described above, including disclosures that constitute the sale of protected health information or for marketing communications paid for by a third party (excluding refill reminders, which the law permits without your authorization). If you provide the facility permission to use or disclose your medical information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your medical information for the reasons covered in your written authorization. You understand that we are unable to take back any disclosures already made with your permission, and that we are required to retain our records of the care that the facility provided to you.

**ADDITIONAL INFORMATION CONCERNING THIS NOTICE:**

- **Changes To This Notice.** We reserve the right to change this notice and make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. The facility will post a current copy of the notice with the effective date. In addition, each time you register at, or are admitted to, the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

- **Complaints.** You will not be penalized for filing a complaint. If you believe your privacy rights have been violated, you may file a complaint with the facility or with the Secretary of the Department of Health and Human Services. Some States may allow you to file a complaint with State's Attorney General, Office of Consumer Affairs or other State agency as specified by applicable State law. To file a complaint with the facility, submit your complaint to the facility's Privacy Officer in writing. The facility's Privacy Officer can provide you with contact information for the Secretary of the Department of Health and Human Services as well as the State agency or agencies authorized to accept your complaints.

**YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION**

You have the following rights regarding medical information the facility maintains about you:

***** NOTE: All Requests Must Be Submitted in Writing to the Facility*****

- **Right to Request Access to Your Health Information.** You have the right to timely inspect and copy medical information that may be used to make decisions about your care. Such access will be granted by the facility in accordance with applicable law.

  To inspect and copy medical information or to receive an electronic copy of the medical information that may be used to make decisions about you, you must submit a written request. If you request a paper copy of your information, we may charge a fee for the cost of copying, mailing or other supplies associated with your request.



Patient Label

If the facility uses or maintains an electronic health record with respect to your medical information, you have the right to obtain an electronic copy of the information if you so choose.

1. You may direct the facility to transmit the copy to another entity or person that you designate provided the choice is clear, conspicuous, and specific.
2. The facility may charge a fee equal to its labor cost in providing the electronic copy (e.g., costs may include the cost of a flash drive, if that is how you request a copy of your information be produced). If you request an electronic copy of your information, we will provide the information in the format requested if it is feasible to do so.

We may deny your request to inspect and copy in some limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional, other than the person who denied your request, will be chosen by the facility to review your request and the denial. The facility will comply with the outcome of the review.

1. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.
2. The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person.
3. The request for access is made by the individual's personal representative, and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment to information kept by or for the facility. Except where individual state laws are more stringent, this facility has a minimum of 60 days to act on your request.

  To request an amendment, you must submit a written request. You must also provide a reason that supports your request.

  Your request for an amendment may be denied if:

  1. Your request is not in writing or does not include a reason to support the request;
  2. The medical information was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  3. The medical information is not part of the medical information kept by or for the facility;
  4. The medical information is not part of the information you would be permitted to inspect and copy; or
  5. The medical information is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your medical information for purposes other than treatment, payment and health care operations. Except where individual state laws are more stringent, this facility has a minimum of 60 days to act on your request.

To request this list or accounting of disclosures:

1. You must submit your request in writing.
2. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003.
3. Your request should indicate in what form you want the list (for example, on paper, electronically).

The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have a right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member.

  To request restrictions, you must make your request in writing. In your request, you must tell us:

  1. What information you want to limit;
  2. Whether you want to limit our use, disclosure or both;
  3. To whom you want the limits to apply, for example, disclosures to your spouse.

  You also have a right to request that a health care item or service not be disclosed to your health plan for payment purposes or health care operations. We are required to honor your request if the health care item or service is paid out of pocket and in full. This restriction does not apply to use or disclosure of your health information related to your medical treatment.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

  For example: You can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to Be Notified of Breach.** We will notify you if we discover a breach of your unsecured protected health information.

- **Right to a Paper Copy of This Notice.** You have the right to a copy of this notice. You may ask us to give you a copy at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

**NOTICE OF PRIVACY PRACTICES:**

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices.

The undersigned certifies that s/he has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above.

| | | | |
|---|---|---|---|
| Patient's Signature or Legal Representative | | Date | Time |
| Relationship to Patient | Interpreter, if Utilized | Date | Time |
| Witness Signature | | Date | Time |
| If Telephone Consent, Second Witness Signature | | Date | Time |



Patient Label