Affiliated Oncologists

Gynecologic Cancer Institute of Chicago
A Division of Affiliated Oncologists

New Patient Packet

Date: ______________________

Patient Name (as it appears on Primary Insurance Card [include suffix]) | Date of Birth

Address | City | State | Zip Code

(   ) Home Phone Number | (   ) Cell Phone Number | Social Security Number (optional)

Email Address

Gender Identity (check all that apply)**:**
- ☐ Male ☐ Female
- ☐ Female-to-Male (FTM)/Transgender Male/Trans Man
- ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
- ☐ Genderqueer; neither exclusively male nor female
- ☐ Choose not to disclose
- ☐ Additional gender category or other; please specify:

Sexual Orientation:
- ☐ Straight or heterosexual
- ☐ Lesbian, gay or homosexual
- ☐ Bisexual
- ☐ Don't know
- ☐ Choose not to disclose
- ☐ Something else, please describe:

Marital Status: ☐ S ☐ M ☐ D ☐ W **Preferred Language:** ______________________

The following questions on race, ethnicity & language are required to be asked by Federal Government Regulations. (optional)

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Do Not Want to Provide ☐ Do Not Know

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Middle Eastern

PHYSICIANS:

Primary Care Physician | (______) Phone Number

Referring Physician | (______) Phone Number

PHARMACY INFORMATION:

Pharmacy Name | Location

(______) Phone Number

I agree that Affiliated Oncologists may e-prescribe my prescriptions and may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

Patient Signature | Date

Are you currently enrolled in any of the following:
Skilled Nursing Facility (SNF): ☐ Yes ☐ No **Convalescent Home:** ☐ Yes ☐ No **Hospice:** ☐ Yes ☐ No

Name of Facility | (______) Phone Number

Address | City | State | Zip Code

Date: ______________________________ From: ______________________________

To: ______________________________ Fax: ______________________________

Authorization to Release Health Information/Records Request to Affiliated Oncologists

Patient, ______________________________ , (date of birth) ____________________ has an appointment with ______________________________ . In order to make the consultation as meaningful as possible, please provide the following records, as marked, to our office within, at least, 3 business days prior to the appointment.

__Consult/H&P
__OP Report/Procedure Report
__Follow-up Notes
__Progress Notes
__Discharge Summary
__Weekly CBC Reports
__PSA Scores
__All Labs
__Tumor Markers
__Pathology Reports
__Pathology Slides
__EKG
__All CT Scans/X-rays/Ultrasounds
__Mammograms
__Radiotherapy Treatment Records
__Entire Chart
__Chemotherapy Flow Sheet
__Other ____

____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facilities receiving it and then would no longer be protected by federal policy regulations.

Please fax back to ______________________________ with the attention of ______________________________

Patient Name: ______________________________

Patient Signature: ______________________________ Date: ____________________

***** CONFIDENTIALITY NOTICE *****

The documents accompanying this telecopy transmission contain confidential formation belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled, unless otherwise required by state law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of these documents.

MEDICAL RECORDS

Affiliated Oncologists

Gynecologic Cancer Institute of Chicago
A Division of Affiliated Oncologists

Advance Directives

Do you have any of the following Advance Directives?

	Yes	No
1. Medical Power of Attorney?	☐	☐
2. DNR?	☐	☐
3. Living Will?	☐	☐

If you have answered "yes" to any of the above, please bring a copy on your next visit so that we may update your records.

If you answered "no" to any of the above information, would you like an Advance Directives informational packet?

☐ Yes ☐ No

Patient Name: ______________________________ Date of Birth: ________________

Patient Signature: ______________________________ Date: ________________

Request for Alternative Communication Methods

I approve receiving *e-appointment reminders* via text and/or email. Please circle: Text / Email / None

You may email me at: ______________________________

By providing your email, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access My Care Plus, our Patient Portal. At any time you can change or discontinue emails. By providing your email, you understand the security and privacy risks of patient communication via email and the sending or patient records via email.

Affiliated Oncologists

Gynecologic Cancer Institute of Chicago
A Division of Affiliated Oncologists

Assignment of Benefits

Patient Name: ______________________________ **Date of Birth:** ______________

Primary Insurance: ______________________
Member ID#: ______________________
Group #: ______________________
Phone: ______________________
Name of Insured: ______________________
Insured DOB: ______________________

Secondary Insurance: ______________________
Member ID#: ______________________
Group #: ______________________
Phone: ______________________
Name of Insured: ______________________
Insured DOB: ______________________

Guarantor Information (Party responsible for payment of personal balance) ☐ **Same as Patient**

Name: ______________________
(Last, First)
Relationship: ______________________
Date of Birth: ______________________
Phone Number: ______________________
Address: ______________________
Apt/Unit: ______________________
City: ______________________
State: ____________ Zip Code: ____________

The above information is true to the best of my knowledge. I authorize may insurance benefits to be paid directly to Affiliated Oncologists. I authorize Affiliated Oncologists to release any information required to process my claim. I will notify this practice if my insurance changes at any time during my patient-physician relationship.

I acknowledge that I have reviewed and understand my financial responsibilities under GCIC's Financial Policy. I agree to be responsible for the payment of all charges incurred regardless of insurance coverage or other plans available to me. I also acknowledge that any unpaid balance for which I am financially responsible may be subject to a fee.

Patient Signature: ______________________________ Date: ______________

General Assignment of Benefits

I request that payment of authorized insurance benefits be made on my behalf to the Provider for any equipment or services provided to me by those organizations. I authorize the release of any medical or other information to my insurance company in order to determine the benefits payable for the services rendered by the Provider.

I understand that I am financially responsible to the Provider for any charges not covered by my health benefits. It is my responsibility to notify the Provider of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill if the submitted claims or any part of them are denied for payment. I accept financial responsibility for payment for all services or products received.

Patient/Guardian Signature: ______________________________ Date: ______________

Affiliated Oncologists

Gynecologic Cancer Institute of Chicago
A Division of Affiliated Oncologists

Notice of Privacy Practices

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any revised notice will be provided to me or made available in the office.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving a written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

HIPAA Consent to Share Information

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communication or that communication be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

Patient Name: ______________________________ DOB: ______________

Pharmacy Information

Name of Pharmacy: ______________________

Phone Number: (_____) ______________________

Address: ______________________

Emergency Contact

Name (Last, First): ______________________

Relationship: ______________________

Phone Number: (_____) ______________________

Please indicate your preferred method of contact:

☐ Home: (_____) ______________________ May we leave a detailed message? ☐ Yes ☐ No

☐ Cell: (_____) ______________________ May we leave a detailed message? ☐ Yes ☐ No

☐ Work: (_____) ______________________ May we leave a detailed message? ☐ Yes ☐ No

---

I authorize Affiliated Oncologists, LLC, to release my medical information to the person(s) listed below. I understand that the person(s) named on this authorization will be given access to obtain results/information on my behalf. I authorize the person(s) indicated to pick up materials pertinent to my medical care:

Name	Relationship to Patient	Phone Number

Policy Regarding the Recording of Patient-Provider Conversations

It is the policy of Affiliated Oncologists that all patient-provider conversations are privileged and should not be recorded without the written consent of the provider.

Receipt of HIPAA Patient Privacy Rights Notification

My signature below indicates that I have the HIPAA Patient Privacy Rights Notification and that I have been made aware of my privacy rights and how I may exercise those rights. I understand that all contact phone numbers listed on the Patient Registration Form may be used to contact me for treatment or payment purposes unless I submit a written request to restrict the use of any/all contact phone numbers listed.

Patient/Guardian Signature: ______________________________ Date: ______________

In lieu of patient signature, I, ______________________, as a staff member of Affiliated Oncologists, LLC,

state that ______________ has been provided with current notice of privacy practices.

Staff Signature: ______________________________ Date: ______________

Affiliated Oncologists

Gynecologic Cancer Institute of Chicago
A Division of Affiliated Oncologists

Patient Physician List

Name (Last, First):_____________________________________Birthdate:____________ Today's Date:___________

Please list the name(s), city and fax number of physicians who have referred you to us, you are seeing or who you want us to send results to.

Specialty	Name (First and last name)	Location (City)	Fax
Primary care (family practice or internist)			
Gynecology			
Hematology/Oncology			
Cardiology (heart doctor)			
Pulmonology (lung doctor)			
Breast Surgeon			
General Surgeon			
Gastroenterology			
Urology			
Nephrology (kidney doctor)			
Radiation Oncology			
Dermatology			
Neurology			
Endocrinology			
Reproductive Medicine (IVF)			
Other			

Affiliated Oncologists

Gynecologic Cancer Institute of Chicago
A Division of Affiliated Oncologists

MEDICAL HISTORY

Today's Date: ____________

Name (Last, First):____Birthdate:________________ Age: __________
Referring Physician (Last, First): ____
Primary Care Physician (Last, First): ____
REASON FOR VISIT TODAY: ____
____
PAST MEDICAL HISTORY: ____
____
PAST SURGICAL HISTORY (include any complications):____
____
____
Do you consent to blood products if necessary in a surgical procedure? ☐ Yes ☐ No Comment: _______________

FAMILY HISTORY OF ILLNESS (please include any history of cancer & specify what type):
Father: Alive: ☐ Yes ☐ No Cancer: ☐ Yes ☐ No Type:_________________________________
Mother: Alive: ☐ Yes ☐ No Cancer: ☐ Yes ☐ No Type:_________________________________
Other Family Member: ____

ALLERGIES:
To Medications (list name of medication and what reaction you had to it):____________________________________
____
To Other Products (i.e., food, latex, etc):____

MEDICATIONS: (please include non-prescription drugs, aspirin, and/or herbal supplements):

Name & Type of Medication	Dosage and Frequency	Name & Type of Medication	Dosage and Frequency

Have you ever been on a hormone replacement therapy? ☐Yes ☐No If yes, how long? ____________________

SOCIAL HISTORY:
Alcohol usage: ☐Yes ☐ No Type: __________________ How much: _______________ How often: ______________
Tobacco usage: (Please check one):☐Yes ☐No ☐Past ☐Present Type: ☐Cigarettes ☐Cigars ☐Pipe ☐Chew
Illicit drug usage (which drug and last used when):____
____
Occupation/Student Status (briefly describe; if retired, please state your previous occupation):______________________
How often do you exercise: ___________________________ Who do you live with: ________________________________

OB/GYN:
Last normal period: ______ # of Pregnancies: ___ # of Births: ___ # of C-Sections: ___ # of Normal Vaginal Deliveries: ___
Oral Contraceptive Rx (and how long): ______________ Age of 1st Period: __ # Days of Cycle: ___ # Lifetime Partners: ___

PREVENTATIVE SCREENING (list the date or month/year of test/procedure):
DEXA Scan: _______________ Colonoscopy: _______________ Mammogram: _______________
Pap Smear: _______________ History of abnormal pap smears? ☐ Yes ☐ No Last abnormal pap smear: _________

Affiliated Oncologists

Gynecologic Cancer Institute of Chicago
A Division of Affiliated Oncologists

REVIEW OF SYSTEMS

Today's Date: ___________

Name (Last, First):_______________________________________Birthdate:______________ Age: _________

AREA	SYMPTOM (please check all that apply)			Other/Detail (Explain any other symptoms)
CONSTITUTIONAL	☐ Recent weight loss ☐ None	☐ Recent weight gain ☐ Weakness ☐ Fatigue		
EYES	☐ Pain ☐ Glaucoma	☐ Loss of vision ☐ None		
EARS, NOSE, THROAT	☐ Pain ☐ Redness	☐ Soreness ☐ None		
CARDIOVASCULAR	☐ Chest Pain ☐ Palpitations	☐ Irregular Pulse ☐ Fluid Retention	☐ Swelling of Legs ☐ None	
RESPIRATORY	☐ Shortness of Breath ☐ Wheezing	☐ Cough ☐ Asthma	☐ None	
GASTROINTESTINAL	☐ Diarrhea ☐ Constipation ☐ Distension	☐ Bloody stool ☐ Heart Burn ☐ Nausea	☐ Vomiting ☐ Acid Reflux ☐ None	
GU Female (urinary system and/or genitals)	☐ Frequency ☐ Urgency ☐ Blood ☐ Vaginal Pain ☐ None	☐ Incontinence ☐ Slow stream ☐ Hesitancy ☐ Vaginal Dryness	☐ Increased Cramping ☐ Irregular	
MUSCULO/SKELETAL	☐ Pains ☐ Limitation of Range of Motion	☐ Sprains ☐ None	☐ Swelling	
INTEGUMENTARY (skin or breast)	☐ Rash ☐ Itching ☐ Lumps	☐ Ulcers ☐ Scaling ☐ Tenderness	☐ Redness ☐ Masses ☐ None	
NEUROLOGICAL	☐ Dizziness ☐ Light-headedness	☐ Headaches ☐ Numbness	☐ Weakness ☐ None	
PSYCHOLOGICAL	☐ Depression	☐ Anxiety	☐ None	
ENDOCRINE	☐ Diabetes ☐ Adrenal Disease	☐ Hyperthyroidism ☐ None	☐ Hypothyroidism	
HEMA/ LYMPH	☐ Recent Bleeding	☐ Anemia ☐ None	☐ Recent Bruising	
ALLERGIC/IMMUNOLOGY	☐ Running Nose	☐ Itching Eyes	☐ Swelling of Eyes ☐ None	

Physician Assistants, Advanced Practice Nurses and Nurse Practitioners

Affiliated Oncologists employs Certified Physician Assistants (PA-C) and Advanced Practice Nurses/Nurse Practitioners. These staff address your health care needs and are your trusted advisers when it comes to maintaining or improving your health. They obtain medical histories, examine, diagnose and treat patients, order and interpret diagnostic tests and recommend and implement treatment plans. Some can perform minor surgery and assist in major surgery, instruct and counsel patients, order or carry out therapy and prescribe medications. PA-Cs/APNs perform these roles within a scope of practice established by the supervising doctor in accordance with state regulations. Generally speaking, they can perform many tasks delegated by the doctor.

They are licensed and certified health care professionals who practice medicine in partnership with physicians and bring a breadth of knowledge and skills to patient care. Before they can practice, PA-Cs and APNs/NPs graduate from an accredited program. They must pass the Certifying Exam and get licensed by the state in which they will practice.

During the course of your care, you may have follow-up appointments scheduled with the physician assistants/APNs/NPs. They maintain chemotherapy regimens, and you may also be scheduled with them for chemotherapy-related office visits.

Affiliated Oncologists

Gynecologic Cancer Institute of Chicago
A Division of Affiliated Oncologists

Financial Policy

We strive to offer the highest quality of care to all patients. Your treatment will not be contingent upon your insurance coverage. Considerable care has been taken in determining our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care.

INSURANCE: Insurance companies vary greatly in their coverage for medical services. Please be aware that the cost of non-covered services is your responsibility. We will bill your insurance for each service according to the most current billing regulations. We recommend that you personally contact your insurance company with specific questions or concerns regarding your policy.
The office will inform you whether or not we are contracted with your insurance, but you are responsible for knowing if your specific plan is in-network or out-of-network.

REFERRALS: Many insurance companies require a referral for a visit to a specialist. Our physicians are specialists in medical oncology, radiation oncology, hematology, and gynecologic oncology so your visit(s) are NOT considered a primary well visit, nor a routine OB-GYN visit. Please refer to the front of your insurance card or call your insurance company to understand your coverage and whether you need a referral. ***It is the patient's responsibility to obtain a referral from the primary care physician or gynecologist (GCI only) prior to an appointment.*** Referrals are generally limited to a certain period of time or number of visits, so please ensure your referral is up to date before each visit. Referrals can be mailed or faxed to our office or presented at the time of your visit.

PAYMENT: We expect payment of your co-payment and deductible (when applicable) at the time of service. For your convenience, we are pleased to accept cash, checks, and major credit cards. Any patient with a balance on their account is required to make a payment prior to the next office visit. The practice mails statements every month with any balance on the account. We will be forced to send a balance to a collection service when no attempts at balance payments have been received.

NON-COVERED SERVICES: As part of your care, your physician may recommend a test or service that is not covered by your insurance plan. Some services that may not be covered by your insurance are: blood tests, bone density test, mammogram, CA-125 blood test, OVA-1 blood test, Pap smear, ultrasound, CT, MRI, or PET scan. This list may not be all-inclusive.

GCI ONLY:
SURGICAL ASSISTANTS: We feel strongly about providing the best quality surgical care. Gynecologic oncology surgeries require tremendous expertise and time, so our physicians often rely on an experienced surgical assistant. This may include a physician's assistant, resident, or certified surgical assistant provided through the hospital. Some insurance companies do not cover non-physician surgical assistants in which case the patient would be responsible for this fee along with any deductible, co-insurance or co-payment.

ROBOTIC SURGERY: When lifestyle changes, medicine or other treatments do not ease your symptoms, your doctor may suggest surgery. Surgery can include:

- Open surgery: done through one large incision
- Laparoscopic/robotic-assisted *da Vinci* Surgery: this type of minimally invasive surgery is done through a few small incisions

With robotic-assistance, laparoscopic surgeons obtain technical advantages that include visual enhancements, dexterity and ergonomics. The majority of leading payers, such as a Medicare, CIGNA, United Healthcare and most Blue Cross and Blue Shield plans, consider robotic-assistance incidental to the primary surgical procedure and is payable at the carrier's discretion. The patient is responsible for any charges incurred by this procedure that is not covered by the insurance. The patient may choose to appeal any denials, which is managed by the patient and not the office.

DISABILITY FORMS: Patients who require surgery or chemotherapy often request that we complete forms certifying their disability so they may receive income during treatment. This includes paperwork from your employer such as the Family and Medical Leave Act (FMLA.) Given the volume of these forms and the significant time required from our clinical staff to complete these forms, there may be a fee for completion of initial disability forms. Subsequent disability forms will be priced at $5 for completion. We make every effort to complete disability forms within 7-14 business days of receiving them. In some cases, forms require additional information (pathology or hospital reports) that are not immediately available which may delay their completion.

Service	Fee
FMLA/Disability (initial)	$25.00
FMLA/Disability (subsequent)	$5.00

Prices are subject to change without notice.

Your signature on the acknowledgement page later in this packet documents that you have read and understand this form and agree that you are responsible for the payment of all charges incurred regardless of insurance coverage or other plans available.

Affiliated Oncologists

Gynecologic Cancer Institute of Chicago
A Division of Affiliated Oncologists

HIPAA NOTICE OF PRIVACY PRACTICES
EFFECTIVE 7/1/2020

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
You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal action

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 or 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 with you 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.

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 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

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 the cases we never share 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.

Our Uses and Disclosures
How 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.

Bill for your services
- We can use and share your health information to bill and get payment for health plans or other entities.

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 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.
- I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.

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 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 order or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security or 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 and in our office.

Privacy Officer
Jennifer Barker
Practice Manager
(708) 424-9710