ASTHMA & ALLERGY FREE CLINIC

PATIENT REGISTRATION FORM

First _____ MI_____ Last_____ Pt.ID #_____

Prefers to be called_____ Date of Birth ____/_____/_____ Age ____ Marital Status: _____
Married/ Single/Divorced/Widowed/Other

Address Primary _____ City _____ State_____ Zip _____

Alternate Address _____ City _____ State_____ Zip _____

Phone #1 _____ Phone #2 _____ Phone #3 _____
Home/Cell/ Work Home/Cell/ Work Home/Cell/ Work

Email address _____ Preferred method of contact: Letter Phone call Email Other_____

Sex____ SS # _____Referring Physician _____Primary Care Physician_____
M F

Preferred Language _____ Race: _____Ethnicity: _____
Non-Hispanic or Latino/ Hispanic or Latino/ other or Undetermined

Referred by: Physician Self Family/Friend Internet Yellow pages Radio TV Other _____

Occupation_____Employer_____Is this visit related to a work injury? Y N

Current Pharmacy Name and Location _____

Emergency Contact

Name _____ Phone # _____ Relationship to patient_____

Responsible Party/Guardian/Guarantor **Address Same as Patient** ☐

Name_____ Address_____ _____ City_____ State ___ __Zip_____

Home# _____ Cell # _____ Business # _____

SS#_____ Patient's Relationship to Guarantor_____ DOB ____/____/____ ____

Sex _____ Occupation_____ Employer _____

Primary Insurance Information **Address Same as Patient** ☐

Name of Ins.Co. _____ ID # _____Group #_____Group Name_____

Policy Holder Name _____DOB ____/____/_____Relationship to Patient _____ _____

Address_____ ___ City_____ State_____ Zip_____ Phone #_____

SS# _____ Sex_____ Occupation_____ Employer _____

Secondary Insurance Information **Address Same as Patient** ☐

Name of Ins.Co. _____ ID # _____Group #_____Group Name_____

Policy Holder Name _____ DOB ____/____/_____Relationship to Patient_____

Address_____City_____ State. _____Zip_____Phone#

_____

SS# _____Sex_____Occupatio

Print Name/Signature _____Date_____

ASTHMA & ALLERGY FREE CLINIC

ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

Patient Name:_____ **Date of Birth:**_____

Notice of Privacy Practices. I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint.

_____ Date_____
Print Name / Signature Patient/Parent/Guardian

Communication/Messages: I understand that it may be necessary from time to time for Strength To Love Clinic to leave messages when we are unable to reach you. I wish to be contacted as follows: (please designate preferred number to call)

		YES	NO
Home telephone _____	Leave message with confirmation of appointment, or call back only.	☐	☐
	Leave message with results, detailed information.	☐	☐
Work telephone _____	Leave message with confirmation of appointment, or call back only.	☐	☐
	Leave message with results, detailed information.	☐	☐
Cell telephone _____	Leave message with confirmation of appointment, or call back only.	☐	☐
	Leave message with results, detailed information.	☐	☐
	Send appointment reminders via text message.	☐	☐

Family Members/Parents/Friends: I authorize Allergy Partners to share my Patient Health Information with the following:

Print Name_____ Relationship_____

Print Name_____ Relationship_____

*Patients aged 18 years and older: Please note that we cannot discuss your healthcare, insurance or payment with your parents/others unless you fill out the appropriate information above.

Special requests to identify specific person(s) not authorized to receive my PHI, speak directly with the Practice Manager.

I may revoke my consent in writing by completing a new Acknowledgement of HIPAA Privacy Notice and Designation of Disclosure form except to the extent that the practice has already made disclosure in reliance upon my prior consent.

_____ Date_____
Print Name / Signature Patient/Parent/Guardian

RESEARCH

We perform medical **research** at Strength to Love Clinic. Our clinical researchers may look at your health records as part of your current care or to prepare or perform research. All patient research conducted by us goes through a special process required by law that review protections for patients involved in research, including privacy. We will not use your health information or disclose it outside of the practice for research reasons without either getting your prior written approval or determining that your privacy is protected.

If you do not object to being contacted about research opportunities by our clinical research team, please select yes: ☐ Yes

If you prefer not to be contacted by our clinical research team, you must opt out by selecting no: ☐ No

_____ Date_____
Print Name / Signature Patient/Parent/Guardian

ASTHMA & ALLERGY FREE CLINIC

MEDICAL HISTORY FORM

Name:_____ **Date of Birth:**_____

Past Medical History:
(check any of the following which you have now or have been treated for in the past)

- ☐ ADD
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Chronic Hives
- ☐ Chronic Rhinitis
- ☐ Chronic Sinusitis
- ☐ Chronic Pansinusitus
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Food Allergies
- ☐ GERD/Reflux
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ IBD
- ☐ IBS
- ☐ Immune Deficiency
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraines
- ☐ Skin Cancer
- ☐ Other Cancer
- ☐ Prostate Disorder
- ☐ Sleep Apnea
- ☐ Thyroid Disease
- ☐ Tuberculosis

Surgery History:

- ☐ Adenoidectomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Deviated Septum
- ☐ Hip/Knee Surgery
- ☐ Pacemaker
- ☐ Tonsillectomy
- ☐ Appendectomy
- ☐ Colon Resection
- ☐ Ear tubes
- ☐ Hysterectomy
- ☐ Sinus Surgery
- ☐ Thyroid Surgery
- ☐ CABG (heart bypass)
- ☐ C- section
- ☐ Hernia Repair
- ☐ Organ Transplant
- ☐ Tonsillectomy & Adenoidectomy

Other_____

Family History: (Immediate family only Mother, Father, Sibling or Children)

	Mother	Father	Sibling	Patient's children
No Problems				
Unknown History				
Allergies				
Asthma				
Anaphylaxis				
Cystic Fibrosis				
Eczema				
Food Allergies				
Heart Disease				
Hives				
Hypertension (high blood pressure)				
Hyperlipidemia (high cholesterol)				
Immune Deficiency				
Infections, recurring				
Psychiatric Disorder				
Swelling				
Venom Allergies				

Social History ***(13 years of age and older)***

marital status: ☐ single ☐ divorced/separated ☐ married ☐ widow(er)
smoking status: ☐ current every day smoker ☐ current some day smoker ☐ former smoker
☐ never smoker ☐ unknown if ever smoked
☐ cigarettes _____ packs per day ☐ cigars _____# per day ☐ smokeless/chew _____tins per day
smoking duration: ☐n/a ☐1-5 years ☐6-10 years ☐ 11-20 years ☐over 20 years year started: _____
maximum packs per day: ☐½ ☐1 ☐1 ½ ☐2 or more
passive cigarette exposure: ☐home ☐secondary ☐home ☐other ☐none
readiness to quit: ☐ very ready ☐ somewhat ready ☐ not ready ☐ relapsed ☐ not willing to quit target quit date:_____
occupation:_____ work location: ☐indoors ☐outdoor
caffeine intake (per day) ☐ 0 ☐ 1/2 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+
alcohol intake ☐ never ☐ rarely ☐ weekly ☐ daily ☐ socially
hobbies:_____

Pediatric patients only

attends ☐school ☐daycare (name of school/daycare) _____

does child have siblings? ☐yes ☐no if yes, how many _____

child was born ☐premature ☐full term

delivery type ☐vaginal ☐C-section

complicated labor and delivery ☐yes ☐no

prolonged hospitalization as newborn ☐yes ☐no

breast fed ☐yes ☐no

feeding difficulties ☐yes ☐no

severe infections ☐yes ☐no

LATE on immunizations ☐yes ☐no

Abnormal growth and development ☐yes ☐no

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MEDICATION FORM

Name:_____ **Date of Birth:**_____

Current Medications and Supplements
(include milligram and number of times per day)

Medication Name	Strength	Times per Day	Taking This for What Diagnosis?

Allergies to Medications

Name of Medication	Reaction *(hives, throat swelling, other reactions)*

☐ **NO KNOWN DRUG ALLERGIES**

When was your last flu shot?_____

When was your last pneumonia shot?_____

Preferred Pharmacy:
(Name) _____
(Street Address) _____
(City, State, ZIP Code) _____
(Telephone Number) _____
(Fax Number) _____

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REVIEW OF SYSTEMS / ENVIRONMENTAL HISTORY

Name:_____ **Date of Birth:**_____

Reason for today's visit: _____

*Do you **CURRENTLY HAVE ONGOING /RECURRING PROBLEMS** with any of the following:*

General	Nose	Respiratory	Skin
☐ no problem	☐ no problems	☐ no problems	☐ no problems
☐ poor weight gain	☐ nasal congestion	☐ cough	☐ swelling
☐ fevers	☐ clear nasal drainage	☐ chest tightness	☐ dryness
☐ chills	☐ colored nasal drainage	☐ coughing up blood	☐ hives
☐ sweats	☐ post nasal drip	☐ daytime sleepiness	☐ itching
☐ poor appetite	☐ nosebleeds	☐ shortness of breath	☐ rash
☐ fatigue	☐ itching	☐ snoring	☐ eczema
☐ malaise	☐ sneezing	☐wheezing	
☐ weight loss	☐ sinus pressure/pain	☐difficulty with exercise	**Neurologic**
			☐ no problems
Eyes	**Throat**	**Gastrointestinal**	☐ headaches
☐ no problems	☐ no problems	☐ no problems	☐ weakness
☐ blurring	☐ hoarseness	☐ heartburn	☐ seizures
☐ discharge	☐ difficulty swallowing	☐ nausea	☐ passing out
☐ eye pain	☐ sore throat	☐ vomiting	☐ dizziness
☐ itchy	☐ oral ulcers	☐ diarrhea	
☐ red	☐ throat clearing	☐ constipation	**Mental Health**
☐ vision loss	☐ itching	☐ abdominal pain	☐ no problems
☐ watery		☐ bloody stool	☐ depression
☐ dry	**Cardiovascular**	☐ jaundice	☐ anxiety
	☐ no problems		☐ hyperactivity problem
Ears	☐ chest pains	**Musculoskeletal**	☐ behavior problems
☐ no problem	☐ palpitations	☐ no problems	
☐ earache	☐ passing out	☐ back pain	**Allergic /Immunologic**
☐ ear discharge	☐ peripheral edema	☐ joint pain	☐ no problems
☐ ringing in the ears	☐ shortness of breath lying down flat	☐ joint swelling	☐ recurring infections
☐ decreased hearing		☐ stiffness	☐ venom sting reaction
☐ ears popping			☐ latex reaction
☐ room spinning around			☐ food reaction
☐ itching			☐ drug reaction

Housing	Foundation	Air Conditioning	Heating
☐ house	☐ basement	☐ none	☐ none
☐ apartment/condo	☐ crawlspace	☐ window units	☐ wood stove
☐ mobile/ manufactured home	☐ slab	☐ central	☐ central hot air
		☐ evaporative cooler	☐ kerosene
			☐ electric space heater
			☐ natural gas

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Indoor Mold	Water Damage	Pests	Smoke Exposure	Bedroom
☐ none	☐ none	☐ none	☐ none	☐ carpet
☐ AC vents	☐ leaky roof	☐ roaches	☐ parents	☐ ceiling fan
☐ bathroom	☐ plumbing problems	☐ rodents	☐ spouse/partner	☐ humidifier
☐ window frames	☐ musty odors		☐ grandparent	☐ sleeps in own bed
☐ walls	☐condensation		☐ caretaker	☐ shares bed
☐ basement	☐ water stains		☐ other	

Bed	Outdoor Environment	Pets	How Many?
☐ crib mattress	☐ none	☐ none	Dog Inside:
☐ standard mattress	☐ cattle	☐ dogs	Dog Outside:
☐ water bed	☐ chickens	☐ cats	Cat Inside:
☐ down pillow/ comforter	☐ horses	☐ birds	Cat Outside:
☐ dust ruffle	☐ goats	☐ hamsters	
☐ stuffed toys	☐ farm	☐ gerbils	
☐ wool blanket		☐ rabbits	
☐ allergy pillow cover		☐ guinea pigs	
☐ allergy mattress cover		☐ other	
☐ pets sleeps in bed			

ASTHMA & ALLERGY FREE CLINIC

Some Medications can interfere with allergy skin testing. To obtain the most accurate results, **please stop antihistamines used for allergy treatment as noted below prior to New Patient Appointments or other visits if you plan to have allergy skin testing**. If you have a question about whether it is safe for you to stop your antihistamine, please contact your prescribing physician.

PLEASE STOP THE FOLLOWING MEDICATIONS FOR 7 DAYS PRIOR TO YOUR APPOINTMENT

Cyproheptadine (Periactin)
Desloratidine (Clarinex)
Hydroxyzine (Atarax/Vistaril)
Levocetirizine (Xyzal)

PLEASE STOP THE FOLLOWING MEDICATIONS FOR 5 DAYS PRIOR TO YOUR APPOINTMENT

Sedating Allergy Medications (All Forms)

Advil Allergy
Alahist
AlleRX
Allergy Relief Medication
Brompheniramine (Bromfed)
Tylenol Allergy
Carbinoxamine
Chlorpheniramine
Clor-Trimeton
Diphenhydramine (**Benadryl**)
Doxylamine
Extendryl
Ketotifen
Palgic
Polyhistine
Pyrilamine (also found in Midol)

Non-Sedating Allergy Medications (All Forms)

Cetirizine (Zyrtec, Wal-Zyr)
Fexofenadine (Allegra)
Loratadine (Claritin, Alavert)

Nasal Sprays

Azelastine (Astelin, Astepro)
Dymista
Olopatadine (Patanase)

Cough/Cold /Sinus Remedies

Actifed
Advil Cold/Sinus
Aleve Cold
Alka Seltzer Plus/Cold
Allerest
BC Cold Powder
Benylin Cough
Comtrex
Contac
Coricidin
Co-Tylenol
Dimetane
Dimetapp
Drixoral
Norel SR/MD
Nyquil
Pediacare
Percogesic
Phenyltoloxamine
Robitussin (many forms)
Rondec
Rynatan/R-Tannate
Semprex-D
Sinutab
Sudafed Cold + Allergy
Tanafed
Theraflu (All forms)
Time Hist
Triaminic (All forms)
Tussionex
Tylenol Cold+Sinus
Vicks 44 M
Zicam

Sleep Aids

Advil PM
Alertec (Modafinil)
Doxepin (Sinequan)
Doxylamine
Excedrin PM
Night Time Sleep Aid
Nytol
Sominex
Tylenol PM/Tylenol Sleep

Anti-Nausea/Vertigo Medications

Chlorpromazine
Dimenhydrinate (Dramamine)
Meclinzine (Antivert)
Prochlorperazine (Compazine)
Promethazine (Phenergan)

Allergy Eye Drops:

Alcaftadine (Lastacaft)
Epinastine (Elestat)
Azelastine (Optivar)
Ketotifen (Zaditor, Alaway, Zyrtec)
Bepotastine (Bepreve)
Olopatadine (Patanol, Pataday, Pazeo)

Itch Relief Medications: Diphenhydramine (**Benadryl**)

Others: Cyclobenzaprine (Flexeril)
Baclofen

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Some other medications may also interfere with allergen skin testing **but you should continue to take them UNLESS the prescribing physician/clinician tells you it is safe to stop them for 5 days prior to your appointment.** Your provider will discuss testing options at your visit if you have not been cleared to stop these medications:

Tricyclic Antidepressants

Amitriptyline	Amoxapine	Desipramine (Norpramin)
Doxepin (Sinequan)	Imipramine (Tofranil)	Nortriptyline (Pamelor)
Protriptyline	Trimipramine	

Benzodiazepines

Alprazolam (Xanax)	Chlordiazepoxide (Librium)	Clonazepam (Klonopin)
Clorazepate (Tranxene)	Diazepam (Valium)	Estazolam (Prosom)
Flurazepam (Dalmane)	Lorazepam (Ativan)	Midazolam (Versed)
Oxazepam (Serax)	Temazepam (Restoril)	Triazolam (Halcion)
Quazepam (Doral)		

Others:

Mirtazapine (Remeron)	Quetiapine (Seroquel)

ASTHMA & ALLERGY FREE CLINIC

Do not use oil, cream or lotion on the back or arms for 24 hours prior to skin testing.

Please continue taking all of the your other medications as prescribed including:

- Antibiotics
- Antidepressants
- Asthma Medications including inhalers, nebulizer solutions, Montelucast (Singulair) and Zafirlucast (Accolate)
- Blood Pressure Medications
- Cholesterol Medications
- Decongestants
- Heart Medications
- Injectable Medications
- Nasal Sprays- **Except** Astelin/Astepro/Patanase and Dymista
- Steroids such as prednisone, prednisolone, solumedrol
- Thyroid Medications

Do not stop these medications without the approval of your physician.

ASTHMA & ALLERGY FREE CLINIC

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

This medical practice collects health information about you and stores it in a chart and in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or request a medication history from your pharmacy, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your

objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to 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 http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

You will not be penalized in any way for filing a complaint.