INCONTINENCE QUESTIONAIRE (UDI-6)

Name: _____
Date: _____

DO YOU EXPEREINCE ANY URINARY INCONTINENCE?
_____ YES _____ NO

Please circle the number that best describes what you are feeling. Use the following as your guide.

(0) Not at All (1) Slightly□(2) Moderately (3) Greatly

Do you experience, and if so, how much are you bothered by:

1. Frequent urination? (0) (1) (2) (3)□

2. Urine leakage related to the felling of urgency? (0) (1) (2) (3)□

3. Urine leakage related to physical activity, coughing, or sneezing? (0) (1) (2) (3)

4. Small amounts of urine leakage? (0) (1) (2) (3)□

5. Difficulty emptying your bladder? (0) (1) (2) (3)□

6. Pain or discomfort in the lower abdomen or genital area? (0) (1) (2) (3)

(For physician only)

_____ Timed Voiding□_____ Double Voiding□_____ Conservative Fluid Management□_____ Kegel Exercise Program□_____ Anti-cholinergic or Other Medical Therapy _____ Urodynamic Evaluation Discussed□_____ Surgical Intervention Discussed

Jeffrey Stern, MD FACS Aaron LaTowsky, MD Loren Faaborg, MD
Jennifer Klauschie, MD David J. Kaplan, MD Paul Papoff, MD FRCS(C)
Amy Schlaifer, MD Keri Wong, MD

Academic Urology & Urogynecology of Arizona

Patient Intake information:

Dr Jennifer Klauschie

Name: _____

Age: _____

Number of pregnancies: _____ Number of births: _____

Number of C-sections:_____

Date of last menstrual period:_____ Menopause age?_____

Describe the reason for the visit:_____

Last gynecology visit:_____ Date of last pap smear:_____

Hysterectomy: Y/N Route (circle): abdominal or vaginal or laparoscopic

Do you still have your ovaries? Y/N

Do you use hormones (estrogen, progesterone, or testosterone)? Y/N (circle: pill patch vaginal cream/tablet)

Previous surgery for prolapse or incontinence? Y/N Describe:_____

_____

List current medications for bladder or bowel problems:_____

Current symptoms: (circle all that apply)

Prolapse (dropped bladder, rectum, or uterus)? Y/N; circle all that apply: see buldge feel buldge feel pressure difficulty with bowel movements difficulty with emptying bladder

Incontinence (leakage of urine)?Y/N frequent trips to bathroom? Have sudden urge? Wear pad? Leakage with coughing, laughing, sneezing, or activity?

Do you feel like you empty your bladder completely? Y/N

Is your urinary stream (circle all that apply): weak? Strong? Delayed in starting?

Do you use your stomach muscles in order to urinate? Y/N

Do you push on your bladder to empty? Y/N

How many times do you get up at night to urinate?_____

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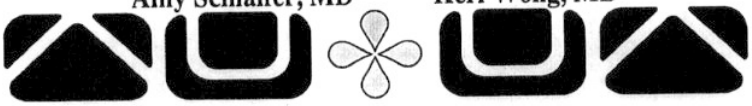

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Do you leak any stool? Y/N Do you pass gas uncontrollably? Y/N

Describe bowel movements: mostly regular? mostly constipated? mostly loose/diarrhea?

Are you sexually active? Y/N Does prolapse or incontinence affect sexual activity? Y/N

For provider use only:

POP Q Measurements

Aa	**Ba**	**C**
GH	**PB**	**TVL**
Ap	**Bp**	**D**

Prolapse is quantified by stages, which are assigned according to the most severe portion of the prolapse when the maximum protrusion has been demonstrated.

STAGE 0
Points Aa, Ap, Ba, and Bp are assigned value of −3 cm. Value for point D or C is less or equal to TVL (cm) −2 cm and has a negative sign. This stage represents no prolapse.

STAGE I
The most severe portion of the prolapse is more than 1 cm above the level of the hymen.

STAGE II
The most severe portion of the prolapse is 1cm or less above the level of the hymen or within one centimeter below the hymen.

STAGE III
The prolapse is more than 1 cm below the hymen, but no further than 2 cm less than the total vaginal length in centimeters

---

STAGE IV
Almost complete eversion of the total length of the vagina is present. The protrusion minimally extends beyond hymen further than TVL-2 cm.

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Historical Intake Sheet

Last Name: _____ First Name: _____Middle Initial: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Email Address: _____

Primary Care Physician: _____ Phone #:_____

Preferred Pharmacy: _____ Phone #:_____

Pharmacy Address/Street and
Crossroads:_____

Reason(s) for Visit Today:
_____

List All Medications and Dosage (including over the counter, herbal supplements, and vitamins):

List All Allergies to medications, Latex, IV Dye, Food, Environmental, Etc.:

List all Previous Surgeries and Dates:

Have you had a Chest X-Ray: Y N If yes, when was the last one? _____

Have you had a colonoscopy: Y N If yes, when was the last one?_____

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Historical Intake (page 2)

Social History (please circle)

Do you smoke or have you smoked in the past?	Y	N	currently	past
Do you drink alcohol?	Y	N		
Do you use any street drugs? (If yes please list)	Y	N		
Do you drink anything with caffeine?	Y	N		

Family History Please circle and list family members with condition

Heart Disease	Y	N	Stroke	Y	N
Bleeding Disorder	Y	N	Hypertension	Y	N
Cancer (specific)	Y	N	Kidney Disease	Y	N
Prostate Cancer	Y	N	Diabetes	Y	N

Patients Past Medical History (please circle condition or N/A)

Alcohol Abuse	Gastric Ulcer	Rheumatic Heart Disease
Alzheimer's/Dementia	Glaucoma	Rosacea
Bleeding Disorder/Blood Clots	Hepatitis A B C	Sleep Apnea/Cpap Mask
Asthma	Heart Disease/Heart attack	Seizures/Convulsions
Cancer (please specify)	Hiatal Hernia	Staph Skin Infection
Congestive Heart Failure	HIV/Aids	Stroke/TIA
Coronary Artery Disease	Hypertension	Thrombophlebitis
COPD/Emphysema	Lung Problems	Thyroid Disease
Elevated Cholesterol	Lupus	Valley Fever
Esophageal Reflux/GERD	Mononucleosis	Diabetes
Nasal Polyp	Duodenal Ulcer	Pneumonia
Psychiatric Disorder	Kidney Stones	Other (list below)

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Historical Intake (page 3)

Review of Symptoms: (please circle for symptoms you are experiencing or circle none)

General: Chills Fever Fatigue Change in Weight Night Sweats None

Skin: Boils Itching Rash None

Breast: Breast Tumor (benign) Breast Cyst Nipple discharge Abnormal Mammogram Skin Problems None

HEENT: Blurred Vision Headache Eye Pain Sinus Problems Glaucoma None

Respiratory: Chronic Cough Wheezing Shortness of breath coughing up blood None

Cardiovascular: Chest Pain Mitral Valve Problems Elevated Blood Pressure Varicose Vein's Palpitations Rapid Heart Beat Swelling of legs (extremities) Elevated Cholesterol None

Gastrointestinal: Abdominal Pain Heartburn Nausea Vomiting Blood Change in Appetite Black Stool Jaundice Diarrhea Constipation Stomach Cramps Gallbladder Problems Diverticulosis/Diverticulitis Spastic Colon None

Musculoskeletal: Back Pain Joint Pain Muscle Pain Limitation of Movement Osteoporosis/Osteopenia Fractures None

Neurological: Numbness Dizziness Tremor Weakness Coordination Problems Seizures None

Psychiatric: Depression Anxiety Panic Attacks Personality change Insomnia Memory Loss None

Hematology: Easy Bruising Enlarged Lymph Nodes Blood Clots Anemia None

Urinary: Painful Urination Blood in Urine Urination at Night Frequency Incontinence Requiring a Pad for Protection

Kidney Stone Infections None

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Historical Intake (page 4)

Women Only :

Pregnancy History:

How Many pregnancies have you had?_____ How Many Children do you have?_____

Vaginal:_____ C-Section?_____

Live Births: _____ Miscarriages: _____ Abortions:_____

Gynecological History: (only if you have an appointment with Dr. Faaborg or Dr.Klauschie)

When was your last pap smear?_____ Where?_____

Have you ever had an abnormal pap? Y N When:_____ Where:_____

When was your last menstrual period? _____

Are you having abnormal vaginal bleeding Y N

Are you having menopausal symptoms? Y N

Are you sexually active? Y N

Do you have pain with sex? Y N

Are you using contraception? Y N Type:_____

Are you currently doing self breast exams: Y N

Have you had a mammogram? Y N When was your last Mammogram? _____

Have you had a bone density scan? Y N When was your last bone density? _____

Do you have a feeling of your pelvic organs falling? Y N

Marital Status? Married Widowed Single Divorced Separated

Academic Urology & Urogynecology of Arizona

LAST NAME: _____ **MIDDLE NAME:** _____ **FIRST NAME:** _____

DOB: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

Phone #: _____ Cell PHONE #: _____

EMPLOYER: _____ EMPLOYER PHONE: _____

EMERGENCY CONTACT: _____

RELATION: _____ PHONE #: _____

PRIMARY INSURANCE CO NAME: _____

ID#: _____ GROUP/CLAIM #: _____

POLICY HOLDER: _____ RELATION: _____ DOB _____

SECONDARY INSURANCE CO NAME: _____

ID#: _____ GROUP/CLAIM # _____

POLICY HOLDER: _____ RELATION: _____ DOB _____

AUTHORIZATION TO RELEASE INFORMATION AND PAYMENTS:

I HEARBY AUTHORIZE ACADEMIC UROLOGY AND UROGYNECOLOGY OF ARIZONA TO RELEASE ANY INFORMATION TO PROCESS CLAIMS. I AUTHORIZE THIS OFFICE TO RELEASE ALL MEDICAL INFORMATION NECESSARY TO ANY HOSPITAL SPECIALIST OFFICE AND ANY INSURANCE COMPANY ACTING ON MY BEHALF CONCERNING ADVICE CARE AND TREATMENT FOR PURPOSES OF MEDICAL TREATMENT AND EVALUATING AND ADMINISTERING CLAIMS. I HERBY ASSIGN TO ACADEMIC UROLOGY AND UROGYNECOLOGY OF ARIZONA ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. IN THE EVENT OF DEFAULT I PROMISE TO PAY COLLECTIONS COST AND/OR REASONABLE ATTORNY FEES AS MAY BE REQUIORED TO COLLECT COLLECTION ON THIS ACCOUNT.

PRINT NAME OF PATIENT:

_____

SIGNATURE OF PATIENT:

_____

DATE SIGNED:

_____

Academic Urology & Urogynecology of Arizona
Phone 623-547-2600 / Fax 623-547-1899

Meaningful Use Informational Form

Name_____ Date of Birth _____

Ethnicity

Hispanic___

Not Hispanic___

Declined ___

Race

Hispanic or Latino___

American Indian/ Alaskan Native___

Asian___

African American___

More than one race___

Native Hawaiian/ Other Pacific Islander___

White/ Caucasian___

Declined___

Preferred Language _____

ACADEMIC UROLOGY & UROGYNECOLOGY OF ARIZONA

(Authorization to Disclose Health Information to Family Members and Friends)

PATIENT NAME _____ **DATE OF BIRTH** _____/_____/_____

I hereby authorize Academic Urology & Urogynecology of Arizona to release my patient health information as described below:

		Type of Information Allowed to Disclose (Check one or both)	
Name of Family Member or Friend	**Relationship**	**Medical**	**Billing**
1.			
2.			
3.			
4.			
5.			
6.			

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA. This authorization expires when I am no longer a patient in this practice or have revoked this authorization.

[Check One]

I Do _____ I Do NOT _____ GIVE PERMISSION to Academic Urology & Urogynecology of Arizona to leave information on my answering machine and/or with my family members in regard to treatment plans, referrals, test results and/or billing and payment information. HIPAA guidelines allow for basic information regarding appointments [time, date, location] to be left on an answering machine or with family members.

_____ _____

Signature of Patient or Personal Representative [i.e. Guardian] Relationship of Personal Representative to Patient

Date of Authorization _____

ACADEMIC UROLOGY & UROGYNECOLOGY OF ARIZONA

Phone 623-547-2600 / Fax 623-547-1899

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____

to release healthcare information of the patient named above to:

Name: Academic Urology & Urogynecology of Arizona

Address: 14044 W Camelback Rd. Suite 118

City: Litchfield Park , Arizona 85340

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates:

_____

- All healthcare information
- Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

_____ Yes _____ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

_____ Yes _____ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES **ONE YEAR** AFTER IT IS SIGNED.

ACADEMIC UROLOGY & UROGYNECOLOGY OF ARIZONA

PATIENT FINANCIAL POLICY

Thank you for choosing us as your health care provider. In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policies. If you have any questions regarding these policies please discuss your concerns with our business office. We are dedicated to providing the best possible care and regard your complete understanding as an essential element of your care and treatment.

PAYMENT IS DUE AT THE TIME OF SERVICE. For your convenience, we accept VISA, MasterCard, Discover, American Express, cash and check.

INSURANCE

If you are a member of an insurance plan with which we participate, we will file your primary insurance for you. At each appointment you will be expected to pay the authorized co-payment and estimated unmet deductible, and/or co-insurance. You will receive a statement for any additional charges your insurance company deems your responsibility after processing your claim. Should your insurance delay payment for more than 120 days, you may be held responsible for full payment of the amount charged. Please check with the office staff to verify our participation with your particular insurance company or plan. If you have insurance coverage with a plan for which we do not have a contract agreement, you will be considered a self-pay patient and will be charged in full for your treatment at the time of service. If you have out-of-network benefits, your insurance generally pays at a lower percentage and deductibles could apply. It will be your responsibility to provide us with complete & current insurance information in order to file your claim. If you fail to provide complete and current insurance information you will be responsible for all charges unpaid by insurance. You will also need to provide us with a signed authorization enabling direct payment to our office. All insurance coverage is a matter between you and your insurance company, and you are ultimately responsible for payment.

REFERRALS / AUTHORIZATIONS

If you have a policy with a Health Maintenance Organization (HMO, MC, POS, or EPO) it is your responsibility to obtain a referral from your primary care physician for your visits.

RETURNED CHECKS

A service fee of $25.00 will be charged for any returned check. If we receive a return check from you, all future payments will be required in the form of cash or credit card.

I have read and understand the financial policy and I agree to be bound by its terms. By signing below, I assume full responsibility for any balance owed after my insurance plan has paid. (NOTE: Even if you refuse to sign this form and you elect to receive services – You are still 100% responsible for any fees.)

Patient Name: _____ DOB: _____ Phone: _____

Patient Signature: _____ Date: _____

Legal Representative: _____ Date: _____

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than **24 hours notice**. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. Cancellations made less than 24 hours notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours notification may be subject to a **$50.00** cancellation fee. Procedure cancellations require 5-7 business day advance notice, without notification they may be subject to a **$150.00** cancellation fee. Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as NO SHOW.

Patients who No-Show two (2) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may also be subject to a **$50.00** fee for office appointment No Show and **$150.00** procedure No Show fee.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication.

Please sign that you have read, understand and agree to this Cancellation and No show Policy.

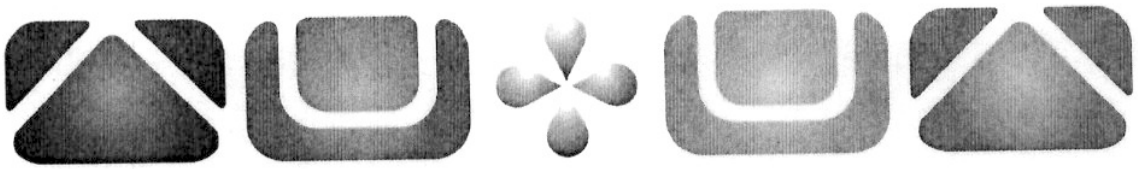
_____

Date_____

Patient Name (Please Print)

_____

Date of Birth: _____



Academic Urology & Urogynecology of Arizona

General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or advanced practice provider (Nurse Practitioner, Physician Assistant), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

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

_____

Signature

Date _____

_____

Print Name

Academic Urology & Urogynecology of Arizona

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

Por la presente reconozco que he recibido una copia del Aviso de esta práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificado estará disponible en cada cita.

Me gustaría recibir una copia del Aviso de Prácticas de Privacidad modificada por e-mail a:

_____

Firmado: _____ Fecha: _____

Imprimir Nombre: _____ Teléfono: _____

Si no está firmada por el paciente, por favor indique la relación:

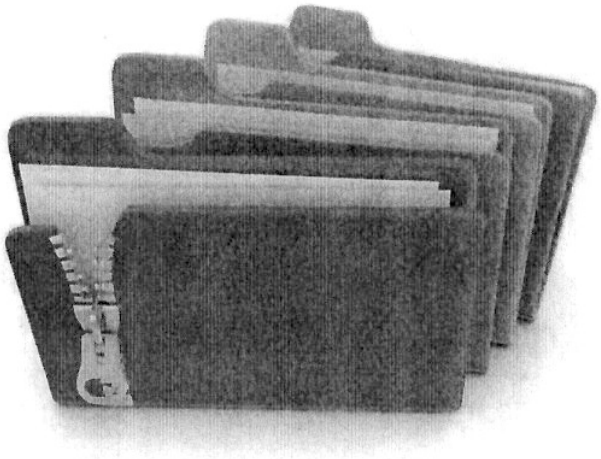
El padre o tutor del paciente menor de edad

Tutor o curador de un paciente incompetente

Nombre y dirección del paciente: _____

Instruction A: Insert the covered entity's name

Instruction B: Insert the covered entity's address, web site and privacy official's phone, email address, and other contact information.



Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example: We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example: We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Instruction C: Insert any special notes that apply to your entity's practices such as "we do not create or manage a hospital directory" or "we do not create or maintain psychotherapy notes at this practice."

Instruction D: The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.

Instruction E: If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.

To leave this section blank, add a word space to delete the instructions.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Instruction F: Insert Effective Date of Notice here.

This Notice of Privacy Practices applies to the following organizations.

Instruction G: If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area."

Instruction H: Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.