LABRADOR
PRIMARY CARE CENTER

Ph: (727) 381-8006 Fax: (727) 381-9629

GENERAL INFORMATION

_____ _____ _____ _____/___/_____
Patient Last Name First Name MI DOB

_(_____)_____ _(_____)_____ Email:_____
Home # Cell Phone #

_____
Home Address City State Zip

_____
Street Address (**if different from mailing**) City State Zip

SS#: _____ - _____ -_____ Male Female Transgender Single Married Divorced Widowed Partner
(Please Circle) (Please Circle)

Employer:_____ Occupation:_____

Primary Ins. Carrier Name:_____ **Secondary Ins. Carrier Name: _____**

_____ _____
Member ID Member ID

Language:_____ Race: _____ Ethnicity:_____

In case of emergency, who would we contact?

_____ _____
Name Relationship

_____ _(_____)_____
Address (Street/City/Zip) Home Phone #

__(_____)_____ __(_____)_____
Cell Phone # Work #

"I authorize disclosure of necessary medical information to determine benefits payable to related services.
By signing this form, I hereby give Labrador Primary Care Center consent to perform medical treatment. If you have a high deductible plan, patient is responsible for payment."

_____ _____
Patient/Guardian Signature Date

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Patient Medical History

Patient Last Name: _____ Patient First Name:_____ D.O. B_____

Date of last physical exam: _____ Previous Physician Name: _____

Physician Address: _____

PAST HISTORY (Personal and Allergies):

Have you had any of the following illnesses?

	Yes	No		Yes	No		Yes	No
Amputation	☐	☐	CVA/TIA	☐	☐			
Anemia	☐	☐	Diabetes	☐	☐	Migraine Headache	☐	☐
Alcohol Overuse	☐	☐	Emphysema/COPD	☐	☐	Nervous Breakdown	☐	☐
Allergies (other than medications)	☐	☐	Falls	☐	☐	Ostomies _____	☐	☐
			Gallbladder Disease	☐	☐	Paralysis	☐	☐
Arthritis	☐	☐	Gout	☐	☐	Rheumatic Fever	☐	☐
Asthma	☐	☐	HIV / AIDS	☐	☐	Seizures	☐	☐
Bleeding Disorder	☐	☐	Heart Attack / MI	☐	☐	Sexually Transmitted Diseases	☐	☐
Cancer location_____	☐	☐	Other Heart Disease (CHF / CAD)	☐	☐	Sickle Cell Anemia	☐	☐
Cardiac Arrhythmias Pacemaker _____	☐	☐	Hepatitis	☐	☐	Sleep Disorder	☐	☐
			High Blood Pressure	☐	☐	Stomach Ulcers	☐	☐
Chicken Pox	☐	☐	Jaundice	☐	☐	Thyroid Disease	☐	☐
Colitis	☐	☐	Kidney Disease	☐	☐	Vascular Disease	☐	☐
Depression	☐	☐	Measles / Mumps	☐	☐			

PERSONAL HABITS

1) Have you ever smoked? ☐Yes ☐No If yes, are you are regular smoker now? ☐Yes ☐No

Have you used chewing tobacco? ☐Yes ☐No If yes, Number of yrs ____ If No, when did you quit? _____

2) Do you regularly drink alcohol: ☐Yes ☐No If yes, how often: _____

3) Have you ever used any of the following: Marijuana ☐ LSD ☐ Heroin ☐ Cocaine ☐ Speed ☐ Other ☐

OPERATIONS: List and indicate approximate year.

_____
_____
_____

SERIOUS INJURIES: List injuries & give approximate dates.

_____
_____
_____

HOSPITALIZATIONS: (Other than operations)

List reasons and approximate dates

_____
_____
_____

DIAGNOSTIC TESTS/EXAMS:

LAST TEST/EXAM	DATE	LOCATION/PROVIDER
EYE EXAM:		
FOOT EXAM:		

IMMUNIZATIONS: (Please give date) Hepatitis B _____ **Flu** _____ Polio _____

Typhoid_____ Smallpox_____ **Tetanus** **Pneumococcal** _____ Chicken Pox _____

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FAMILY HISTORY	Circle Sex	IF LIVING		IF DECEASED	
		AGE	HEALTH	AGE AT DEATH	CAUSE
Father					
Mother					
Brothers/Sisters	Select				
	Select				
	Select				
Sons/Daughters	Select				
	Select				

Check if any blood relative has or had any of the following and enter their relationship

	Yes	No	Relationship to you		Yes	No	Relationship to you
Arthritis	☐	☐	_____	High Blood Pressure	☐	☐	_____
Asthma	☐	☐	_____	Intestinal Polyps	☐	☐	_____
Bleeding Tendency	☐	☐	_____	Kidney Disease	☐	☐	_____
Cancer	☐	☐	_____	Leukemia	☐	☐	_____
Colitis	☐	☐	_____	Migraine	☐	☐	_____
Congenital Heart Disease	☐	☐	_____	Nervous Breakdown	☐	☐	_____
Diabetes	☐	☐	_____	Rheumatic Fever	☐	☐	_____
Emphysema	☐	☐	_____	Sickle Cell Anemia	☐	☐	_____
Epilepsy	☐	☐	_____	Stomach Ulcers	☐	☐	_____
Goiter	☐	☐	_____	Stroke	☐	☐	_____
Gout	☐	☐	_____	Suicide	☐	☐	_____
Hay Fever	☐	☐	_____	Tuberculosis	☐	☐	_____
Heart Attack	☐	☐	_____	Other	☐	☐	_____

Do you have a: Living will_____ Advanced Directive_____ Surrogate decision letter_____

(If so, please bring a copy for our files)

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Patient Last Name: _____ Patient First Name:_____ D.O. B_____

List each medication; its dosage and how often you take it, **including vitamins and herbal supplements.**

Medication	Dosage	How Often?	When Started?

Are you allergic to any medications: Yes ☐ No ☐ If yes, please list medications and the reactions.

Medication	Reaction

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Patient Last Name: _____ Patient First Name:_____ D.O. B_____

Social / Lifestyle History:	Primary Language _____
Is there someone that lives in your residence? ☐ YES ☐ NO	If yes, please list name and relationship:
Type of Residence	Apartment ☐ Mobile Home ☐ House ☐ One Story ☐ Two Story ☐ Assisted Living Facility ☐ Facility Name_____ Other_____
Durable Medical Equipment ☐ YES ☐ NO	Wheelchair _____ Oxygen _____ Walker _____ Nebulizer _____ Cane _____ CPAP/BIPAP _____ Other _____
Can you afford medicines? ☐ YES ☐ NO	Potential Referral to Patient Assistance Program
Transportation provided by?	
Nutritional History:	
Current Weight _____ **Lbs**	Current Height _____ Ft _____ In
Current Diet Plan	
Exercise / Activity:	
Current Activity	How Often
Physical Limitations:	
Activities of Daily Living:	
Do you require assistance to bathe or groom? ☐ YES ☐ NO	If yes, Explain: _____ _____
Do you require assistance for your toilet needs? ☐ YES ☐ NO	If yes, Explain: _____ _____
Do you require assistance to eat? ☐ YES ☐ NO	If yes, Explain: _____ _____
Do you have hearing loss? ☐ YES ☐ NO	Do you wear hearing aids? Yes ☐ No ☐ Last hearing exam date: _____

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Patient Last Name: ____________________ Patient First Name:___________________ D.O. B________________

Preventative Service History

Preventive Services	**Date**	
Bone Mass Measurement (Density) **Fracture:** YES ☐	______________ ______________	What part of your body did you fracture?:
Cardiovascular Disease Screening Cholesterol >>>>>>>>>>>>>>>>>>>>>>>>>> LDL >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>> EKG >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>	 ______________ ______________ ______________	**Do you exercise regularly?** YES☐ NO☐ **Have you fallen in the last 12 months?** YES ☐ **Do you frequently lose your balance or feel dizzy?** YES ☐ **Bladder Control Problem?** YES☐ NO☐
Colorectal Cancer Screening Flexible Sigmoidoscopy>>>>>>>>>>>>>> Colonoscopy (not high risk)>>>>>>>>>> Fecal Occult Blood Test>>>>>>>>>>>>>>	 ______________ ______________ ______________	
Diabetes Screening Hg A1C >>>>>>>>>>>>>>>>>>>>>>>>>> Foot Exam >>>>>>>>>>>>>>>>>>>>>>>>>> Eye Exam >>>>>>>>>>>>>>>>>>>>>>>>>>	 ______________ ______________ ______________	Cataracts ☐ Other ______________________
Glaucoma Screening	______________	Glaucoma ☐
PAP and Pelvic Examination		
Prostate Cancer Screening Digital Rectal Exam (DRE) Prostate Specific Antigen Test (PSA)		
Mammogram Screening Mammogram	 ______________	
Alcohol Screening	______________	
Tobacco Screening	______________	
Pneumonia Vaccine	______________	
Influenza Vaccine	______________	
Sexual History	______________	
Depression Screening	______________	

****

Signature:____ Date:_______________

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Pharmacy _____

Telephone # _____

Authorization to view RX history from External Source

I authorize Labrador Primary Care Center to view any and all available RX history from an external source. I am aware that Labrador Primary Care Center and Staff use a secure connection to SureScripts to send and receive most prescription in the office.

By initialing I have read and understand the above_____

I certify that the above information is correct to the best of my knowledge. Labrador Primary Care Center or any staff members will not be responsible for any errors or omissions that occur secondary to incorrect or incomplete data on this form.

By initialing I have read and understand the above_____

Consent for the Release of Protected Health Information to Personal Representative.

I, _____ give my written consent for Labrador Primary Care Center to share information regarding my protected health information and care to the following listed persons: I understand that these persons will be treated as personal representatives of myself.

Personal Representatives that Carlos A. Labrador, M.D., P.A.,D/B/A Labrador Primary Care Center may share my Protected Health Information with:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I do not want my Protected Health Information shared with anyone other than myself at any time. (initial here) _____

Labrador Primary Care Center staff may leave a message:

At Home _____ At Work _____ At Cell_____ On Answering machine _____

Please provide Insurance Card and Driver License to our Receptionist.

Patient Authorization Form

HIPAA Privacy Notice

I have received and read a copy of Carlos A. Labrador, M.D.,P.A.,D/B/A Labrador Primary Care Center Notice of Privacy Practices

By initialing I have read and understand the above_____

Authorization to Release Information

I consent to the use or disclosure of my protected health information by Carlos A. Labrador, M.D.,P.A.,D/B/A/ Labrador Primary Care Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills.

By initialing I have read and understand the above_____

Authorization for treatment

I hereby authorize the medical staff of Carlos A. Labrador, M.D.,P.A.,B/D/A Labrador Primary Care Center to render medical services and treatments as deemed necessary.

By initialing I have read and understand the above_____

By signing, I have read, understand and agree to comply with Carlos A. Labrador, M.D.,P.A.,D/B/A Labrador Primary Care Center policies so noted in the Notice of Privacy Practices.

Signature _____Date _____

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MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize the following healthcare provider(s) and its physicians, employees and agents to release or disclose to Carlos A. Labrador, M.D.,P.A.,D/B/A/ Labrador Primary Care Center and its representatives all of my medical records including records pertaining to treatment, prognosis and diagnosis, including any specially protected or listed records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection. Please list at least one healthcare provider.

Dr (s): _____

Telephone #: _____ Fax# : _____

Address: _____

I further authorize you to provide to and discuss with Carlos A. Labrador, M.D.,P.A. and its representatives any confidential information with respect to my medical condition or treatment, either formally or informally.

Release Medical Records To:
LABRADOR PRIMARY CARE CENTER
6775 Crosswinds Dr. North
SAINT PETERSBURG, FL 33710
Fax: (727) 381-9629

Patient's Name: _____
SSN: _____
Date of Birth: _____

Which Records?: All medical, psychiatric, psychological diagnosis and treatment records, hospital records, and any records pertaining to my medical history, pathology, including tissue samples, slides and/or blocks, charts and x-ray film reports.

Purpose of Disclosure: New PCP.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the release information may no longer be protected by Federal privacy regulations. I understand that I am not required to sign this Authorization to ensure treatment and I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rule. This authorization shall remain valid for 12 months from the date signed below.
Any re-disclosure of this information by recipient is not protected under this authorization.

Patient or Authorized Representative's Signature:_____

Relationship to Patient: _____ **Date:** _____

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Advance Directives

What are advance directives?

"Advance Directive" is a general term that refers to your oral or written Instructions about your future medical care in the event you become unable to speak for yourself.

What is a living will?

A living will is a type of advance directive in which you put in writing your wishes about medical treatment should you be unable to communicate your wishes.

What is a medical power of attorney?

A medical power of attorney is a document that lets you appoint someone you trust make decisions about your medical care if you cannot make those decisions yourself.

Why do I need an advance directive?

Advance directives give you a voice in decisions about your medical care when you are unconscious or too ill to communicate. As long as you are able to express your own decisions your advance directives will not be used and you can accept or refuse any medical treatment. But if you become seriously ill, you may lose the ability to participate in decisions about your own treatment.

What happens if I don't have an advance directive?

In the event that you cannot speak for yourself, health and medical decisions may be made by someone not of your choosing or by the court.

Once I make an advance directive, can I cancel it?

Yes, your advance directive can be canceled or revoked by you at any time.

Who should I talk to about an advance directive?

Your Primary Care Physician is the best person to answer your questions. Your doctor has the knowledge and cares about you to put your concerns at ease. All the necessary paperwork and information is available at our office. Ask your doctor or see the receptionist.

In order to comply with the Omnibus Budget Reconciliation Act (OBRA) of 1990 and Chapter 765 of the Florida Statutes, please answer the following questions:

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Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

___ I have made such a declaration.
___I have **NOT** made such a declaration.

Health Care Surrogate

___I have designated a Health Care Surrogate.
___I have **NOT** designated a Health Care Surrogate.

Durable Power of Attorney

___I have appointed a Durable Power of Attorney for Health Care decisions.
___I have **NOT** appointed a Durable Power of Attorney for Health Care decisions.

I have been provided information regarding the PATIENT SELF DETERMINATION ACT:

_____ _____ - _____ - _____
Please Print Full Name Social Security Number

Signature: _____ Date:_____
Patient or Patient Representative

Relationship of Patient Representative (If applicable) :_____

YEARLY RECONFIRMATION

I acknowledge that this information remains accurate.

_____ _____
Signature of Patient or Patient Rep Date

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but decline to answer the above questions.

Signature of Patient or Patient Rep:_____ Date:_____

Relationship of Patient Representative (If applicable):_____

Don't forget to bring a copy for our records.

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Financial Agreement & Payment Policy.

All co- pays/Deductibles and/or account balances are collected at time of check-in/out.

Patients covered by Insurance

I hereby agree to allow Carlos A. Labrador, M.D.,P.A.,D/B/A Labrador Primary Care Center services to file any claims to my insurance company or companies for payment of services rendered in this medical practice.

I fully understand that any unpaid balances not covered by my insurance company due to insurance cancellation, deductibles and co pays, or non covered services on your policy, will be deemed due within 30 days from date of service. (Financial arrangements will have to be made with management to carry balances over this period of time.)

Self pay patients

Patients seen without insurance coverage will be required to pay Full Amount on first day of service. This amount will cover only the office visit and will not include any procedures or medications the doctor may need for patient treatment.

Patient accounts with overdue balance or accounts in collections status, will have to be (paid in full) prior to having another appointment. (Unless prior arrangements have been made with Office Manager)

No samples or non-medically necessary prescriptions will be dispensed or written to accounts with overdue or collection balances.

*By initialing I have read and understand the above*_________

Authorization for treatment

I hereby authorize the medical staff of Carlos A. Labrador, M.D.,P.A.,D/B/A Labrador Primary Care Center to render medical services and treatments as deemed necessary.

*By initialing I have read and understand the above*_________

By signing, I have read, understand and agree to comply with Carlos A. Labrador, M.D.,P.A. , D/B/A Labrador Primary Care Center policies so noted in the Notice of Privacy Practices.

Form Fee Agreement

Please note: The completion of informational/insurance forms represents an administrative service to our patients above and beyond the provision of medical care.

Recent changes in health care have resulted in the tremendous increase in the volume of information requests to our practice. The time and effort involved in providing this detailed information results in significant costs, especially when multiplied over the large number of patients our practice serves. The refusal of insurance companies and requesting agencies to cover the costs requires us to institute a policy of charges for the completion of the forms as follows:

$15.00:

• Disabled Parking Applications (Forms are provided by DMV)

****

$55.00/ per form:

• Private Disability Insurance Form • School, Educational, Disability or Limitation Forms • Family Medical Leave Act (FMLA)

• If you are unable to make your scheduled appointment, please call the office within 24 hours prior to your appointment time. Otherwise, a fee will be applied for no show. ($35.00 per no show visit)

• NSF/Return Checks fee** **Writing bad checks is a crime** Returned checks will have fees added and will be due within 10 days of bank notification.

By signing I agree to comply with the Form Fee policy of Carlos A. Labrador, M.D.,P.A.,D/B/A Labrador Primary Care Center.

___________________________________ ____________________________

Patient Name (printed) Signature

PATIENT CONTRACT FOR PAIN CONTROL

Ph: (727) 381-8006 Fax: (727) 381-9629

The pain you are currently experiencing may be helped with the use of narcotic pain medications. A doctor may prescribe appropriate narcotic medications for your specific type of pain. Narcotic pain medications may:

a. Become ineffective with time.
b. Become habit forming or cause addiction.
c. Cause severe constipation that requires frequent use of laxative.
d. Interfere with your ability to operate complex machinery. It is recommended that you not drive an automobile or operate such machinery as power tools while taking narcotic medications.

I understand that I have a chronic pain problem that currently requires the prescription for narcotic pain medication for relief of pain and to improve my functional ability. The risks, benefits and alternatives of medication have been discussed with me by the physician in detail, including but not limited to, drug dependency, respiratory depression, cardiovascular depression, liver and/or kidney damage, etc.

I will not take any illegal substances.

I will have my prescriptions filled only by my Pain Management doctor and/or my Primary Care Doctor at only one pharmacy and I will notify my Primary Care Physician of the name of the pharmacy if prescribed by Pain Management doctor.

I waive my right to privacy regarding these medication(s). My physician may contact any health care provider, legal authority, other doctors and or pharmacy to obtain or provide information about the patient's care.

I will take the medication(s) only as prescribed and will notify my physician if I do not. If necessary, I agree to random urine and blood tests to assess my compliance.

I understand that the eventual goal is to taper off the narcotic medication(s). I agree to meet regularly with my physician to assess my progress.

Federal and state law regulates dispensing narcotic medications. Forging or altering a narcotics prescription is a crime. Mandatory compliance by both the patient and physician is required. Failure to comply with all the laws regarding narcotic medications may result in criminal action being taken against you. We will notify also your insurance carrier.

Refills will not be given early for any reason. PRESCRIPTIONS WILL ONLY BE GIVEN DURING REGULAR OFFICE HOURS AND WILL NOT BE GIVEN OR REFILLED BY THE PHYSICIAN DURING WEEKENDS. No narcotics can be given over the telephone. NO AFTER HOURS CALLS WILL BE ACCEPTED FOR THESE MEDICATIONS.

An increase in your pain will NOT necessarily be a reason to increase your pain medication. Contact the doctor for an appointment if you feel a change in your medication is needed.

Eliminating or rescuing the use of your narcotic medications may be a treatment goal, and this may require hospitalization.

A psychological evaluation regarding addiction and drug dependency may be necessary for continuation of narcotics more than 3 (three) months.

Failure to follow these instructions may require the doctor to stop prescribing narcotic medications and recommend treatment in a psychiatric, substance abuse, or detoxification program. If this should occur, the doctor may still continue to manage your pain in other ways, such as with non-narcotic medications.

If I deviate from the above guidelines or if the medication losses its effectiveness in increasing my function ability, I understand that the narcotic may be tapered off by the physician. My signature at the bottom indicates my understanding and agreement with the above guidelines.

Your signature below indicates that you have read and understand these instructions and that you agree to comply with the terms of this agreement.

PATIENT NAME (Print) _____

PATIENT SIGNATURE _____ **DATE** _____

WITNESS _____ DATE _____

Pharmacy Name: _____ Pharmacy Phone No. _____

HIPAA Notice of Privacy Practices

Revised on: 01/02/2017

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND/OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT

This Notice of Privacy Practices is NOT an authorization. It describes how we, our Business Associates, and their subcontractors may use and disclose your Protected Health Information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. "Protected Health Information" is information that identifies you individually, including demographic information that relates your past, present, or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your Protected Health Information in the following situations:

- **Treatment:** We may use or disclose your Protected Health Information to provide medical treatment and/or services in order to manage and coordinate your medical care. For example, we may share your medical information with other physicians and health care providers, DME vendors, surgery centers, hospitals, rehabilitation therapists, home health providers, laboratories, nurse case managers, worker's compensation adjusters, etc. to ensure that the medical provider has the necessary medical information to diagnose and provide treatment to you.
- **Payment:** Your Protected Health Information will be used to obtain payment for your health care services. For example, we will provide your health care plan with the information it requires prior to paying us for the services we have provided to you. This use and disclosure may also include certain activities that your health plan requires prior to approving a service, such as determining benefits eligibility and prior authorization, etc.
- **Health Care Operations:** We may use and disclose your Protected Health Information to manage, operate, and support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, licensing, fundraising, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **Minors:** Protected Health Information of minors will be disclosed to their parents or legal guardians, unless prohibited by law.
- **Required by Law:** We will use or disclose your Protected Health Information when required to do so by local, state, federal, and international law.
- **Abuse, Neglect, and Domestic Violence:** Your Protected Health Information will be disclosed to the appropriate government agency if there is belief that a patient has been or is currently the victim of abuse, neglect, or domestic violence and the patient agrees or it is required by law to do so. In addition, your information may also be disclosed when necessary to prevent a serious threat to your health or safety or the health and safety of others to someone who may be able to help prevent the threat.
- **Judicial and Administrative Proceedings:** As sometimes required by law, we may disclose your Protected Health Information for the purpose of litigation to include: disputes and lawsuits; in response to a court or administrative order; response to a subpoena; request for discovery; or other legal processes. However, disclosure will only be made if efforts have been made to inform you of the request or obtain an order protecting the information requested. Your information may also be disclosed if required for our legal defense in the event of a lawsuit.
- **Law Enforcement:** We will disclose your Protected Health Information for law enforcement purposes when all applicable legal requirements have been met. This includes, but is not limited to, law enforcement due to identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or warrant, and grand jury subpoena.
- **Coroners and Medical Examiners:** We disclose Protected Health Information to coroners and medical examiners to assist in the fulfillment of their work responsibilities and investigations.
- **Public Health:** Your Protected Health Information may be disclosed and may be required by law to be disclosed for public health risks. This includes: reports to the Food and Drug Administration (FDA) for the purpose of quality and safety of an FDA-regulated product or activity; to prevent or control disease; report births and deaths; report child abuse and/or neglect; reporting of reactions to medications or problems with health products; notification of recalls of products; reporting a person who may have been exposed to a disease or may be at risk of contracting and/or spreading a disease or condition.
- **Health Oversight Activities:** We may disclose your Protected Health Information to a health oversight agency for audits, investigations, inspections, licensures, and other activities as authorized by law.
- **Inmates:** If you are or become an inmate of a correctional facility or under the custody of the law, we may disclose Protected Health Information to the correctional facility if the disclosure is necessary for your institutional health care, to protect your health and safety, or to protect the health and safety of others within the correctional facility.
- **Military, National Security, and other Specialized Government Functions:** If you are in the military or involved in national security or intelligence, we may disclose your Protected Health Information to authorized officials.

- **Immunizations:** We will provide proof of immunizations to a school that requires a patient's immunization record prior to enrollment or admittance of a student in which you have informally agreed to the disclosure for yourself or on behalf of your legal dependent.
- **Worker's Compensation:** We will disclose only the Protected Health Information necessary for Worker's Compensation in compliance with Worker's Compensation laws. This information may be reported to your employer and/or your employer's representative regarding an occupational injury or illness.
- **Practice Ownership Change:** If our medical practice is sold, acquired, or merged with another entity, your protected health information will become the property of the new owner. However, you will still have the right to request copies of your records and have copies transferred to another physician.
- **Breach Notification Purposes:** If for any reason there is an unsecured breach of your Protected Health Information, we will utilize the contact information you have provided us with to notify you of the breach, as required by law. In addition, your Protected Health Information may be disclosed as a part of the breach notification and reporting process.
- **Research:** Your Protected Health Information may be disclosed to researchers for the purpose of conducting research when the research has been approved by an Institutional Review or Privacy Board and in compliance with law governing research.
- **Business Associates:** We may disclose your Protected Health Information to our business associates who provide us with services necessary to operate and function as a medical practice. We will only provide the minimum information necessary for the associate(s) to perform their functions as it relates to our business operations. For example, we may use a separate company to process our billing or transcription services that require access to a limited amount of your health information. Please know and understand that all of our business associates are obligated to comply with the same HIPAA privacy and security rules in which we are obligated. Additionally, all of our business associates are under contract with us and committed to protect the privacy and security of your Protected Health Information.

USES AND DISCLOSURES IN WHICH YOU HAVE THE RIGHT TO OBJECT AND OPT OUT

- **Communication with family and/or individuals involved in your care or payment of your care:** Unless you object, disclosure of your Protected Health Information may be made to a family member, friend, or other individual involved in your care or payment of your care in which you have identified.
- **Disaster:** In the event of a disaster, your Protected Health Information may be disclosed to disaster relief organizations to coordinate your care and/or to notify family members or friends of your location and condition. Whenever possible, we will provide you with an opportunity to agree or object.
- **Fundraising:** As necessary, we may disclose your Protected Health Information to contact you regarding fundraising events and efforts. You have the right to object or opt out of these types of communications. Please let our office know if you would NOT like to receive such communications.

USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

We will not disclose or use your Protected Health Information in the situations listed below without first obtaining written authorization to do so. In addition to the uses and disclosures listed below, other uses not covered in this Notice will be made only with your written authorization. If you provide us with authorization, you may revoke it at any time by submitting a request in writing:

- **Disclosure of Psychotherapy Notes:** Unless we obtain your written authorization, in most circumstances we will not disclose your psychotherapy notes. Some circumstances in which we will disclose your psychotherapy notes include the following: for your continued treatment; training of medical students and staff; to defend ourselves during litigation; if the law requires; health oversight activities regarding your psychotherapist; to avert a serious or imminent threat to yourself or others; and to the coroner or medical examiner upon your death.

Disclosures for marketing purposes and sale of your Protected Health Information

PROTECTED HEALTH INFORMATION AND YOUR RIGHTS

The following are statements of your rights, subject to certain limitations, with respect to your Protected Health Information:

- **You have the right to inspect and copy your Protected Health Information (reasonable fees may apply):** Pursuant to your written request, you have the right to inspect and copy your Protected Health Information in paper or electronic format. Under federal law, you may not inspect or copy the following types of records: psychotherapy notes, information compiled as it relates to civil, criminal, or administrative action or proceeding; information restricted by law; information related to medical research in which you have agreed to participate; information obtained under a promise of confidentiality; and information whose disclosure may result in harm or injury to yourself or others. We have up to 30 days to provide the Protected Health Information and may charge a fee for the associated costs.

- **You have a right to a summary or explanation of your Protected Health Information:** You have the right to request only a summary of your Protected Health Information if you do not desire to obtain a copy of your entire record. You also have the option to request an explanation of the information when you request your entire record.
- **You have the right to obtain an electronic copy of medical records:** You have the right to request an electronic copy of your medical record for yourself or to be sent to another individual or organization when your Protected Health Information is maintained in an electronic format. We will make every attempt to provide the records in the format you request; however, in the case that the information is not readily accessible or

producible in the format you request, we will provide the record in a standard electronic format or a legible hard copy form. Record requests may be subject to a reasonable, cost-based fee for the work required in transmitting the electronic medical records.

- **You have the right to receive a notice of breach:** In the event of a breach of your unsecured Protected Health Information, you have the right to be notified of such breach.
- **You have the right to request Amendments:** At any time if you believe the Protected Health Information we have on file for you is inaccurate or incomplete, you may request that we amend the information. Your request for an amendment must be submitted in writing and detail what information is inaccurate and why. Please note that a request for an amendment does not necessarily indicate the information will be amended.
- **You have a right to receive an accounting of certain disclosures:** You have the right to receive an accounting of disclosures of your Protected Health Information. An "accounting" being a list of the disclosures that we have made of your information. The request can be made for paper and/or electronic disclosures and will not include disclosures made for the purposes of: treatment; payment; health care operations; notification and communication with family and/or friends; and those required by law.
- **You have the right to request restrictions of your Protected Health Information:** You have a right to restrict and/or limit the information we disclose to others, such as family members, friends, and individuals involved in your care or payment for your care. You also have the right to limit or restrict the information we use or disclose for treatment, payment, and/or health care operations. Your request must be submitted in writing and include the specific restriction requested, whom you want the restriction to apply, and why you would like to impose the restriction. Please note that our practice/your physician is not required to agree to your request for restriction with the exception of a restriction requested to not disclose information to your health plan for care and services in which you have paid in full out-of-pocket.
- **You have a right to request to receive confidential communications:** You have a right to request confidential communications from us by alternative means or at an alternative location. For example, you may designate we send mail only to an address specified by you which may or may not be your home address. You may indicate we should only call you on your work phone or specify which telephone numbers we are allowed or not allowed to leave messages on. You do not have to disclose the reason for your request; however, you must submit a request with specific instructions in writing.
- **You have a right to receive a paper copy of this notice:** Even if you have agreed to receive an electronic copy of this Privacy Notice, you have the right to request we provide it in paper form. You may make such a request at any time.

Name **Signature** **Date**

LABRADOR
PRIMARY CARE CENTER

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CHANGES TO THIS NOTICE: We reserve the right to change the terms of this notice and will notify you of such changes. We will also make copies available of our new notice if you wish to obtain one. Complaints: If at any time you believe your privacy rights have been violated and you would like to register a complaint, you may do so with us or with the Secretary of the United States Department of Health and Human Services.