6775 Crosswinds Drive N Ph (727) 381-8006
St. Petersburg, FL 33710 Fax (727) 381-9629

LABRADOR PRIMARY CARE CENTER

2191 9th Avenue N, #220 Ph (727) 327-9667
St. Petersburg, FL 33713 Fax (727) 321-1655

GENERAL INFORMATION

How did you hear about us?_____

_____ _____ ____ _____/_____/_____
Patient Last Name First Name MI Date of Birth

(_____)_____-_____ (_____)_____-_____ _____
Home # Cell # Email

_____ _____ ____ _____
Mailing Address City ST Zip

_____ _____ _____ _____
Physical Address (if different than mailing) City ST Zip

_____-_____-_____ ❑Male ❑Transgender ❑ Single ❑ Married ❑ Divorced
SSN# ❑Female ❑ Widowed ❑ Life Partner

_____ _____
Employer Occupation

INSURANCE INFORMATION

_____ _____
Primary Health Insurance Carrier ID#

_____ _____
Secondary Health Insurance Carrier ID#

Language_____Race_____Ethnicity _____

EMERGENCY CONTACT

_____ _____
Name Relationship

_____ _____ _____ _____
Mailing Address City ST Zip

(_____)_____-_____ (_____)_____-_____ (_____)_____-_____
Home# Cell# Work#

May we share your protected health information with this person? ❑ Yes, you can share information
❑ No, just use as emergency contact

Signature _____ _____/_____/_____
Patient or Patient Representative Date

Relationship of Patient Representative (if applicable) _____

LABRADOR PRIMARY CARE CENTER PATIENT NAME_____DOB _____

PATIENT MEDICAL INFORMATION

Previous Physician Name _____

Physician Address / Location _____

Ph# (_____)_____-_____ ***Date of last physical*** _____

HAVE YOU HAD ANY OF THE FOLLOWING ?

	YES	NO		YES	NO		YES	NO
Amputation	❑	❑	CVA (Stroke) /TIA	❑	❑	Migraines	❑	❑
Anemia	❑	❑	Diabetes	❑	❑	Nervous Breakdown	❑	❑
Alcohol Overuse	❑	❑	Emphysema/COPD	❑	❑	Ostomy- Location _____	❑	❑
Allergies other than medication	❑	❑	Falls	❑	❑			
Arthritis	❑	❑	Gallbladder Disease	❑	❑	Pacemaker	❑	❑
Asthma			Gout	❑	❑	Paralysis	❑	❑
Balance issues / Dizzy	❑	❑	HIV/AIDS	❑	❑	Rheumatic Fever	❑	❑
Bladder control issues	❑	❑	Heart Attack (MI)	❑	❑	Seizures	❑	❑
Bleeding Disorder	❑	❑	Other heart disease	❑	❑	Sexually Transmitted	❑	❑
Cancer	❑	❑	(CHF/CAD)	❑	❑	Disease	❑	❑
Location_	❑	❑	Hepatitis	❑	❑	Sleep Disorders	❑	❑
Cardiac Arrhythmias	❑	❑	High Blood Pressure	❑	❑	Stomach Ulcers	❑	❑
Colitis	❑	❑	Jaundice	❑	❑	Thyroid Disease	❑	❑
Depression	❑	❑	Kidney Disease	❑	❑	Vascular Disease	❑	❑

PERSONAL HABITS

Do you exercise regularly? ❑Yes ❑No If **yes**, how often? _____

Have you ever smoked? ❑Yes ❑No

If **yes,** are you a regular smoker now? ❑Yes ❑No

If **yes,** number of years smoked_____. If **no**, when did you quit? _____

Have you ever used chewing tobacco? ❑Yes ❑No

Do you regularly drink alcohol? ❑Yes ❑No If **yes**, how often? _____

If you have ever used any of the following drugs, please check and provide the date last used:

❑Marijuana_____❑LSD_____❑Heroin_____❑Cocaine_____❑Speed_____Other_____

OPERATIONS List & indicate approx. year _____

_____

_____

SERIOUS INJURIES List & indicate approx. year _____

_____

OTHER HOSPITALIZATIONS List reason & dates _____

_____

_____

PREVENTATIVE HISTORY

PREVENTIVE SCREENING / TEST	DATE	IMMUNIZATIONS	YEAR
DEXA (bone density test)		Hepatitis A	
Eye exam		Hepatitis B	
Foot exam		Polio	
EKG		Chicken Pox	
Cholesterol / Lipids		Tetanus	
HgbA1c (lab test for diabetes)		Pneumococcal	
Colonoscopy		Flu	
FOBT (fecal occult blood test)		Shingles	
PAP / Pelvic Exam		Covid	
PSA (prostate test)			
Digital rectal exam (prostate check)			
Mammogram			

FAMILY HISTORY

Family Member	Sex		If Living		If Deceased	
			AGE	Current Health	AGE at death	Cause of death
Father	M					
Mother		F				
Brothers / Sisters	M	F				
Brothers / Sisters	M	F				
Sons/ Daughters	M	F				
Sons/ Daughters	M	F				

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

	YES	NO	Relationship to you		YES	NO	Relationship to you
Asthma	❑	❑		High Blood Pressure	❑	❑	
Bleeding Tendency	❑	❑		Intestinal Polyps	❑	❑	
Cancer	❑	❑		Kidney Disease	❑	❑	
Colitis	❑	❑		Leukemia	❑	❑	
Congenital Heart Disease	❑	❑		Nervous Breakdown	❑	❑	
Diabetes	❑	❑		Rheumatic Fever	❑	❑	
Epilepsy	❑	❑		Sickle Cell Anemia	❑	❑	
Gout	❑	❑		Stomach Ulcers	❑	❑	
Epilepsy	❑	❑		Stroke	❑	❑	
Heart Attack	❑	❑		Suicide	❑	❑	
				Other	❑	❑	

LABRADOR PRIMARY CARE CENTER

PATIENT NAME_____DOB _____

PRIMARY PHARMACY _____ **PHARMACY #2**_____

PHONE #_____ **PHONE #** _____

ADDRESS/LOCATION_____ **ADDRESS/LOCATION**_____

_____ _____

LIST OF CURRENT MEDICATIONS / VITAMINS / SUPPLEMENTS If no current medications, check here❑

MEDICATION	DOSAGE	HOW OFTEN	WHEN STARTED?

Are you allergic to any medications? ❑Yes ❑No if yes, please list medication and adverse reaction

MEDICATION	ALLERGIC REACTION

ALL MEDICATION BOTTLES MUST BE BROUGHT TO EACH OFFICE VISIT

Do you use any of these? If so, please specify how use you use them: ❑ Oxygen _____

❑CPAP_____❑Nebulizer machine_____❑Other equipment_____

What other doctors / specialists do you see?

Doctor name_____Specialty_____

Doctor name_____Specialty_____

Doctor name_____Specialty_____

Doctor name_____Specialty _____

LABRADOR PRIMARY CARE CENTER PATIENT NAME_____DOB _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO LABRADOR PRIMARY CARE CENTER

I hereby authorize the following healthcare provider(s) and its physicians, employees and agents to release or disclose to 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.
I further authorize you to provide to and discuss with Labrador Primary Care staff and its representatives any confidential information with respect to my medical condition or treatment, either formally or informally.

Authorized to release medical records:

Dr. _____

Address: _____

Phone (_____)_____-_____ **Fax (_____)_____-_____**

Release medical records to: LABRADOR PRIMARY CARE CENTER

❑ **6775 Crosswinds Dr. N, St. Petersburg, FL 33710** **Ph: 727-381-8006** **Fax: 727-381-9629**

❑ **2191 9th Avenue N, #220, St. Petersburg, FL 33713** **Ph (727) 327-9667** **Fax: 727-321-1655**

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. Include the following **circled** items:

Progress notes	**Case Manager notes**	**Mammogram**	**Echo / Stress test**
Emergency Dept notes	**Discharge Summary**	**Colonoscopy / FOBT**	**EKG**
Operative Reports	**Labs**	**DEXA**	**ALL MEDICAL RECORDS**
Consultation Reports	**Radiology reports**	**Eye exam**	

Purpose of Disclosure: Continuity of care

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the release of 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.

Signature _____ _____/_____/_____
Patient or Patient Representative Date

Relationship of Patient Representative (if applicable) _____

1st request_____2nd request_____3rd request _____

Consent for 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 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 ____

_____INITIAL **PATIENT AUTHORIZATIONS**

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 prescriptions in the office.

HIPAA Privacy Notice / Office Policy Agreement

I have received and read a copy of Notice of Privacy Practices/ Office Policies and agree to comply with Office Policies

Authorization to Release Information

I consent to the use or disclosure of my protected health information by Labrador Primary Care Center for the purpose of diagnosing, providing treatment to me, or obtaining payment for my health care.

Authorization for treatment

I hereby authorize Labrador Primary Care Center staff to render medical services and treatments as deemed necessary.

_____INITIAL **FINANCIAL AGREEMENT & PAYMENT POLICY**

You are financially responsible for all services rendered in this office.

We may file your Insurance as a courtesy, however any final balance due is ultimately your responsibility.

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

No samples or non-medically necessary prescriptions will be dispensed or written for patient if account is in overdue or collections status.

Lab draw fees - $20 blood draw fee for all private pay patients. Medicare recipients are excluded.

Late cancellation / No-show - **$35** fee will be assessed for all provider appointments not cancelled with 24 hours' notice

NSF/Return Checks fee – $45 Returned checks will have fees assessed and will be due within 10 days of bank notification.

Form Fee Agreement – **$15** - Disabled Parking Application (forms provided by DMV provided)

$55 - FMLA / School / Educational / Disability / Limitation Forms

Patients covered by Insurance – I hereby agree to allow Labrador Primary Care 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, co-insurance, co-payments, or non-covered services, will be deemed due within 30 days from date of service. (Financial agreements 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 the full amount for services rendered on the day of services. Provider visits, lab draws, injections, procedures, and treatments are each priced separately. You will be given all pricing information prior to services being rendered.

Patient accounts with overdue balance or in collection status will have to be paid in full prior to having another appointment. (unless prior arrangements have been made with management)

_____INITIAL **OFFICE POLICY AGREEMENT**

1. Accounts must be kept current in order to continue to receive care.
2. Co-pays, deductibles, and overdue balances are collected prior to appointment.
3. Please arrive 15 minutes before your appointment time
4. Appointments are cancelled if you have not arrived after 15 minutes of appointment time.
5. Provider & Physical Therapy appointments require a 24-hour notice to cancel/re-schedule.
6. All medicine bottles must be brought to each office visit.
7. Medication refills / new requests:
    a. Medications can only be prescribed to patients that have been evaluated in the last year.
    b. Prescriptions only provided during office hours; do not contact the on-call provider for refills.
    c. Request refills when you are near the end of your current supply; we request 24 hours to process refills.
8. Office visits with Providers:
    a. Please do not ask us to address health issues of family members during your appointment.
    b. Respect our schedule and address all questions within your 15 min. appointment time frame.
9. Due to large call volumes, your call may be routed to our answering machine. Please leave a clear message including your name, date of birth, and phone number so that we can return your call promptly.
10. To best answer all of your questions we ask that you return to the office to obtain your lab and test results.

_____INITIAL **CANCELLATION / NO SHOW POLICY**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

1. All provider appointments, including physical therapy which are cancelled with less than 24 hours notification may be subject to a **$35 cancellation fee**; this fee will not be billed to your insurance company. This does not apply to Lab or nursing appointments.
2. Patients who do not show up for their appointment without notification will be considered as NO SHOW and will be subject to a **$35 NO SHOW** fee. Patients who No-Show three (3) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments.
3. We understand that delays can happen however we cannot delay the next patient's appointment. If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.
4. All cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

BEHAVIOR CONTRACT

As a patient in this office, you have a responsibility for conducting yourself in a manner consistent with appropriate behavior. We are establishing expectations as to what is, and is not, considered "appropriate behavior" with respect to what will be tolerated in our office. "Appropriate behavior" is defined, but not specifically limited to, the following:

1. You will neither threaten nor carry out any form of physical abuse to any physician or other staff members involved in your care in this office.
2. You will not touch any physician or other staff members involved in your care.
3. You will not emotionally, psychologically or mentally abuse any physician or other staff member involved in your care. Examples of such activities include, but are not limited to, swearing, bullying, insulting, demeaning, degrading or otherwise using offensive language during the course of office visits, telephone calls, e-mails or other communication with the office staff during the course of your seeking care. Such behavior will not be tolerated at any time and may result in your being transferred from the office's care.
4. You will also conduct yourself appropriately with other patients seeking care in the office. Failure to do so will be considered the equivalent of acting with inappropriate behavior to the staff.
5. You will come to your appointments as scheduled. You will not consistently cancel or “No-show” for appointments. You will have ample opportunity to change appointments when absolutely necessary, but no-call, no-show will not be tolerated. Processes are in place to transfer you from the practice if necessary.

Our Commitment & Responsibilities to You

We are committed to doing all we can to treat your health conditions. We consider our working with you to be a partnership where we will work together cordially and respectfully to help you achieve your best health. As a part of that commitment, we will offer you recommendations as to treatments and/or therapies to help you achieve your best health. Moreover, we will respect your choices and decisions with respect to how you wish to manage and address your health.

Patient Statements

I have been informed that in order to remain a patient of the practice, I need to conduct myself so that my behavior is appropriate within the office setting. Appropriate behavior needs to be exhibited to any physician who practices in the office as well as to the office staff. Appropriate behavior also needs to be exhibited towards other patients on the premises who are seeking care for their own maladies.

I have been informed and understand that, while my physician will make recommendations as to treatments and/or therapies that could improve my health, my physicians will ultimately respect my decisions with regard to management of my health and well-being.

In addition, I authorize Labrador Primary Care Center to provide a copy of this agreement to my pharmacy, other healthcare providers, or insurance carrier upon request. I also authorize and consent to allow my physician/physician assistant and any other office personnel to disclose or share my medical information and treatment received with any other third parties for purposes of treatment and/or payment purposes. In addition, I agree to waive any applicable privilege or right to privacy or confidentiality with respect to authorizing Labrador Primary Care Center and its personnel to cooperate fully with any state or federal law or any state or federal agency (eg. CMS).

I certify that the information provided by me 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 signing I affirm that I have read, understand, and agree to all of the above authorizations and policies

Signature _____ _____/_____/_____

Patient or Patient Representative Date

Relationship of Patient Representative (if applicable) _____

PATIENT CONTRACT FOR PAIN CONTROL

Chronic pain 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 a chronic pain problem may require 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 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.

Signature _____ _____/_____/_____
Patient or Patient Representative Date

Relationship of Patient Representative (if applicable) _____

ADVANCED 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 that 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 to 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 even 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 cancelled 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:

Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

☐ I have made such a declaration (please provide us a copy for our records)

☐ I have **NOT** made such a declaration

Health Care Surrogate

☐ I have designated a Health Care Surrogate (please provide us a copy for our records)

☐ I have **NOT** designated a Health Care Surrogate

Durable Power of Attorney

☐ I have appointed a Durable Power of Attorney for Health Care decisions (please provide us a copy for our records)

☐ I have **NOT** appointed a Durable Power of Attorney for Health Care decisions

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

Signature _____ _____/_____/_____

Patient or Patient Representative Date

Relationship of Patient Representative (if applicable) _____

HIPAA NOTICE OF PRIVACY PRACTICES

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

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.

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.