KURE MOBILE MEDICAL, LLC

Excellence in Mobile Healthcare

Consent to Release of Information for Treatment, Payment, and Health Care Operations

I consent to the use and disclosure of my treatment information (or of the named patient for whom I am the parent or legal guardian) by Kure Mobile Medical for the following purposes:

- Providing treatment by Kure Mobile Medical staff or providing treatment information, including treatment records, to other health providers or agencies that are or will be involved in my care, including pharmacies; treatment may include health screening, diagnosis, medical treatment, laboratory procedures, minor or emergency surgical treatment, and/or mental health and drug and alcohol screening assessment, diagnosis and treatment.

- Obtaining payment for health care bills, including sending such treatment information and records as is needed to secure payment for Kure Mobile Medical services to the insurance company, worker's compensation company or agency that pays for my health services, as identified in my Kure Mobile Medical registration form or other updated insurance information on file with Kure Mobile Medical; I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee. I acknowledge that patient records may be stored electronically and made available through computer networks.

- Conducting health care operations of Kure Mobile Medical include but are not limited to release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care and obtaining my medication history from pharmacies.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I understand that I have the right to revoke this consent at any time, in writing, but revoking this consent will not affect any actions which were taken by Kure Mobile Medical LLC in reliance on this consent before I revoked it. I understand that I may request restrictions on use or disclosure of treatment records and information for the purposes described in this consent and that Kure Mobile Medical may or may not agree to the requested restrictions. I also understand that except for those restrictions on use or disclosure of treatment records and information to which it agrees, Kure Mobile Medical will not be able to provide services to me (or the named patient) without this signed consent I also understand that Kure Mobile Medical may not disclose treatment information contained in psychotherapy notes or for marketing purposes without my written agreement in a separate Authorization. A photocopy of this consent shall be considered as valid as the original.

Medicare Lifetime Authorization

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment. I request this authorization also apply to all other insurances.

Release of Medical Information to Family and Others

I give permission for my protected health information to be disclosed for purposes of communicating results, findings, and care decisions to the family members and others listed below. I understand that I may request individuals to leave the exam room at any time. I also understand that I must notify the office if any of the information below changes.

If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from re-disclosure

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Guardian Signature:_____

Patient/Guardian Printed Name: _____

Date: _____

PATIENT INFORMATION SHEET

NAME; DOB

PRIMARY INSURANCE NAME; _____

POLICY ID#: _____GROUP_____

CUSTOMER SERVICE TELEPHONE#:_____

SECONDARY INSURANCE NAME: _____

POLICY ID#:_____GROUP_____

CUSTOMER SERVICE TELEPHONE#: _____

MEDICAID ID #_____

SOCIAL SECURITY #_____

PRIMARY CONTACT NAME; _____

RELATIONSHIP TO PATIENTPOA YES or NO_____

TELEPHONE #_____EMAIL_____

MAILING ADDRESS; _____

_____

EMERGENCY CONTACT NAME: _____

TELEPHONE : _____

PATIENT INFORMATION SHEET

NAME: _____ GENDER: _____ DOB: _____ DATE: _____

ALLERGIES: _____

Pharmacy name: _____ Tel: _____ Social Security _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____ _____ _____

_____ _____ _____

_____ _____ _____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD/ Emphysema	High Cholesterol	Rheumatoid Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disorder
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Liver Disease	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Macular Degeneration	
Asthma	Glaucoma	Neuropathy	
Bipolar	Heart Disease	Osteopenia/Osteoporosis	
Bladder Problems / Incontinence	Heart Attack (MI)	Parkinson's Disease	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer: _____	High Blood Pressure	Peptic Ulcer	
Headaches	Kidney Stones	Psoriasis	
Crohn's Disease	Kidney Disease	Pulmonary Embolism (PE)	

Last Menstrual Period	Date: _____	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date:____	Normal Abnormal
Pap	Yes/No Date:____	Normal Abnormal

* please circle: DNR of Fullcode

Other medical problems not listed above:

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____

_____ _____

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Are there any vision problems that affect your communication? ☐Yes ☐ No

Are there any hearing problems that affect your communication? ☐Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐ No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _____

Continued on other side.

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type: _____ Amount/day: _____ Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

Are you sexually active? ☐Yes ☐ No Employed YES NO Retired YES NO Employment type_____

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

_____

_____

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

SIBLINGS:

_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Patient Signature: _____ Date: _____

POA _____

Primary contact name_____ Tel#_____ Email address_____

Financial Policy for Kure Mobile Medical, LLC

Appointments:

1. If you are not able to keep an appointment, we would appreciate a 24-_-hour notice. There is a "NO-_-SHOW" charge of $15.00 for missed appointments. This does not apply to facility patients.

2. If you are late for your appointment, we will do our best to accommodate you; please understand there will be a wait. However, on certain days it may be necessary to reschedule your appointment.

Insurance Plans:

L It is your responsibility to keep us updated with your correct insurance information and to make sure we are listed as your primary care physician (PCP) if applicable. If the insurance company you provide is incorrect or we are not your PCP, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.

2. It is your responsibility to understand your benefit plan with regards to covered/non-covered services and participating laboratories.

3. It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered. Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days. It is your responsibility to know if a selected specialist participates in your plan.

Forms:

1. Any forms that need to be reviewed, filled out, and signed by a provider are subject to a $10.00 per- form fee. [For example: Family Medical Leave Act (FMLA), disability forms, etc.]

Transfer of Records:

1. If you transfer to another physician, we will provide a summary of your health record free of charge as a courtesy to you. We will need a 3-day notice.

2. A copy of your complete record is available for a $1.00 per page fee up to (25) pages. A $0.25 per page charge thereafter.

3. We provide records of your visits rendered here at Kure Mobile Medical only. For any previous records you must request them directly from your previous doctor.

Prescription Refills:

1. For monthly medication refills, we require 48 hours' notice via the Patient Portal if you have requested access or call during regular business hours Monday thru Friday 8am-4pm. Please plan accordingly.

Financial Responsibility:

1. According to your insurance plan, you are responsible for all copayments, deductibles, and coinsurances. Co-payments and deductibles are due at the time of service. If patient uses responsible party for all financial transactions, they will be due day prior to seeing the patient.

2. Self-pay patients are expected to pay for services in FULL at the time of the visit.

3. If we do not participate in your insurance plan (we are considered OUT OF NETWORK), payment in full for copay is expected from you at the time of your visit. If patient uses responsible party for all financial transactions, they will be due day prior to seeing the patient.

4. For scheduled appointments, previous balances must be paid prior to the visit.

5. If previous arrangements have not been made with our billing office, any account balance outstanding longer than 28 days will be charged a $5.00 re-bill fee for each 28-day cycle.

6. Any balance outstanding longer than 90 days will be forwarded to a collection agency. You will still be responsible for any bill, together with all collection costs, including a reasonable attorney fee in the event it becomes necessary to seek this method to collect payment. Patients who have had an outstanding balance for ninety (90) days and have been turned over to a collection agency will be discharged from our practice and must find another physician who will continue their care.

7. We accept cash, local checks, Visa, MasterCard, Discover, and American Express. A $40.00 fee will be charged for any checks returned for insufficient funds.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Responsible Party Signature_____Date_____

If electronic signature sees next page below.

KURE MOBILE MEDICAL, LLC
Office: 561-677-9685
Fax: 561-658-4541

I authorize my health information to be sent electronically to Kure Mobile Medical, LLC which includes but is not inclusive to phone calls, voice mail, email, and texting, I realize that all these modes of communication are encrypted in transit but may not be fully HIPAA compliant once the information reaches its destination.

I agree to receive health care information by all modes of communication listed above.

FULL NAME: _____

SIGNATURE: _____

KURE MOBILE MEDICAL

AGREEMENT TO RECEIVE CHRONIC CARE MANAGEMENT SERVICES

As of January 1, 2015, Medicare covers chronic care management services provided by physician/non physician provider practices per calendar month. I understand that my primary care provider, named below, is willing to provide such services to me, including the following:

-Access to my care team 24/7, including telephone access and other non-face to face means of communication such as emails and text messaging services.

-The ability to get successive, routine appointments with my designated primary care provider or other member of my care team.

-Care management of my chronic conditions, including timely scheduling of all recommended preventive care services, medication reconciliation, and oversight of my medication management.

-Creation of a comprehensive plan of care for all health care issues that is specific to me and congruent with my values and choices.

-Management of my care as I move between and among health care providers and settings, including the following:

*Referrals to other health care professionals
*Follow up after visit to an emergency department
*Follow up after hospital of skilled facility stay
*Coordination with home and community-based providers and clinical services.

I understand that as part of these services I may receive a copy of my care plan. I also understand that I can revoke this agreement (affective at end of calendar month) and can choose, instead, to receive these services from another health care professional after the calendar month in which I revoke this agreement. I understand Medicare will only pay for ONE physician or non-physician provider per any given calendar month.

I understand these chronic care management services are subject to usual Medicare deductible and coinsurance applied to services (unless you're dually enrolled in state Medicaid program which waves your copay). Secondary Medicare insurances will cover the copay.

I hereby indicated by my signature that KURE MOBILE MEDICAL, LLC is designated as my primary care provider for purposes of providing Medicare chronic care management services to me and billing for them.

My signature also authorizes my primary care provider providing CCM services to electronically communicate my medical information with other treating providers and my designated health care power of attorney as part of the care coordination involved in chronic care management services.

PATIENT NAME (PRINTED): _____

PATIENT OR GUARDIAN SIGNATURE: _____

DATE: _____ ELECTRONIC SIGNATURE and DATE: see below

Kure Mobile Medical, LLC

Ph: (561) 677-9685 Fax: (561) 658-4541

HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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 about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that involved in your care and treatment for the purpose of providing care services to you to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services, this may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. 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 of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglects: Food and Drug Administration requirement: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine compliance with the requirement of Sections 164.500.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice, whenever an arrangement between our office and a business associated involves the use or

disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information as necessary to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you, we may also use and disclose your protected health information for other marketing activities, for example, your name and address may be used to send information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you, Other permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information.
This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information, A record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you, Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction or your protected health information.
This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician not required to agree to a restriction that you may request If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests; we may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation for you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at this time. upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Complaints:

You may complain to us or to the Office of Civil Rights if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. You may obtain the address of the OCR Regional Manager, Denver, CO, from our privacy officer.

CLINIC CONTACT:

This notice was published and becomes effective on/or before

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

atient Signature: X _____ Date: _____

_____

Printed name of patient representative

_____

Signature of patient representative

_____

presentative's authority to sign for patient
e parent guardian, power of attorney for
althcare, executor)

KURE MOBILE MEDICAL, LLC

Ph: (561) 677-9685 Fax: (561) 658-4541

GENERAL MEDICAL RECORDS RELEASE

Please complete the following information:

Patient Name:_____

Phone Number:_____

SSN: _____ Date of Birth: _____

I authorize the custodian of records of or other person/entity (specifically describe) to disclose/release the following information* (check all applicable):

X All records
Billing records
Laboratory/pathology records
Abstract/Summary
X-ray/radiology records
Pharmacy/prescription records

Other (describe specifically):_____

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information. These records are for services provided on the following date(s):

Please send the records listed above to (use additional sheets if necessary):

Name: Kure Mobile Medical, Erica Florea APRN Release to Self:

Phone: 561-677-9685 Fax: 561-6584541

EMAIL: Kuremobilemedical@gmail.com

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by lawn By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Patient Signature: X_____ Date: _____

Printed name of patient representative

Representative's authority to sign for patient (i.e. parent, guardian, power of attorney for healthcare, executor)

X_____

Signature of patient representative

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.

This Notice of Privacy Practices describes how we 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 about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or at-ranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law , (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.

We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure IS necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object:

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be

disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the light to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record,

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact your doctor if you have any other questions about privacy practices.