Genesis Medical Group

YOUR VISIT

Dear Patient,

Welcome to Genesis Medical Group!

Our goal here at Genesis Medical Group is to provide you with the highest level of care and get you back to living life to the fullest.

We want to make your first appointment an easy and pleasant experience. Here are a few reminders about your first appointment:

- Please bring the following items to your new patient appointment:
- Medical insurance card
- Driver's license or state id
- Medical records, we will request your medical records but need authorization. Bring all records you have in your possession as well.
- Current medication list
- Allergy list
- Completed new patient forms

Please plan to arrive to your appointment 30 minutes prior to your scheduled appointment time, this will allow you to complete the new patient paperwork if you have not completed beforehand. The new patient paperwork is located on our website at www.genesisdoctors.com.

Please be prepared to spend up to two hours at your first appointment; your first appointment will be a comprehensive visit including a physical exam and review of your medical history. We also want to allow enough time for you to communicate any questions or concerns you may have.

Be prepared with a list of questions for your physician; this will allow you to effectively communicate all your questions during your appointment.

We will verify your insurance and obtain any required referrals/authorizations prior to your appointment. In the event we encounter any issues in verifying or obtaining referral/authorization we will contact you prior to the appointment.

Your copay or patient responsibility will be due at the time of service.

If you have any questions regarding your new patient appointment please contact our new patient coordinators at 832-289-5801.

We look forward to meeting you at your first appointment and taking care of your healthcare needs.

Sincerely,
Genesis Medical Group

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NEW PATIENT MEDICAL QUESTIONNAIRE

Please complete this questionnaire by answering each question as accurately as possible.

GENERAL INFORMATION

Patient Name: _____ _____ Date of Birth: _____ Sex: Male Female

Social Security:_____ -_____ -_____ Insurance Carrier: _____Insurance ID#: _____

Address:_____ City: _____ Zip Code: _____

Phone: (_____) _____ - _____ Cell/Wk: : (_____) _____ - _____

Referring Physician: _____ Primary Care Physician: _____

Marital Status: ___ Married ___ Single ___ Divorced ___ Widow ___ Other

CHIEF COMPLAINT/REASON FOR VISIT

What is the reason for your visit today? _____

Are you experiencing any pain? (circle one) **YES** **NO** , if yes where is the pain location _____

If you marked yes, please indicate on the scale of 1 to 10 with 10 being the highest your level of pain **1 2 3 4 5 6 7 8 9 10**

MEDICATIONS

Please list all prescriptions and over-the-counter medication you take on a regular basis. **(If you have a list readily available, please give copy to the front desk)**

Medication Name	Dose (ex. 50mg)	Frequency (ex. Once a day)	Reason for Taking

ALLERGIES

Are you allergic to any medications? **YES** **NO** if yes please list medications _____
Are you allergic to intravenous contrast? **YES** **NO** if yes please list your reaction _____
Any other allergies? Incl. Latex **YES** **NO** if yes please list _____

PHARMACY INFORMATION

Name: _____ Phone #: _____

Address:_____

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SOCIAL HISTORY

1. Select All That Apply:

___Current smoker, every day ___Current smoker, some days ___ Smoker, status unknown

___ Light tobacco smoker ___Heavy tobacco smoker ___ Former Smoker ___ Never Smoker

Cigarettes Amount: _____ per day Cigars Amount: _____ per day

Smokeless Amount: _____ per day Pipes Amount: _____ per day

2) Have you had exposure to second hand smoke? (circle one) **YES** or **NO**

3) Do you drink alcoholic beverages? (circle one) **YES** or **NO**, if yes how often _____

FAMILY MEDICAL HISTORY

Please list if any of your family members below have or had any of the following diseases or medical conditions: ***Bleeding/Clotting Disorders, Cancer (list type if known), Diabetes, Heart Disease, Hypertension, Leukemia, Lymphoma, Heart Attack, or stroke.***

Mother: **Alive** **Deceased** Age: Medical Condition _____

Father: **Alive** **Deceased** Age: Medical Condition _____

Sister(s): **Alive** **Deceased** Age: Medical Condition _____

Brother(s): **Alive** **Deceased** Age: Medical Condition _____

Grandmother: **Maternal** **Paternal** Age: Medical Condition _____

Grandfather: **Maternal** **Paternal** Age: Medical Condition _____

Aunts: **Maternal** **Paternal** Age: Medical Condition _____

Uncles: **Maternal** **Paternal** Age: Medical Condition _____

PAST MEDICAL HISTORY

1) Have you had any of the following tests within the last 6 months? (Select All That Apply, if yes where and when?)

Pet Scan When _____ Where _____

CT Scan When _____ Where _____

Ultrasound When _____ Where _____

Other (specify) When _____ Where _____

2) Have you been hospitalized in the last 6 months? **YES** **NO**

If YES, when and reason for hospitalization _____

3) Please list any additional information about your medical history that the physician should know:

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REVIEW OF SYSTEMS

Check the symptoms you currently have or have had in the past year. Please check all that apply.

GENERAL

___ Chills
___ Depression/Nervousness
___ Dizziness/Fainting
___ Excessive Weight Gain or Loss
___ Fever
___ Headache
___ Numbness

CARDIOVASCULAR

___ Chest Pain
___ High/Low Blood Pressure
___ Irregular/Rapid Heart Beat
___ Poor Circulation
___ Shortness Of Breath
___ Swelling In Ankles
___ Varicose Veins

SKIN

___ Any Chronic Rashes Or Eruptions
___ Change In Moles
___ Hives
___ Itching
___ Irregular Scars
___ Poor Healing Of Lesions or Wounds
___ Poor Healing Of Foot Lesions

EYE, EAR, NOSE, & THROAT

___ Bleeding Gums
___ Blurred Vision
___ Crossed Eyes
___ Difficulty Swallowing
___ Double Vision
___ Earache Or Ear Discharge
___ Hay Fever
___ Hoarseness
___ Loss of Hearing
___ Nosebleeds
___ Persistent Cough
___ Ringing In Ears
___ Sinus Problems
___ Vision – Flashes or Halos

GASTROINTESTINAL

___ Bloating
___ Black Or Tarry Stools
___ Bowel Changes
___ Change In Appetite
___ Constipation
___ Diarrhea
___ Excessive Thirst
___ Gas
___ Hemorrhoids
___ Indigestion/Heartburn
___ Nausea
___ Rectal Bleeding
___ Stomach Pain
___ Vomiting

HEMATOLOGIC

___ Anemia
___ Easy Bruising
___ Excessive Bleeding

RESPIRATORY

___ Chronic Cough
___ Coughing Up Blood
___ Wheezing Or Asthma

URINARY

___ Blood In Urine
___ Frequent Urination
___ Lack Of Bladder Control
___ Painful Urination

NEUROLOGICAL

___ Double Vision/Vision Loss
___ Prior Stroke
___ Muscular Weakness/Tingling
___ Speech Difficulty
___ Transient Paralysis
___ Transient Neurologic Deficit

MUSCLE/BONE/JOINT

___ Pain, Weakness, Numbness In:
___ Arms
___ Back
___ Feet
___ Hands
___ Hips
___ Legs
___ Neck/Shoulders

MEN ONLY

___ Erection Difficulties
___ Lump In Testicles
___ Penis Discharge
___ Sore On Penis
___ Other Issue

WOMEN ONLY

___ Abnormal Pap Smear
___ Bleeding Between Periods
___ Breast Lump
___ Extreme Menstrual Pain
___ Hot Flashes
___ Nipple Discharge
___ Painful Intercourse
___ Vaginal Discharge

Date of Last Period:_____
Date of Last Pap Smear: _____
Date of Last Mammogram: _____
Are you pregnant? Yes or No

Number of Children: _____

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REVIEW OF SYSTEMS CONTINUED

Circle all the conditions you have or have had in the past.

Aids	Chicken Pox	HIV Positive	Polio
Appendicitis	Diabetes	Kidney Disease	Prostate Problem
Arthritis	Emphysema	Liver Disease	Rheumatic Fever
Asthma	Epilepsy	Measles	Scarlet Fever
Bleeding Disorders	Glaucoma	Migraine Headaches	Stroke
Breast Lump	Heart Disease	Multiple Sclerosis	Thyroid Problems
Cancer	Hepatitis	Mumps	Tuberculosis
Cataracts	Herpes	Pacemaker	Ulcers
Chemical Dependency	High Cholesterol	Pneumonia	Venereal Disease

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I ever have a change in health.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Print Name of Patient or Personal Representative **Relationship to Patient**

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ADVANCE DIRECTIVES INFORMATION SHEET

An **advance directive** is a legal document that tells your family, friends and healthcare professionals the care you would like to have if you become unable to make medical decisions. Through advance directives, you can make legally valid decisions about your future medical treatment.

You do not need a lawyer to complete your advance directives. However, you should be aware that each state has its own laws for creating advance directives.

There are three advance directives recognized in Texas:

• The **Texas Medical Power of Attorney** appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life. Your attending physician must certify in writing that you are unable to make health care decisions and file the certification in your medical record. If you would like more information and a copy of the Texas Medical Power of Attorney form please ask the front desk staff.

• A **living will**, officially known in Texas as the Directive to Physicians and Family or Surrogates, describes the kind of medical treatments or life-sustaining treatments you would want if you were seriously or terminally ill. A living will should be signed, dated and witnessed by two people, preferably individuals who know you well but are not related to you and are not your potential heirs or your health care providers. If you would like more information and a copy of the Directive to Physicians and Family Members form please ask the front desk staff.

• The **Out-of-Hospital Do Not Resuscitate (DNR) order** provides you with the right to withhold or withdraw cardiopulmonary resuscitation (CPR) or other treatments such as defibrillation and artificial ventilation. If you would like more information and a copy of the Texas Department of Health Services Standard Out of Hospital Do Not Resuscitate form please ask the front desk staff.

By creating an advance directive, you are making your preferences about medical care known before you're faced with a serious injury or illness. This will spare your loved ones the stress of making decisions about your care while you are sick. Any person 18 years of age or older can prepare an advance directive.

In order to make your directive legally binding, you must sign it, or direct another to sign it, in the presence of two witnesses who must also sign the document.

It is our responsibility to inform all competent adult patients about Advance Healthcare Directives and ask whether they have one in place. The staff is instructed to know the different types of advance directives. All staff members know where to direct patients who have questions or want more information about advance directives. If a patient provides an advance directive to Genesis Physicians, the physicians and staff should know the patients' decisions related to treatment.

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ADVANCE DIRECTIVES CONFIRMATION FORM

Under Texas law you have the right to make decisions concerning your healthcare. The rights include the right to accept or refuse medical treatment and the right to create advance directives to make preferences about your medical care. In the state of Texas any person age 18 years or old who is legally competent has the right to make these decisions in advance.

Advance directives recognized in Texas are the Texas Durable Medical Power of Attorney, a Living Will, and an Out of Hospital Do Not Resuscitate. No patient can be discriminated against for exercising their right to elect and create advance directives.

Advance Healthcare Directives Confirmation:

☐ **YES**, I have an Advance Healthcare Directives *(select which advance directive you have below).*

- Texas Durable Medical Power of Attorney
- Living Will, officially known as the Directive to Physicians and Family or Surrogates
- Out of Hospital Do Not Resuscitate (DNR)

****If you have selected YES, please provide a copy of your advance directive to the front office staff.*

☐ **NO**, I do not have Advance Healthcare Directives *(select which advance directive you have below).* I understand that I can request more information about advance directives.

- I have received the information sheet about advance directives.
- I would like additional information about the three advance directives recognized in Texas.

_____ _____

Patient Name (Print) Patient Signature

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GENERAL CONSENT FOR TREATMENT AND ACKNOWLEDGEMENT

MEDICAL CONSENT: I consent to all medical care, treatment, laboratory, imaging and other medical procedures performed or prescribed by a physician of Genesis Medical Group and his/her designees as directed in his/her judgement.

RIGHT TO REFUSE TREATEMENT: I understand that I have the right to make informed decisions regarding all my care and treatments, and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any treatments that I do not want.

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT RIGHTS & NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received both notices, Notice of Patient Rights/Responsibilities and Notice of Privacy Practices.

ADVANCE DIRECTIVES: I understand that I have an opportunity to make known my wishes, in writing regarding my health care and/or end of life decisions. This directive is in the form of a living will and/or durable power of attorney for health care.

RELEASE OF MEDICAL INFORMATION: I authorize Genesis Medical Group to release any information necessary to facilitate healthcare processing of claims, and audit of payments relative to my care/treatment with Genesis Medical Group. I also consent to the release of any information as needed for my care to other facilities, agencies, or healthcare providers as I direct or as required by law. This order will remain in effect until revoked by me in writing.

FINANCIAL AGREEMENT: I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists. I understand I am financially responsible to Genesis Medical Group for charges not paid under this agreement. I am responsible for all charges for services provided to me which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. Genesis Medical Group will make every attempt to notify me in advance if a service is not covered. I agree to pay all applicable co-payments, deductibles, and co-insurance. I am responsible to pay all copays, deductibles, and patient responsibility at the time of service unless other arrangements have been made in advance.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medigap, Medicare Replacement, private insurance and any other health / medical plan, to issue payment check(s) directly to **Genesis Medical Group** for medical services rendered to myself. I understand that I am responsible for any amount not covered by insurance.

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorized any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. (Consent applies only when applicable.)

By signing below, I acknowledge that I have read, understand, and agree to the terms and conditions of this form and that I am authorized as the patient or the Patient's Legal Representative to sign this document.

_____	_____	_____
Patient /Legal Representative Name (Print)	Patient/Legal Representative Signature	Date

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PATIENT AUTHORIZATION TO COMMUNICATE AND DISCLOSE PROTECTED HEALTH INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means or communicated to authorized designated parties including family members.

I wish to be contacted in the following manner *(Check All That Apply):*

___ **Home Telephone**
__Leave message with detailed information.
__Only leave message with call back details.

___ **Cell Telephone**
__Leave message with detailed information.
__Only leave message with call back details.

___ **Work Telephone**
__Leave message with detailed information.
__Only leave message with call back details.

___ **Written Correspondence**
__ Mail to my home address on file.
__ Mail to my work/office address:
_____
_____

I hereby authorize one or all of the designated parties below to request, discuss, and receive any protected health information regarding my healthcare and treatment. This PHI includes my treatment information, billing, payments, or any information in my medical records. I understand that the identity of designees must be verified before release of PHI.

Authorized Designees:

Name: _____Relationship: _____ Telephone: (_____) -_____-_____

Name: _____Relationship: _____ Telephone: (_____) -_____-_____

Name: _____Relationship: _____ Telephone: (_____) -_____-_____

Name: _____Relationship: _____ Telephone: (_____) -_____-_____

This authorization shall remain in effect from the date signed below until revoked.
You have the right to revoke this authorization in writing.

• I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.
• I understand information disclosed to any above designees is no longer protected by federal or state law and may be subject to redisclosure by the above designee.

_____ _____ _____
Patient/Legal Representative Print Name Patient/Legal Representative Signature Date

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PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: (_____) – _____ - _____

I hereby authorize:

_____	_____	_____
Name of Provider/Hospital/Physician	Provider/Hospital/Physician Address	Telephone Number

To release the following information from my health record covering the period of
From _____ to _____ , if I do not specify a period I am authorizing the release of records for entire duration of care with the provider. *(check all that apply below)*

____Complete Medical Record (includes information regarding insurance, demographic, referral documents, and medical Records). ***If this box is checked, do not check any additional boxes.***

____ Progress/Office Visit Notes ____ Radiology/Imaging Reports ____Chemotherapy/Radiation Records

____ Lab Reports ____ Pathology Reports ____ Billing/Payment Records

Information is to be released to:

Genesis Medical Group _____ Telephone: (_____) -_____- _____ Fax: (_____) -_____- _____
Office Address

The information is being released for the following purposes:

____ Continued Care/Treatment ____ Disability ____ Attorney/Litigation ____ Other

I understand that this authorization will remain in effect until I revoke it in writing.

I understand that according to applicable state and or/federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment.

_____	_____	_____
Patient/Legal Representative Print Name	Patient/Legal Representative Signature	Date

Genesis Medical Group

PATIENT RIGHTS AND RESPONSIBILITIES

At Genesis Medical Group we respect your rights as a patient and recognize that you are an individual with unique healthcare needs. We want you to know what your rights are as a patient, as well as what your obligations are to yourself, to other patients, and to your physician.

We encourage a partnership between you and your healthcare team. Your role as a member of this team is to exercise your rights and to take responsibility by asking for clarification of things you do not understand, by following your physician's recommendations and to promptly report any side effects that may occur.

As a patient you have the right …

- To be informed of your rights and responsibility as a patient of Genesis Medical Group.
- To be informed of all rules, regulations, and services provided by the clinic, including the days and hours of service and what to do in an emergency, and clinic telephone numbers.
- To receive care in a safe setting that is free of abuse, neglect, and harassment by physicians and clinic employees.
- To receive considerate and respectful care. We respect your right to:
  - Expect quality treatment within the scope of our mission.
  - Be treated with dignity without discrimination. Your care will not be affected by race, religion, beliefs, cultural values, sex, or age.
  - Choose your own physician.
  - Ask all personnel involved in your care to introduce them-selves, state their role in your care and explain what they are going to do for you.
- To be informed about your treatment and healthcare. Your healthcare team will describe your proposed treatment to you. You can expect the team to explain:
  - A description of our condition and diagnosis.
  - Treatment plan.
  - The alternatives of treatment.
  - The prognosis and any problems related to treatment.
  - Recuperation.
  - The benefit and risks of each treatment option and alternatives.
  - The explanation of risks faced if treatment is not pursued.
- The right to make an informed consent.
- The right to make treatment choices and the right to refuse treatment.

PATIENT RIGHTS AND RESPONSIBILITIES CONTINUED..

- To be informed of any experimental, investigation, or research activities that involve your treatment. Your healthcare team will:
  - Ask you if you wish to participate in these activities. You have the right to refuse to participate in these activities or withdraw your previous consent.

- To receive a reasonable estimate of charges for medical care and a payment schedules prior to receiving treatment.

- To have privacy and confidentiality respected. Your healthcare team and clinic staff will:
  - Respect your privacy related to your medical care.
  - Provide confidential treatment of your condition, medical care, medical records, and financial information

- To have access to your personal medical records and obtain copies upon written request.

- To complain or file a grievance with the Clinic Administrator without fear of retaliation or discrimination.

As a patient you have the responsibility to …

- Give the physician and your healthcare team accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about your healthcare.

- Report unexpected changes in your condition to your physician or nurse.

- Inform your physician or nurse of any discomfort/pain and changes in pain.

- Participate in the development of your plan of care, advance directives, and living will.

- Follow the treatment plan and medical directions recommended by your physician and healthcare team.

- Attend all appointments and when unable to do so contact the office 24 hours prior to your appointment to reschedule.

- Follow facility conduct rules, demonstrate good behavior, and assist in maintaining a safe/peaceful environment.

- Report new or changed insurance information, address changes, telephone number changes, email changes, and any other demographic changes to the front desk staff.

- Make sure financial responsibilities are carried out and pay copays/patient responsibility at the time of service.

You have a right to file a formal grievance/complaint against a nurse or physician at the following agencies:

Nurse: Texas Board of Nursing, 333 Guadalupe Street, Suite 3-460, Austin, Texas 78701, (512) 305-6838

Physician: Texas Medical Board, PO Box 2018, Austin, Texas 78768-2018, (800) 201-9353

Your Information. Your Rights.
Our Responsibilities.

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 out-of-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.

YOUR RIGHTS CONTINUED..

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 fee if you ask for another one within 12 months.

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 page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or 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 instructions.

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
- Contact you for fundraising efforts

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.

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.*

continued on next page

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.