INTEGRITY **FAMILY CARE**

DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

FIRST NAME | MIDDLE | LAST NAME

DATE OF BIRTH | SEX | SSN

HOME TEL | CELL | WORK TEL

EMAIL

HOME ADDRESS | CITY | STATE | ZIP

ETHNICITY ☐ White/Caucasian ☐ Black/African American ☐ American Indian ☐ Native Hawaain/ Other Pacific Islander ☐ Other: ☐ Hispanic/Latino ☐ Asian ☐ Alaskan Native ☐ Decline

MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated | LANGUAGE | # OF CHILDREN

EDUCATION ☐ High School ☐ College ☐ Post Grad | CURRENT SCHOOL

HOW DID YOU HEAR ABOUT US?

OCCUPATION | EMPLOYER NAME

EMPLOYER ADDRESS | CITY | STATE | ZIP

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY | INSURED'S NAME

RELATIONSHIP TO INSURED | INSURED'S DOB | INSURED'S SSN

SUBSCRIBER # | GROUP # | COPAY AMOUNT

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY | INSURED'S NAME

RELATIONSHIP TO INSURED | INSURED'S DOB | INSURED'S SSN

SUBSCRIBER # | GROUP # | COPAY AMOUNT

DOES YOUR INSURANCE CARRIER REQUIRE YOU TO USE A PARTICULAR LAB AND/OR IMAGING FACILITY? IF SO, WHICH ONE?

PREFERRED PHARMACY

NAME OF LOCAL PHARMACY | LOCATION

NAME OF MAIL ORDER PHARMACY

PREFERRED METHOD OF CONTACT

HOW WOULD YOU LIKE TO BE REMINDED OF APPOINTMENTS? CHECK ALL THAT APPLY.

☐ Home Phone
☐ Mobile Phone
☐ Work Phone
☐ Portal

INTEGRITY **FAMILY CARE**

MEDICAL HISTORY

NAME DOB TODAY'S DATE

IMMUNIZATIONS

LAST TETANUS LAST FLU SHOT LAST PENUMONIA SHOT

HAVE YOU HAD A SHINGLES VACCINE? WHEN?

PREVIOUS PRIMARY CARE PHYSICIAN

NAME TEL DATE OF LAST EXAM

CURRENT MEDICAL SPECIALISTS

NAME TYPE

NAME TYPE

NAME TYPE

ALLERGIES

ALLERGEN REACTION

ALLERGEN REACTION

ALLERGEN REACTION

ALLERGEN REACTION

SURGERIES

PROCEDURE DATE

PROCEDURE DATE

PROCEDURE DATE

PROCEDURE DATE

PROCEDURE DATE

PROCEDURE DATE

PROCEDURE DATE

PROCEDURE DATE

PROCEDURE DATE

SOCIAL

EXERCISE? TIMES A WEEK

TOBACCO? PACKS ☐ Per day ☐ Per week QUIT? DATE

ALCOHOL? DRINKS ☐ Per day ☐ Per week QUIT? DATE

CAFFEINE/WEEK

STREET DRUGS? TYPE QUIT? DATE

SEXUALLY ACTIVE? STD?

SEXUAL PREFERENCE ☐ Heterosexual ☐ Homosexual ☐ Bisexual

INTEGRITY **FAMILY CARE**

MEDICAL HISTORY

NAME DOB TODAY'S DATE

CURRENT AND PAST MEDICAL DIAGNOSES

CONSTITUTIONAL

- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Exercise Intolerance
- ☐ Sedation
- ☐ Lethargy
- ☐ Chills
- ☐ Malaise (Tiredness)

EYES

- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Change
- ☐ Eye Disease/Injury

ENMT

- ☐ Difficulty Hearing
- ☐ Ear Pain
- ☐ Frequent Nose Bleeds
- ☐ Nose Problems
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Bleeding Gums
- ☐ Snoring
- ☐ Dry Mouth
- ☐ Oral Abnormalities
- ☐ Mouth Ulcer
- ☐ Teeth Abnormalities
- ☐ Mouth Breathing
- ☐ Ringing In The Ears
- ☐ Sinusitis

CARDIOVASCULAR

- ☐ Chest Pain On Exertion
- ☐ Arm Pain Or Exertion
- ☐ Shortness Of Breath When Walking
- ☐ Shortness Of Breath When Lying Down
- ☐ Palpitations
- ☐ Known Heart Murmur
- ☐ Light-Headed On Standing
- ☐ Ankle Swelling

RESPIRATORY

- ☐ Cough
- ☐ Wheezing
- ☐ Shortness Of Breath
- ☐ Coughing Up Blood
- ☐ Sleep Apnea

GASTROINTESTINAL

- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Change In Appetite
- ☐ Black Or Tarry Stools
- ☐ Frequent Diarrhea
- ☐ Vomiting Blood
- ☐ Dyspepsia
- ☐ Gerd

GENITOURINARY

- ☐ Urinary Loss Control
- ☐ Difficulty Urinating
- ☐ Increased Urinary Frequency
- ☐ Hematuria
- ☐ Incomplete Emptying

MUSCULOSKELETAL

- ☐ Muscle Aches
- ☐ Muscle Weakness
- ☐ Arthralgias/Joint Pain
- ☐ Back Pain
- ☐ Swelling In The Extremities
- ☐ Neck Pain
- ☐ Difficulty Walking
- ☐ Cramps
- ☐ Osteoporosis
- ☐ Fractures

INTEGUMENTARY

- ☐ Abnormal Moles
- ☐ Jaundice
- ☐ Rash
- ☐ Itching
- ☐ Dry Skin
- ☐ Growth/Lesions
- ☐ Laceration
- ☐ Non-Healing Areas
- ☐ Changes In Hair/Nails
- ☐ Psoriasis
- ☐ Change In Skin Color
- ☐ Breast Lump

NEUROLOGIC

- ☐ Loss Of Consciousness
- ☐ Weakness
- ☐ Numbness
- ☐ Seizures
- ☐ Dizziness
- ☐ Frequent Or Severe Headaches
- ☐ Migraines
- ☐ Restless Legs
- ☐ Tremor
- ☐ Gait Dysfunction
- ☐ Paralysis

PSYCHIATRIC

- ☐ Depression
- ☐ Sleep Disturbances
- ☐ Feeling Unsafe In Relationship
- ☐ Restless Sleep
- ☐ Alcohol Abuse
- ☐ Anxiety
- ☐ Hallucinations
- ☐ Suicidal Thoughts
- ☐ Moods Swings
- ☐ Memory Loss
- ☐ Agitation
- ☐ Dementia
- ☐ Delirium

ENDOCRINE

- ☐ Fatigue
- ☐ Increased Thirst
- ☐ Hair Loss
- ☐ Increased Hair Growth
- ☐ Cold Intolerance

HEMATOLOGIC/LYMPHATIC

- ☐ Swollen Glands
- ☐ Easy Bruising
- ☐ Excessive Bleeding
- ☐ Anemia
- ☐ Phlebitis

ALLERGIC/IMMUNOLOGIC

- ☐ Runny Nose
- ☐ Sinus Pressure
- ☐ Itching
- ☐ Hives
- ☐ Frequent Sneezing

FAMILY HISTORY

Indicate which family members have the following ailments.

(F)ather (M)other (B)rother (S)ister

☐ Heart Failure	F	M	B	S
☐ Diabetes	F	M	B	S
☐ High Blood Pressure	F	M	B	S
☐ Cancer	F	M	B	S
☐ Stroke	F	M	B	S
☐ Mental Illness	F	M	B	S
☐ Other:	F	M	B	S

FEMALES

NUMBER OF PREGNANCIES

AGE WHEN PERIODS BEGAN

LENGTH OF PERIODS

HOW OFTEN?

DO YOU HAVE IRREGULAR PERIODS?

DATE OF LAST PERIOD

HOW ARE YOU PREVENTING PREGNANCY?

DATE OF LAST MENSTRUAL CYCLE

DATE OF LAST PAP

DATE OF LAST MAMMOGRAM

DATE OF LAST BREAST EXAM

DIABETICS

LAST HEMOGLOBIN A1C TEST

RESULT

LAST FOOT EXAM

LAST EYE EXAM

COLON CANCER SCREENS

TYPE OF MOST RECENT

DATE OF MOST RECENT

RESULT OF MOST RECENT

WHEN NEXT IS DUE

INTEGRITY **FAMILY CARE**

MEDICATIONS

NAME DOB TODAY'S DATE

CURRENT MEDICATIONS

Include over-the-counter supplements i.e.: vitamins, calcium, or herbal remedies), frequency of usage, and dosage of medication.

MEDICATION	DOSAGE/ FREQUENCY	PRESCRIBING DOCTOR

INTEGRITY **FAMILY CARE**

CONTACTS

NAME | DOB | TODAY'S DATE

EMERGENCY CONTACTS

NAME | RELATIONSHIP | TEL

NAME | RELATIONSHIP | TEL

NAME | RELATIONSHIP | TEL

AUTHORIZED PEOPLE

Please list the names and relations of anyone you authorize to be involved in your care and payment and with whom we may share your medical information.

NAME | RELATIONSHIP

NAME | RELATIONSHIP

NAME | RELATIONSHIP

NAME | RELATIONSHIP

NAME | RELATIONSHIP

NAME | RELATIONSHIP

NAME | RELATIONSHIP

NAME | RELATIONSHIP

INTEGRITY **FAMILY CARE**

CONSENTS

CONSENT TO CALL OR TEXT

I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from Integrity Family Care, Inc., its successors or assigns, can contact me in any manner including but not limited to, manually placing a call, using an automatic telephone dialing system or an artificial or prerecorded voice, texting, or by emailing, regarding any matter. This may include but is not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing, or collection matters. This consent includes any updated or additional contact information that I may provide.

I understand that I will be able to change my preference at any time. I understand that I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

☐ **ACCEPT**

CONSENT FOR MEDICAL PHOTOGRAPHY

PATIENT NAME DATE

NAME OF LEGAL GUARDIAN

I consent for medical imaging (photo, video, and/or audio) to be made of me or my child (or for person whom I am legal guardian). I understand that the information will be used in my medical record.

Refusal to consent to photographs, video, and/or audio recording will in no way affect the medical care I will receive. By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

I agree to the use of my image for medical records ONLY.

☐ **ACCEPT**

ACKNOWLEDGEMENT OF RIGHT TO REVIEW NOTICE OF PRIVACY PRACTICES

I understand I have a right to review Integrity Famly Care's Notice of Privacy Practices prior to signing this document.

The Notice of Privacy Practices is available at the reception desk. Periodically, regulations may change which could require an update to our policy.

I understand that I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail, or by requesting a revised copy at the time of my next appointment.

MOBILE / PHONE NUMBER Phone number(s) must be provided

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY (I.E. LEGAL GUARDIAN, PARENT, ATTORNEY, ETC.)

If you wish to request RESTRICTIONS or limitations on the use of your Protected Health Information, or to request confidential communications please let our receptionist know, so that the proper forms may be completed. Please indicate below if you do not want us to leave account information on your cell phone, answering system or your home answering machine.

SIGNATURE PRINT NAME DATE

INTEGRITY FAMILY CARE

CHRONIC CARE MANAGEMENT

NAME DOB TODAY'S DATE

By signing this Agreement, you consent to Integrity Family Care providing chronic care management services (referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline.

CCM Services include 24-hours-a-day, 7-days-a-week access to a health care provider in Provider's practice to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings. The Provider will discuss with you the specific services that will be available to you and how to access those services.

With the CCM Program your doctor can spend more time on your care – even when you aren't in the office.

Benefits include:

- Chart review in advance of every visit to identify issues that should be discussed and addressed.
- Follow-up after each visit to make sure you're feeling well and that your medications are working.
- Coordinated care between specialists, testing centers, and hospitals to make sure everyone is working together.
- More personalized attention to you and your health management goals.

SIGNATURE PRINT NAME DATE

INTEGRITY FAMILY CARE

OFFICE POLICIES

We are dedicated to providing you the best possible care, and want you to be aware and understand our office policies. We hope that these efforts will make your visits to our office more efficient and less stressful for you.

CONTACTING US

We have a new phone system that both our staff and our patients are adjusting to. If you are contacting our office with a pressing issue and a message cannot be left on our staff's voicemail you may press 0 at any time to be connected with our front office. If you need to leave a message, schedule future appointments, request prescription refills, or have questions regarding your account, please contact our office through our secure messaging via your patient portal.

MISSED APPOINTMENTS

As a courtesy to our patients, you will be notified of your upcoming appointments through your patient portal and reminder calls/texts. If you are unable to keep your scheduled appointment please contact our office 24 hours prior to your scheduled visit. Continued missed appointments and failure to notify the office of such cancellations may result in charges for missed appointments and dismissal from the practice.

BLOODWORK/LAB APPOINTMENTS

In order to provide you with the best care possible, all labwork is to be ordered by the practitioner. There may be times when the practitioner feels it is in the best interest of the patient to schedule a return appointment to review these lab results.

TEST RESULTS

Please allow 5-7 days for test results to be reviewed by the providers. We will contact you by secure messaging through your patient portal or by phone. At times, appointments may be required by the practitioner to review these results with you. If you do not have an appointment, and are not notified within 7 days, please contact us for results.

WORK/SCHOOL EXCUSE

Please notify the medical assistant or receptionist at the time of your visit, if you will require an excuse

PRESCRIPTION REFILLS

Our medical office is implementing ePrescribing per mandate of health insurance companies. Our ePrescribing program sends prescriptions over the internet to your pharmacy in a safe, secure manner, which helps protect the privacy of your personal information as well as loss of a written prescription. ePrescribing also lets our medical providers know which medications are covered by your formulary as well as drug interactions and your prescription history with medical providers.

There is a 48-hour turn-around time on prescription refills. If you have requested a refill of your medication, please check with the pharmacy to see if your request has been filled; continued calls to the office will delay the process. If a written prescription is requested you will be required to pick it up at the front office; please bring a photo ID when picking it up.

If a prescription is not approved, we will contact you. Antibiotics will not be approved without your seeing the practitioner first, and the providers reserve the right to decline a refill at his/her discretion for proper continued care. If you have not been seen in over 6 months, you will need to schedule an appointment with the practitioner for prescription refills. Please bring all medications with you for this appointment, and inform the practitioner at the time of your visit which medications require refills.

THIRD PARTY FORMS/APPLICATIONS

We realize that special forms are sometimes necessary to provide documentation of medical conditions. Completing forms is time consuming and generally falls outside the contractual relationship between you and your insurance company. All forms requested without an appointment will need to be reviewed by the office to determine if an appointment is necessary. Fees for these types of forms will vary according to the complexity of the paperwork. Stricter policies apply to controlled substances.

FMLA PAPERS

All FMLA papers require an appointment with a doctor. Fees for completion of FMLA papers will vary according to the complexity of the case.

FINANCIAL POLICY

Payment is due at the time of service unless arrangements have been made in advance with written approval by the office manager. We accept cash, check, and credit/debit card payments. Please keep in mind that your insurance policy is a contract between you and your insurance company. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay all co-payments, deductibles, and non-covered services at the time of your visit.

If you are insured by a plan that we do not have a prior arrangement with, we will file the claim for you on an unassigned basis as a courtesy to you, provided we have accurate claims billing information. Charges for your care are due in full at the time of service.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Health plan coverage varies significantly by carrier, by employer, and/or by contract. We cannot know the benefits and exclusions of each patient's health plan. It is the patient's responsibility to know and understand their plan coverage and benefits.

All questions regarding your policy benefits should be directed to your insurance carrier. Many insurance companies do not cover visits with the Nurse Practitioner/Physician Assistant. If you are seeing the Nurse Practitioner/Physician Assistant, please contact your insurance carrier prior to your appointment to avoid any unexpected expenses. Do not assume your visit is covered unless your carrier confirms these visits are a covered benefit.

Also, please verify if your insurance requires you to use a particular lab and/or radiological (imaging) facility.

In signing this form, you have read and understand the office policies of Integrity Family Care in addition to authorizing the use of prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

SIGNATURE _____ PRINT NAME _____ DATE _____

INTEGRITY **FAMILY CARE**

RECORDS RELEASE

REMIT THIS FORM TO YOUR PREVIOUS PHYSICIAN

☐ I am mailing myself
☐ I have requested this be faxed using the fax number below

PATIENT NAME _____ DOB _____

PATIENT ADDRESS _____

_____ CITY _____ STATE _____ ZIP _____

PHYSICIAN/FACILITY _____

TEL _____ FAX _____

PHYSICIAN ADDRESS _____

_____ CITY _____ STATE _____ ZIP _____

I authorize the use or disclosure of the above named individual's health information as described below:

☐ Complete Medical Record
☐ Other

_____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome, or human immunodeficiency virus. It may also include information about behavioral or mental health services and treatment for alcohol and drug use and abuse.

This information may be disclosed to and used by the following for the purpose of treatment of the patient:

☐ Integrity Family Care, 1041 Balch Road, Suite 300, Madison, AL 35758

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the physician listed as Previous Physician. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, the authorization will expire on ____/____/____ or if I fail to specify an expiration date, event or condition, this authorization will expire six months from the date of signing.

I understand that once the information is disclosed, the recipient may redisclose it and the information may not be protected by federal privacy regulations.

SIGNATURE _____ DATE _____

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT IS _____

INTEGRITY **FAMILY CARE**

REFERRAL FORM

PATIENT INFORMATION

PATIENT NAME | PHONE | BIRTHDATE

ADDRESS | CITY | STATE | ZIP

INSURANCE INFORMATION

INSURANCE COMPANY | POLICY NUMBER | GROUP NUMBER

SUBSCRIBER NAME | SUBSCRIBER BIRTHDATE

REFERRING PHYSICIAN INFORMATION

REFERRING PHYSICIAN

REASON FOR REFERRAL

IF PREVIOUSLY TREATED BY YOU, PLEASE PROVIDE DETAILS/MEDICATIONS

PLEASE INCLUDE A COPY OF THE PATIENT'S MOST RECENT OFFICE NOTE.

INTEGRITY **FAMILY CARE**

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

EMERGENCY CONTACT

NAME	RELATIONSHIP	TEL

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITY.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item outof-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on the back page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights, visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instruction

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.
- Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
- Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research.

We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

- We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.