Myrtle Hilliard Davis
Comprehensive Health Centers, Inc.

"The People We Are…Are The People We Serve."
www.mhdchc.org

Patient Registration Form

PERSONAL

SS#_____ Patient Name:_____
Last *First* *MI* *(Jr. or Sr.)*

Gender: □ M or □ F Marital Status: □ Single □ Married □ Divorced □ Widowed DOB:_____
Race: □ Black □ White □ Asian □ American Indian □ Native Hawaiian/Pacific Islander □ Other
Ethnicity: □ Hispanic/Latino □ Non-Hispanic/Latino

Preferred Language: □ English □ other_____ Are you Employed? □ Y or □ N

Employer Address:_____City:_____State:_____ Zip Code: _____

Home Address:_____City:_____State:_____ Zip Code: _____

Email: _____ Phone #: _____ Wk. Phone# _____
(Area Code) (Area Code)

Referral Source: □ Self □ Relative □ Friend □ Other Health Care Provider: _____
Name

May we contact you: Email: □Y □N Text Message: □Y □N Cell Phone: □Y □N

SLIDING FEE POLICY

Are you seeking to qualify to participate in the Sliding Fee Discount program? □ Y or □ N

In order to apply for the program please indicate # of dependents in the household you support and annual household income. Please be aware that you must be completely uninsured or require services not covered by your insurance. Income verification required (i.e. pay stub, unemployment statement, W-2 form etc.). If you do not have proof of income or desire not to provide proof you will be expected to pay 100% of the costs of services received.

Annual Gross Household Income $_____ # in Household _____
Are you homeless? □ Y or □ N Are you a migrant/seasonal worker? □ Y or □ N
Do you live in Public Housing? □ Y or □ N Are you a Veteran? □ Y or □ N Are you Disabled? □ Y or □ N

ELECTRONIC PHOTO CONSENT

I,_____, hereby give consent to have an electronic photo taken and entered into
Parent or Guardian Signature

_____electronic medical record.
Child's Name

HOW DID YOU KNOW ABOUT US? (Referral Source)
□ Self □ Relative □ Friend □ Yellow Pages □ Radio/TV Ad □ Internet/ Website □ Referral Service
□ Walk –In □ Health Care Provider: Dr. _____ □ Other _____

HEALTH INSURANCE INFORMATION

Primary Subscriber: □ Self □ Spouse □ Dependent Child
Private Insurance Plan Type: _____
Group #_____ Member ID# _____
□ Uninsured □ Medicare#_____Medicare Plan Name _____
□ Medicaid #_____ Medicaid Plan Name _____

CONTACT INFORMATION

EMERGENCY/NEXT OF KIN

Name:_____ Relation: _____
Last First MI (Jr. or Sr.)

Gender: □ M or □ F Preferred Language: □ English □ other _____

Hm. Phone #: _____ Wk. Phone# _____ Email: _____
(Area code) (Area code)

PARENT/GUARDIAN

SS# _____ Name:_____ Relation: _____
Last First MI (Jr. or Sr.)

Gender: □ M or □ F Preferred Language: □ English □ other _____

Hm. Phone #:_____ Wk. Phone#_____ Email: _____
(Area Code) (Area Code)

PHARMACY INFORMATION

Preferred Provider:_____ Preferred Pharmacy: _____

Treatment Authorization and Financial Responsibility

Providing any false information on your registration form to benefit from the sliding fee discount program violates the Federal uninsured guidelines which will result in the organization (MHDCHC) taking legal action. I consent to receive medical, dental, surgical, diagnostic and/or hospital treatment as deemed necessary by MHDCHC professional staff. I also request and authorize that all third-party payments be forwarded directly to MHDCHC as reimbursement for services I receive. I understand and agree that I will be responsible for the payment of any unpaid balance in accordance with the payor's contractual agreement. I further authorize release of my medical information to the Centers for Medicare and Medicaid (and its agents) as required for determination of benefits.

Signature (Patient or Responsible Party):_____Relationship_____Date _____

MHDCHC Employee Witness:_____Title_____Date _____

MHDCHC at
5471 Dr. Martin Luther King Drive
Saint Louis, Missouri 63112
Phone: 314.367.5820
Fax: 314.367.7010
Email: admin@mhdchc.org

MHDCHC at
4500 Pope Avenue
Saint Louis, Missouri 63115
Phone: 314.385.3990
Fax: 314.389.2464
Email: admin@mhdchc.org

Homer G. Phillips
2425 Whittier Street
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Phone: 314.371.3100
Fax: 314.289.8718
Email: admin@mhdchc.org

Florence Hill
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Fairview Elementary School
7047 Emma Avenue
Saint Louis, Missouri 63136
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (ñHIPAAò), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my **PHI**. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

MHDCHC USE ONLY

I attempted to obtain the patientôs signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:

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Federal Poverty Guidelines
Sliding Fee Scale
Effective March 2017

Size of Family Unit	FULL SUBSIDY	PARTIAL SUBSIDY				FULL PAYMENT
	100% 100% Discount Nominal Fee	101% - 125% 80% Discount 20% Pay	126% - 150% 60% Discount 40% Pay	151% - 175% 40% Discount 60% Pay	176% - 200% 20% Discount 80% Pay	201% 0% Discount 100% Pay
1	0 - $12,060	$12,061 - $15,075	$15,076 - $18,090	$18,091 - $21,105	$21,106 - $24,120	Over $24,121
2	0 - $16,240	$16,241 - $20,300	$20,301 - $24,360	$24,361 - $28,420	$28,421 - $32,480	Over $32,481
3	0 - $20,420	$20,421 - $25,525	$25,526 - $30,630	$30,631 - $35,735	$35,736 - $40,840	Over $40,841
4	0 - $24,600	$24,601 - $30,750	$30,751 - $36,900	$36,901 - $43,050	$43,051 - $49,200	Over $49,201
5	0 - $28,780	$28,781 - $35,975	$35,976 - $43,170	$43,171 - $50,365	$50,366 - $57,560	Over $57,561
6	0 - $32,960	$32,961 - $41,200	$41,201 - $49,440	$49,441 - $57,680	$57,681 - $65,920	Over $65,921
7	0 - $37,140	$37,141 - $46,425	$46,426 - $55,710	$55,711 - $64,995	$64,996 - $74,280	Over $74,281
8	0 - $41,320	$41,321 - $51,650	$51,651 - $61,980	$61,981 - $72,310	$72,311 - $82,640	Over $82,641
9	0 - $45,500	$45,501 - $56,875	$56,876 - $68,250	$68,251 - $79,625	$79,626 - $91,000	Over $91,001
10	0 - $49,680	$49,681 - $62,100	$62,101 - $74,520	$74,521 - $86,940	$86,941 - $99,360	Over $99,361
Each Addt'l member add	$4,180	$5,225	$6,270	$7,315	$8,360	$8,361
	$20 med/$40 $0 Bal. Billed	*$20 med/$40 dental 20% Bal. Billed*	*$20 med/$40 40% Bal. Billed*	*$20 med/$40 dental 60% Bal. Billed*	*$20 med/$40 dental 80% Bal. Billed*	*$50 med/$75 100% Bal. Billed*

1. A nominal fee of $20 for medical and $40 for dental will be assessed to all patients including 0% patients.
2. If a patient presents with no conclusive proof of income to establish their sliding fee scale eligibility, place the patient on 100% pay until proof is
3. Certain dental & medical procedures do not qualify for sliding fee discount.

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Authorization for Release of Information

Patient Name	Date of Birth	Social Security Number
Patient Address		

I hereby authorize the use and disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as protected by law. This authorization is valid for a 90 day period from the date it is signed or sooner if so specified by me. I understand that a photocopy or fax of this authorization is as valid as the original. Once this information has been released pursuant to this authorization; it may no longer be protected by federal and state law(s) regulations and may no longer be deemed confidential. This authorization may include disclosure of information relating to **Alcohol** and **Drug Abuse**, **Mental Health Treatment**, and **Confidential AIDS/HIV Related Information**. I may revoke this authorization at any time, except where information has already been released in reliance of my authorization, provided that my revocation is in writing.

Name and address of health provider or entity to release this information:

Name and address of person(s) or category to whom this information will be sent:

Specific Information to be released:

☐ Medical Records from (insert date) _____to (insert date) _____

☐ Entire Medical Record including, including patient histories, office notes, test results, Radiology studies, referrals, consults alcohol/drug treatment, mental health information, and AIDS/HIV-related information

☐ Other_____

_____ _____
Signature of Patient or legal representative Date

_____ _____
Signature of Witness Date

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COMP1 Location

Get Directions

5471 Dr. Martin Luther King Dr.
St. Louis, MO 63112
Office: 314.367.5820
Fax: 314.367.7010

Monday-Friday: 8am – 5pm
Wednesday: 8am – 6pm
Saturday: Closed
Sunday: Closed

FLORENCE HILL LOCATION

Get Directions

5541 Riverview Blvd.
St. Louis, MO 63120
Office: 314.389.4566
Fax: 314.389.5514

Monday-Friday: 8am – 5pm
Monday: 7am – 5pm
Saturday: Closed
Sunday: Closed

HOMER G. PHILLIPS LOCATION

Get Directions

2425 North Whittier St.
St. Louis, MO 63113
Office: 314.371.3100
Fax: 314.289.8718

Monday-Friday: 8am – 5pm
Thursday: 7am – 5pm
Saturday: Closed
Sunday: Closed

Pope Location

Get Directions

4500 Pope Ave.
St. Louis, MO 63115
Office: 314.385.3990
Fax: 314.389.2464

Monday-Friday: 8am – 5pm
Tuesday: 7am – 5pm
Saturday: Closed
Sunday: Closed

Myrtle Hilliard Davis
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The Health Centers will be closed on the following dates during the 2017 calendar year

Staff Meetings
Centers will be open for business at 1:00 pm

January 24, 2017

April 25, 2017

August 22, 2017

November 28, 2017

Staff Development
Centers will be open for business at 10:30 am

February 28, 2017

June 27, 2017

September 26, 2017

Holidays
Centers are CLOSED

January 02, 2017

January 16, 2017

February 20, 2017

May 29, 2017

July 4, 2017

September 4, 2017

November 10, 2017

November 23, 2017

November 24, 2017

December 25, 2017

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Patient's Bill of Rights and Responsibilities

1. You have the right to choose Myrtle Hilliard Davis Comprehensive Health Centers, Inc. (MHDCHC) as your Medical Home.
   - ✓ It is your responsibility to be a partner in the care you are being provided.

2. You have the right to select your preferred provider or change medical or dental providers and specialists upon your request.
   - ✓ It is your responsibility to make a request if such a change is desired.

3. You have the right to seek treatment regardless of your race, age, sex disability, religion, or political belief.
   - ✓ If treatment is denied you, you may file a complaint of discrimination with the Corporate Compliance Officer of the Health Center.

4. You have the right to be treated with courtesy and respect. You have the right to be addressed in a respectful manner, by your proper name and without undue familiarity by MHDCHC Staff.
   - ✓ It is your responsibility to respond with courtesy and respect to the Health Center Staff or services may be denied for that visit date.

5. You have the right to obtain and understand your provider's diagnosis treatment, and/or procedures and prognosis of your condition.
   - ✓ It is your responsibility to listen and ask questions to understand.

6. You have the right to give an "Informed Consent" prior to the start of any procedure and/or treatment. You must be given all necessary information, so that you can make an informed decision. You should also be aware of all "medically significant" alternatives.
   - ✓ It is your responsibility to read and understand all documents before you sign them.

7. You have the right to refuse medical treatment except in certain cases. These exceptions will be explained by your provider.
   - ✓ If treatment is refused, the provider will ask you to sign an Against Medical Advice form that says he/she is not responsible for what happens to you as a result of your decision.

8. You have the right to privacy. Your examination and treatments should be done in an enclosed area with only necessary staff present. You have the right to know the names and titles of any observers.
   - ✓ It is your responsibility to report a violation of privacy to the Corporate Compliance Officer.

9. You have the right to expect that your illness, treatment, medical records/EHR and all communications will be treated with confidentiality.
   - ✓ It is you responsibility not to inquire about another patient's illness or treatment.

10. You have the right to expect that within its capacity, the Health Center will make a reasonable response to your request for patient services.
    - ✓ It is your responsibility not to misuse Health Center services.

11. You have the right to know when you are being used in research and the right to refuse to participate in said research.
    - ✓ It is your responsibility to be fully aware of possible adverse reactions, successes, failures or other choices.

12. You have the right to expect reasonable continuity of care. You should be told if you need further treatment, as well as when and where to get it. This includes helping you to make appropriate appointments.
    - ✓ It is your responsibility to be prompt for all subsequent appointments and to follow the advice of the providers regarding procedures and treatment.

13. You have the right to a full explanation of your bill, regardless of your method of payment.
    - ✓ It is your responsibility to inform the Billing staff of your method of payment. It is also your responsibility to inform the Billing Staff when your payment method changes. i.e. Medicaid, Medicare, Insurance, Self Pay, (cash), or Credit Card.

14. You have the right to know that weapons, drinking intoxicating beverages, gambling, using illicit drugs, disruptive behavior including profanity, playing radios/CD recorders, suggestive dressing (female or male), using cell phones when receiving service, and smoking is prohibited in the Health Center.
    - ✓ It is your responsibility to conduct yourself respectfully in the health center.

15. You have the right to offer a compliment or voice a complaint.
    - ✓ It is your responsibility to report a complaint to the Corporate Compliance Officer.

16. You have a right to ongoing pain assessment and management.
    - ✓ It is your responsibility to report to your provider that you have pain.

17. You have the right to access confidential information from your personal medical records/EHR and the right to request a summary of your visits and if errors noted, that errors be amended.
    - ✓ It is your responsibility to notify the Health Information Management Department with concerns or request to have errors in documentation in your medical record/EHR reviewed.

18. You have the right to expect Data Security of your confidential medical information, including also your demographic profile be protected from Identity Theft.
    - ✓ It is your responsibility to immediately notify the Corporate Compliance Officer if you suspect or have definitive knowledge that you are being or have been the victim of Identity Theft.

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Note this is a NPP that reflects Omnibus changes as of March 2013

Myrtle Hilliard Comprehensive Health Centers, Inc.

NOTICE OF PRIVACY PRACTICES

Effective Date: 03/03/2013

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.

If you have any questions about this Notice of Privacy Practices ('Notice'), please contact:

Privacy Officer: Dion Starks
Phone Number: 314-367-5820 ext 2245

Section A: Who Will Follow This Notice?

This Notice describes Myrtle Hilliard Davis Comprehensive Health Centers, Inc. (hereafter referred to as 'Provider') Privacy Practices and that of:

Any workforce member authorized to create medical information referred to as Protected Health Information (PHI) which may be used for purposes such as Treatment, Payment and Healthcare Operations. These workforce members may include:

- All departments and units of the Provider.
- Any member of a volunteer group.
- All employees, staff and other Provider personnel.
- Any entity providing services under the Provider's direction and control will follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for Treatment, Payment or Healthcare Operational purposes described in this Notice.

Section B: Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Provider. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated or maintained by the Provider, whether made by Provider personnel or your personal doctor.

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

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and

- Follow the terms of the Notice that is currently in effect.

Section C: How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or other Provider personnel who are involved in taking care of you at the Provider. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the Provider also may share medical information about you in order to coordinate different items, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the Provider who may be involved in your medical care after you leave the Provider.

- **Payment.** We may use and disclose medical information about you so that the treatment and services you receive at the Provider may be billed and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at the Provider so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a prescribed treatment to obtain prior approval or to determine whether your plan will cover the treatment.

- **Healthcare Operations.** We may use and disclose medical information about you for Provider operations. These uses and disclosures are necessary to run the Provider and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many Provider patients to decide what additional services the Provider should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, health care students, and other Provider personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning a patient's identity.

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

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

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

- **Fundraising Activities.** We may use information about you to contact you in an effort to raise money for the Provider and its operations. We may disclose information to a foundation related to the Provider so that the foundation may contact you about raising money for the Provider. We only would release contact information, such as your name, address and phone number and the dates you received treatment or services at the Provider. If you do not want the Provider to contact you for fundraising efforts, you must notify us in writing and you will be given the opportunity to 'Opt-out' of these communications.

- **Authorizations Required**
  We will not use your protected health information for any purposes not specifically allowed by Federal or State laws or regulations without your written authorization, this includes uses of your PHI for marketing or sales activities.

- **Emergencies.** We may use or disclose your medical information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.

- **Psychotherapy Notes**
  Psychotherapy notes are accorded strict protections under several laws and regulations. Therefore, we will disclosure psychotherapy notes only upon your written authorization with limited exceptions.

- **Communication Barriers.** We may use and disclose your health information if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

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

- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care and we may also give information to someone who helps pay for your care, unless you object in writing and ask us not to provide this information to specific individuals. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with

specific medical needs, so long as the medical information they review does not leave the Provider. We will almost always generally ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the Provider.

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

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

- **E-mail Use.**
  E-mail will only be used following this Organization's current policies and practices and with your permission. The use of secured, encrypted e-mail is encouraged.

Section D: Special Situations

- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs.

- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:
  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose

medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
    - in response to a court order, subpoena, warrant, summons or similar process;
    - to identify or locate a suspect, fugitive, material witness, or missing person;
    - about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
    - about a death we believe may be the result of criminal conduct;
    - about criminal conduct at the Provider; and
    - in emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Provider to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Section E: Your Rights Regarding Medical Information About You

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

- **Right to Access, Inspect and Copy.** You have the right to access, inspect and copy the medical information that may be used to make decisions about your care, with a few exceptions. Usually, this includes medical and billing records, but may not include psychotherapy notes. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

- We may deny your request to inspect and copy medical information in certain very limited circumstances. If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by the Provider will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Provider. In addition, you must provide a reason that supports your request.

- We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the medical information kept by or for the Provider;
    - Is not part of the information which you would be permitted to inspect and copy; or
    - Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an 'Accounting of Disclosures'. This is a list of the disclosures we made of medical information about you. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the accounting (for example, on paper or electronically, if available). The first accounting you request within a 12 month period will be complimentary. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both, and to whom you want the limits to apply (for example, disclosures to your spouse). We are not required to agree to these types of request. We will not comply with any requests to restrict use or access of your medical information for treatment purposes.

  You also have the right to restrict use and disclosure of your medical information about a service or item for which you have paid out of pocket, for payment (i.e. health plans) and operational (but not treatment) purposes, if you have completely paid your bill for this item or service. We will not accept your request for this type of restriction until you have completely paid your bill (zero balance) for this item or service. We are not required to notify other healthcare providers of these restrictions, that is your responsibility.

- **Right to Receive Notice of a Breach.** We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

- a brief description of the breach, including the date of the breach and the date of its discovery, if known;
- a description of the type of Unsecured Protected Health Information involved in the breach;
- steps you should take to protect yourself from potential harm resulting from the breach;
- a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
- contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional Information.

In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our website or in a major print or broadcast media. If the breach involves more than 500 patients in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or hard copy or e-mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice at our website www.mhdchc.org

To exercise the above rights, please contact the individual listed at the top of this Notice to obtain a copy of the relevant form you will need to complete to make your request.

Section F: Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice. The Notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you register at or are admitted to the Provider for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current Notice in effect.

Section G: Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Provider or with the Secretary of the Department of Health and Human Services;
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

To file a complaint with the Provider, contact the individual listed on the first page of this Notice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Section H: Other Uses of Medical Information

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

Section I: Organized Healthcare Arrangement

The Provider, the independent contractor members of its Medical Staff (including your physician), and other healthcare providers affiliated with the Provider have agreed, as permitted by law, to share your health information among themselves for purposes of treatment, payment or health care operations. This enables us to better address your healthcare needs.

Revision Date: March 03, 2013, to be compliant with HIPAA Omnibus Privacy Rules.

Original Effective Date: April 14, 2003.