Fairhope Internal Medicine. P.C.

CHART # _____ DATE _____

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____ MAIDEN _____ PREFERRED NAME _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

MARITAL STATUS
S☐ M☐ W☐ D☐

SEX
FEMALE☐ MALE☐

SOCIAL SECURITY NUMBER _____

DOB _____ AGE _____ EMAIL _____

PREFERRED CONTACT
C☐ H☐ W☐

( ) CELL _____ ( ) HOME _____ ( ) WORK _____

☐ BLACK OR AFRICAN AMERICAN ☐ WHITE OR CAUCASIAN ☐ ASIAN ☐ AMERICAN INDIAN ☐ HISPANIC ☐ NON-HISPANIC ☐ OTHER ☐ UNKNOWN

YOU MUST PROVIDE INSURANCE CARDS & PHOTO ID TO RECEPTIONIST

SPOUSE AND EMERGENCY CONTACT INFORMATION

SPOUSE NAME _____ DOB _____

IN CASE OF EMERGENCY, CONTACT _____ RELATIONSHIP _____ ( ) PHONE _____

PLEASE READ AND SIGN

I understand there may be certain services that are necessary for the maintenance of my good health that are not covered by my insurance and ***I agree to pay for those services in full.***

I hereby authorize my insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required in the processing of any claim. In instances where I have been referred to another physician or medical facility, I hereby give my permission to fax or mail pertinent medical information for continuity of my care.

I have read the above policies and agree to pay for services not covered by my insurance. I also agree to pay reasonable attorney's fees and costs of collection if this matter is referred to an attorney.

Let us reassure you that we will order only tests that we feel are necessary for your treatment and care. If you have any questions, someone in our office will be happy to assist you. Thank you very much for your understanding.

SIGNATURE _____ DATE ___/___/___

LIST PAST MEDICAL HISTORY OF SURGERIES AND/OR SERIOUS ILLNESS'

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? **YES☐ NO☐** *IF YES, PLEASE LIST NAMES OF MEDICATIONS BELOW:*

IF YOU DID NOT BRING YOUR MEDICATIONS WITH YOU, PLEASE LIST THEM ALL BELOW INCLUDING SUPPLEMENTS, HERBS AND OVER THE COUNTER MEDICINE:

LAST TETANUS SHOT **LAST PNEUMONIA SHOT** **LAST BONE DENSITY** **LAST MAMMOGRAM** **LAST PELVIC/PAP**

LAST EYE EXAM **LAST COLONOSCOPY** **LAST PSA BLOOD TEST**

Do you have an advanced directive/living will? YES☐ NO☐
IF YOU ANSWERED YES, PLEASE PROVIDE TO FRONT DESK

TOBACCO USAGE? ☐ ***FORMER*** ☐ ***NEVER*** ☐ ***CURRENT***

ALCOHOL USAGE? ☐ ***NEVER*** ☐ ***RARE*** ☐ ***OCCASIONAL*** ☐ ***DAILY***

SUBSTANCE USE? ☐ ***NOT CURRENTLY*** ☐ ***NEVER*** ☐ ***DAILY*** ☐ ***OCCASIONAL***

FAMILY MEDICAL HISTORY ☐ ***Family History UNKNOWN*** ☐ ***NO SIGNIFICANT FAMILY MEDICAL HISTORY***

PREFERRED PHARMACY

--

Frank Wang, M.D
Steven Wittmer, M.D.
Regina Felkner, D.O.
William B. Herron, M.D.
Kimberly Nolte, CRNP
Mollie Dean, CRNP

150 S. Ingleside St. Suite 6
Fairhope, AL 36532
Phone (251) 990-1740
Fax (251) 929-1886
www.fimpc.com

Authorization to Release Immunization Status to the Health Department

Patient Name _____ DOB _____

By signing this authorization, I authorize or refuse to allow Fairhope Internal Medicine, P. C. to release my immunization status to the Health Department.

This authorization is ***indefinite*** or will expire _____.

☐ **Yes**, I consent to release my immunization status to the Health Department.

☐ **No**, I do not consent to release my immunization record to the Health Department.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule, I have the right to revoke this authorization in writing except to the extent that Fairhope Internal Medicine, P. C. has acted in reliance upon this authorization. My written revocation must be submitted to the clinics above address, attention to the Privacy Officer.

_____ _____
Print Name of Patient or Legal Guardian **Signature of Patient or Legal Guardian**

_____ _____
Date **Witness**

Frank Wang, M.D
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Fairhope Internal Medicine No Show/Prescription Policy

A "no show" occurs when a patient neither calls to cancel a scheduled appointment 24 or more hours in advance, nor comes in for the appointment. A "no show" wastes both time and resources of the physician and office staff, and also prevents another patient from utilizing that appointment time.

Fairhope Internal Medicine charges a fee ***($30.00)*** for this "no show". There are two reasons for this charge. Primarily, it is to recoup lost office overhead expenses; second, it is a reminder to call in advance to reschedule an appointment should something unavoidable arise.

Generally, we track "no shows," and after the third occurrence, our policy is to discharge you from our care. With this being said, we would prefer you to call ahead if something comes up and you are unable to keep your appointment, thus avoiding a "no show."

Our office policy for prescription refills is to call in advance before you are completely out of your medications. There is a ***72 hour business day allowed for requests***. We understand there are times when this could be expedited depending on the severity of the refill request. When you put the request in, we ask that you check with your pharmacy to make sure it is there before contacting our office to ask if we have filled the prescription.

Signature of Patient/Guardian **Date** **Witness** **Date**

Guarantee of Payment

I, the undersigned, hereby agree to pay all amounts and charges incurred by members of my family for services rendered by our physician(s). I further agree that it is my responsibility to know and understand the provisions and limitations states in my insurance policy, as well as the current list of providers in my contract and accept full responsibility for all charges not covered by my insurance. Failure to make payment requested is basis for legal action and the undersigned agrees to pay all costs of collection including a reasonable fee and waives his/her right of exemption under law of the State of Alabama and any other state.

Assignment of Benefits

In consideration of care and services rendered to me by physician(s) during this office visit, I assign the benefits payable under my insurance policies for physician furnishing the services or to their authorized billing agent insofar as necessary to cover their charges. I authorize such physician(s) (or their billing agent) to submit a claim to my insurance carrier for payment for me and authorize payment to be made directly to said physician(s), billing agent or organization.

Assignment of Claims against Third Parties

In consideration of care rendered to me by physician(s), I hereby assign to the physician(s) rendering services all claims that I may have against third parties who may be liable for any of my medical expenses, to the extent necessary to cover my expenses for physician(s) care and services. Any funds received by me in connection with such claims against third parties, or settlement of such claims, shall be paid to the said physician(s) to cover my expenses. I hereby authorize payment directly to said physician(s) or their authorized billing agent of any of the above mentioned funds which are otherwise payable to me but not to exceed the regular reasonable charges for this service.

Medicare Benefits to Physicians

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to be by physician(s). I authorize any holder of medical or other information about me to be released in order to process claim(s) and request payment of my benefits to the physician rendering service.

Medicaid Authorization and Assignment

I authorize any holder of medical information about me to release information needed for this or a related Medicaid claim to the Alabama Medicaid Agency and I authorize the further release of any such information to any other parties who may be liable for any of my medical expenses. I hereby assign to the Alabama Medicaid Agency all claims against third parties who may be liable for any of my medical expenses to the extent that such expenses are paid by Medicaid: I also assign all right whether or not a portion of any such settlement is designated as being for medical expenses. Any such funds received by one shall be paid to the Alabama Medicaid Agency. I permit a copy of the Authorization and Assignment to be used in place of the original.

Authorization to Release Information

I hereby authorize physicians rendering services to release to my insurers, billing and certain medical information including final diagnosis and operative procedure(s) relative to this or related hospital claim(s) and/or office claim(s) for the purpose of determining eligibility for coverage and payment of charges for services rendered in connection with this hospitalization and/or office care. I also give permission for my physician to release my medical information to another physician assisting in my healthcare.

Telephone Consumer Protection Act (TCPA) Disclosure

I agree, in order for the practice to service my account or to collect monies I may owe, Fairhope Internal Medicine, P.C., and/or your agents may contact me by telephone at any telephone number associated to my account, including wireless telephone numbers, which could result in charges to me. You may also contact me by text messages and by email using the email address I provided. I understand methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, if applicable

I/we have read this disclosure and agree that Fairhope Internal Medicine, P.C., the practice's employees and/or agents, may contact me/us as described above.

Privacy Notice

I hereby acknowledge receipt of your practice's privacy notice and understand that your Privacy Policy's posted in your patient waiting room.

_____ _____

Signature of Patient/ Guarantor **Date** **Witness** **Date**

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HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical service providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above –
(CHECK EITHER **A** OR **B)**

☐ A. ***Disclose*** my complete health record (including but not limited to diagnosis, lab tests, prognosis, treatment, and billing, for all conditions) ***OR***

☐ B. ***Disclose*** my health record, as above, ***BUT do not disclose*** the following
(CHECK AS APPROPRIATE)

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other ***(PLEASE SPECIFY)***: _____

This authorization shall be effective until ***(CHECK ONE)***:

☐ All past, present, and future periods, ***OR***

☐ Date or event: _____

Unless I revoke it. ***(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing)***

_____ _____
NAME OF INDIVIDUAL GIVING THIS AUTHORIZATION DATE OF BIRTH

_____ _____
SIGNATURE OF INDIVIDUAL GIVING THIS AUTHORIZATION DATE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide specific examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Payment.** We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example, it may be essential that you provide us with your health plan information regarding care you receive at the Practice so that your health plan will pay us or reimburse you for those services. In addition, we may tell your health plan about a treatment you are going to receive in order to obtain necessary approval or to determine whether your plan will cover the treatment. You may restrict the disclosure of your PHI to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full.
- **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other Practice personnel who are involved in taking care of you at the Practice. For example, a doctor treating you for a broken leg may need to know if you have diabetes so that he/she can arrange for an appropriate diet. Different departments of the Practice also may share medical information about you in order to coordinate the different services you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the Practice who may be involved in your medical care after you leave the Practice, such as family members, clergy or other persons that are part of your care.
- **For Health Care Operations.** We may use and disclose medical information about you for Practice operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. For example, we may combine medical information about a variety of Practice patients to decide what additional services the practice should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. We may combine the medical information we have along with medical information from other practices to compare how we are doing and thus, evaluate where we can make improvements in the care and services we provide. We may remove information that identifies you from this set of medical information so that others may use it to study health care and health care delivery, without learning the identity of the patients.

WHO WILL FOLLOW THIS NOTICE.

This notice describes our organization's practices and that of:

- Any health care professional authorized to enter information into your chart.
- All departments and units of the Practice.
- All employees, staff and other Practice personnel.
- All of these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or Practice operations purposes described in this notice.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION.

We understand that medical information pertaining to you and your health is personal. We are committed to protecting your medical information. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will inform you about the different ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

The law requires us to:

- Make sure that medical information that identifies you is kept private;
- Acquire your authorization before any use or disclosure of any psychotherapy notes, PHI for marketing purposes, and sales of PHI;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.
- OTHER CATEGORIES OF INFORMATION THAT WE MAY USE OR DISCLOSE INCLUDE.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Practice.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

Fundraising Activities. We may use medical information about you to contact you in an effort to raise money for the Practice and its operations. We may disclose medical information to a foundation related to the practice so that the foundation may contact you in raising money for the Practice. We would only release contact information, such as your name, address and phone number and the dates you received treatment or services at the Practice. However, you have the right to opt out of receiving such fundraising communications. If you do not want the Practice to contact you for fundraising efforts, you must notify in writing.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interests to you.

Practice Directory. We may include certain limited information about you in the practice directory while you are a patient at the Practice. This information may include your name, location in the Practice, your general condition (e.g. fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. This is so your family, friends and clergy can call the Practice about you and generally know how you are faring.

Individual Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also inform your family or friends about your condition. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve

comparing the health and recovery of all patients who received another treatment, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information in order to balance the research needs with patients' need for privacy of their medial information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, as long as the medical information they review does not leave the Practice. We will almost always ask for your specific permission if the researcher obtains access to your name, address or other information that reveals who you are, or will be involved in your care at the Practice.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Treatment Alternatives. We may use and disclose medical information to inform you about, recommend possible treatment options or alternatives that may be of interest to you.

LESS FREQUENT USES AND DISCLOSURES OF YOUR PERSONAL INFORMATION INVOLVING THOSE NOT DIRECTLY INVOLVED IN YOUR CARE COULD INCLUDE:

- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner, in order to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Practice to funeral directors as necessary to carry out their services.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
    - In response to a court order, subpoena, warrant, summons or similar process;
    - To identify or locate a suspect, fugitive, material witness, or missing person;
    - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
    - About a death we believe may be the result of criminal conduct;
    - About criminal conduct at the Practice; and
    - In emergency circumstances to report a crime; the location of the crime or victims; or to identify, description or location of the person who committed the crime.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.
- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, and foreign heads of state or conduct special investigations.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following, but are not limited to:
    - Preventing or controlling disease, injury or disability;
    - Reporting births and deaths;
    - Reporting child abuse or neglect;
    - Reporting reactions to medications or problems with products;
    - Notifying people of recalls of products they may be using;
    - Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
    - Notifying the appropriate government authority if we believe a patient has been a victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Worker's Compensation.** We may release medical information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Uses and disclosures not described in this Notice of Privacy Practices will be made only with your authorization.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Practice's Privacy Officer. Your request must state a time period, which may not be longer than six years and may not include dates before February 26, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that

- time before any costs are incurred.
- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Practice. To request an amendment, your request must be made in writing and submitted to the Practice's Privacy Officer. In addition, you must provide a reason that supports your request.
    - We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the medical information kept by or for the Practice;
    - Is not part of information which you would be permitted to inspect and copy; or
    - Is accurate and complete.
- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. You may access PHI maintained electronically in one or more designated record sets, whether or not the designated record set is an electronic health record. Usually, this includes medical and billing records, but does not include psychotherapy notes.To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Practice's Privacy Officer. If you request a copy of the information, we are entitled to charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request, whether it is in paper or electronic form.
  If you request an electronic copy of PHI that is maintained electronically in one or more designated record sets, we will provide you with access to the electronic information in the electronic form and format that you requested, if it is readily producible, or if not, in a readable electronic form and format as agreed. If so requested, we will transmit the requested copy of PHI directly to a designated person, if your request is: (1) in writing; (2) signed by you; and (3) clearly identifies the designated person and where we should send the PHI. We will respond to your request within 30 days. If the information cannot be gathered within the initial 30-day period, then we will respond with a written notice of the reasons for the delay and the expected date, no later than 60-days from the original request. However, we may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.fimpc.com. To obtain a paper copy of this notice contact the Practice's Privacy Officer.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing in the Practice's Privacy Officer. We will not ask you the reason for the request and will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to Restrict Disclosures to Health Plan**. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full.
- **Right to be Notified of Breach.** You have the right to or you will be notified following a breach of unsecured PHI if you are affected by the breach.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse. We will honor your request to restrict disclosure of your PHI to a health plan if (1) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and (2) the PHI pertains solely to a health care item or service for which you, or a person other the health plan on your behalf (such as a family member), has paid the covered entity for in full.

CHANGES TO THIS NOTICE We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the Practice. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you visit the Practice for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact [insert the name, title, and phone number of the contact person or office responsible for handling complaints]. This should be the same person or department listed on the first page as the contact for more information about this notice. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

If you have any questions about this notice, please contact the Practice Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

Patient or Patient's Personal Representative_____ Date_____

Form presented to patient on _____ by _____ but the patient refused to sign.
(Date) (Employee)