Today's Date:_____ Referred By:_____

Last Name:_____ First Name:_____

Date Of Birth:_____ Age:_____ Sex_____

Patient Address:_____

_____

Patient Email Address:_____

Patient Home Phone #_____ Cell Phone #_____

Emerg Contact Name:_____ Relation:_____ P#_____

Primary Care Physician:_____ Phone:_____

Cardiologist:_____ Phone:_____

***All Copays will be collected at the time of the appointment unless it is percent based and you will receive a bill via mail along with any other charges pending.**

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Palm Beach GI or insurance company to release any information required to process my claims.

***PLEASE READ AND SIGN THE FOLLOWING**

1. Payment for services is expected at the time of service.
2. If insurance is filed, I authorize benefits to be paid directly to Palm Beach GI
3. I am responsible for the balance on my account, regardless of insurance coverage. My failure to pay off outstanding balances on my account may result in collection procedures being taken.
4. I authorize the doctor to release any information requested regarding the processing of my claims.
5. Failure to give 24-hour notice prior to canceling appointments may result in a cancellation fee charge to an account not payable by health insurance.

***Patient/Parent's/Guardian's Signature**_____ **Date**_____

PREFERRED PHARMACY (PLEASE SPECIFY)

Name _____ Address_____ City_____

State ____ Zip Code _____ Phone #_____

Preferred Lab:_____ ***Preferred*** Imaging center:_____

*Did you get the Flu Vaccine this year? YES OR NO
Date of last vaccine?(MM/DD/YYYY)_____

*Are you pregnant or planning a pregnancy? Yes_____ No_____

PAST MEDICAL HISTORY PLEASE SPECIFY

☐ Anxiety	☐ Hearing Loss
☐ Arthritis	☐ HIV/AIDS
☐ Asthma	☐ Hypercholesterolemia
☐ Atrial Fibrillation	☐ Hyperthyroidism
☐ Benign prostatic hyperplasia	☐ Hypothyroidism
☐ Cancer, if so what type: _____	☐ Leukemia
☐ Cerebrovascular Accident	☐ Malignant lymphoma
☐ COPD	☐ Malignant tumor of breast
☐ Coronary Arteriosclerosis	☐ Malignant tumor of lung
☐ Depression	☐ Malignant tumor of prostate
☐ Diabetes	☐ Radiation Therapy
☐ COVID-19	☐ Bone Marrow transplant
☐ Elevated Blood Pressure/Hypertension	
☐ End Stage Renal Disease	☐ Other:
☐ Epilepsy	

*PAST GENERAL SURGICAL HISTORY (PLEASE SPECIFY DATES)

☐ Bilateral knee replacements	☐ History of Appendectomy	☐ Resection of Rectum
☐ Biopsy of Breast	☐ History of cholecystectomy (gallbladder removed)	☐ Pancreatectomy
☐ Biopsy of Prostate	☐ History of colectomy	☐ Splenectomy
☐ Coronary Artery Bypass Graft	☐ History of percutaneous transluminal coronary angioplasty	☐ Heart Transplant
☐ Kidney Transplant	☐ History of heart valve replacement	☐ Liver Transplant
☐ Skin Cancer	☐ Hysterectomy	☐ Other:

Past or Current GI Conditions

☐ Achalasia	☐ Gilbert's Syndrome
☐ Alcoholic Hepatitis	☐ Gluten Intolerance
☐ Anal Fissure	☐ Hemorrhoids
☐ Ascites	☐ Hepatic Encephalopathy
☐ Autoimmune Hepatitis	☐ Hepatitis B
☐ Barrett's Esophagus	☐ Hepatitis C
☐ Celiac Disease	☐ Hiatal Hernia
☐ Cholecystitis	☐ H.Pylori
☐ Choledocholithiasis	☐ Iron Deficiency Anemia
☐ Cholelithiasis	☐ Irritable Bowel Syndrome
☐ Chronic Constipation	☐ Lactose Intolerant
☐ Cirrhosis	☐ Microscopic Colitis
☐ Colon Cancer	☐ NASH
☐ Crohn's Disease	☐ Pancreatic Cancer
☐ C.Diff Colitis	☐ Pancreatic Cyst
☐ Diverticulitis	☐ Pancreatitis
☐ Diverticulosis	☐ Peptic Ulcer Disease
☐ Dyspepsia	☐ Portal Hypertension
☐ Esophageal Cancer	☐ Primary Biliary Cirrhosis
☐ Esophageal Varices	☐ Spontaneous Bacterial Peritonitis
☐ Gastric Cancer	☐ Small Bowel Obstruction
☐ Gastroparesis	☐ Ulcerative Colitis
☐ GERD	☐ Upper GI Bleeding

Past GI Surgical History:

☐ EGD	☐ EUS	☐ Gastrectomy	☐ Lysis of Adhesions
☐ Capsule Endoscopy	☐ ERCP	☐ Gastric Bypass	☐ Colectomy
☐ Colonoscopy	☐ Esophagectomy	☐ PEG Tube	☐ Colostomy
☐ Flex Sigmoidoscopy	☐ Esophageal Banding	☐ Small Bowel Resection	☐ Hernia Repair

Other: _____

***IMMEDIATE GI or LIVER FAMILY HISTORY Please specify any GI related illnesses, diseases or cancers.**

Relation	Alive & Well (Y/N)	Condition/Diagnosis	Age of Onset	Cause of Death (Y/N)

***LIST OF ANY MEDICATIONS CURRENTLY TAKING (INCLUDING NON PRESCRIPTION OVER THE COUNTER VITAMINS OR SUPPLEMENTS)**

1.	12.
2.	13.
3.	14.
4.	15.
5.	16.
6.	17.
7.	18.
8.	19.
9.	20.
10.	21.
11.	22.

***ALLERGIES** (MEDICATIONS, FOOD, ANIMAL, PLANT, OR ENVIRONMENT):_____

Please check off if No Known Drug Allergies:_____

SOCIAL HISTORY

***USE TOBACCO:**	**TYPE OF TOBACCO USED:**	
☐ Current ☐ Quantity per day_____ Years_____	☐ Chewing ☐ Cigarettes	☐ Never
☐ Former ☐ Quantity per day_____ Years_____ ☐	☐ Cigar ☐ Pipe	

***ALCOHOL:** Yes/No/Former	Amount/Last Drink:	*Caffeine
If yes, type: _____ If former, Year quit:	Frequency:_____ (Have you ever had 5 or more daily?)_____Amt._____	Use: Yes/No Quantity Per Day: _____

For patients 65 and older:

Have you received a pneumonia vaccination? Y____N____

Do you have a health care proxy in the event you are unable to make your own medical decisions? Y___N___

Do you have a living will? Y___N___

*Circle if you are experiencing any of the following:

Chest Pain	Fever/Chills	Wheezing
Unintentional Weight Loss	Thyroid problems	Anxiety
Abdominal Pain	Sore throat	Depression
Bloody stool	Blurry vision	
Nausea/Vomiting	Bloody urine	
Dysphagia/Difficulty Swallowing	Joint aches	
Constipation	Muscle weakness	
Diarrhea	Headaches	
Problems with bleeding	Seizures	
Rash	Cough	
Immunosuppression	Shortness of breath	

Other: _____

Are You Taking Any Blood Thinners: YES or NO _____

Examples: Aspirin, Plavix, Xarelto, Coumadin, Pradaxa, Heparin, Warfarin

Pregnant or Planning a Pregnancy?: YES or NO _____

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

Consent for Medical services and treatment:

I consent to treatment, diagnostic and/or therapeutic services as ordered and/or provided by Dr. Naveen Reddy as a Physician of Palm Beach GI and his/her designee(s).

Financial Agreement

The undersigned individually obligates him/herself and guarantees prompt payment of all charges for services rendered to the patient when not covered by insurance carriers or others. Payment of any unpaid balance is due within 30 days of final billing. If payment is not received within 30 days of final billing, financial charges may begin to accrue at the maximum rate allowed by law. In addition, such balance may be turned over to collection activity, at which time the undersigned shall be liable for attorney's and/or collection agency fees and expenses. The undersigned understands that Palm Beach GI has the right to examine credit bureau files for financial information regarding collection of unpaid debt.

Assignment of Benefits

In the event that I am entitled to physician benefits of any and all types, I assign such benefits to Palm Beach GI for services rendered to me. I authorize payment directly to Palm Beach GI of all such insurance benefits payable to me. Such insurance includes, but is not limited to, private commercial insurance, auto/liability insurance, or any government program such as Medicare, Medicaid, or Worker's compensation and authorize Palm Beach GI to release medical information to such insurance providers as necessary to satisfy the conditions for payment of the assigned benefits. I certify that the information given regarding my insurance is accurate and current.

Release of Information

I also authorize Palm Beach GI to release all or part of my medical record information when required or permitted by law or government regulation, including any physician(s) or healthcare provider responsible for continuing my care.

Insurance Precertification

I understand that, before service is rendered, I personally am responsible for any required notification to my insurance company to obtain authorization for treatment. If this is not done, insurance benefits may be reduced and I am responsible for all charges not covered by my insurance.

****Consent for Medical Services and Treatments and Financial Agreement:***

I have been provided with a copy of the HIPAA Notice of Privacy Practices that describes how Palm Beach GI may use and disclose my health information, and describe my rights regarding my health information.

****Evaluation or Services and Treatment***

I give permission for Palm Beach GI and/or its agent (s) to contact me for the purpose of evaluation the services rendered to me. **YES** _____ **NO** _____

The undersigned certifies that he/she has read and understood the above, fully accepts all specific terms therein, and has received the information on patients' rights, including the mechanism for the initiation, review, and resolution of complaints and a copy of the HIPAA Notice of Privacy Practices.

****Signature*** **of Patient or Legally Authorized Representative** _____ **Date**_____

****Print*** **Name of Patient of Patient or Legally Authorized Rep** _____ **Date**_____

FOR Medicare/Medicaid Patients ONLY:

Lifetime Medicare B and Medigap Signature Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in the Palm Beach GI including physician services. I authorize any holder of medical or other information about me to release to the Center of Medicare & Medicaid Services or its agents any information needed to determine these benefits for related services.

Name of Beneficiary _____ HIC Number_____

Lifetime Medigap Signature Authorization

I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf for any services furnished to me by or at Palm Beach GI for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits for related services.

Name of Medigap Insurer_____ Name of Beneficiary _____

Medigap Policy Number_____

Patient Signature_____Date_____

Authorization for Use and Disclosure of Individually Identifiable Health Information and Confidential Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations authorized to use or disclose the information: Palm Beach GI and it's employees or contractors.
2. ***I acknowledge and agree that the practice may disclose my protected health information and information contained in my medical record to the following (check allowances) ☐Spouse ☐Adult Children ☐ All family members ☐Legal Representatives ☐ Guardians ☐Health Care Surrogates ☐ Other_____ ☐ ALL LISTED**
3. Specific information that may be used/disclosed for: information relating to treatment, payment, and health care operations.
4. The information will be used/disclosed for: treatment, payment, and health care operations.
5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign, or my revocation of this authorization will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.
6. I understand that I may inspect or copy the information used or disclosed.
7. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing, except to the extent that (a) an action has been taken in reliance on this authorization; or (b) if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.
8. I have read and agree to the information regarding "How We May Use and Disclose Medical Information About You." Our notice of "Privacy Practices" (posted in reception) provides information about how we may use and disclose health information about you. You have the right to review our notices before signing this form. The practice reserves the right to change the terms of its Notice of Privacy practices at any time. If so, the patient may obtain a copy of this revised Notice. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

9. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations as described in our notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.
10. Patient agrees and consents to the practice of releasing information to the patient in the following alternative manners:
11. * ☐ **Via Regular mail with envelope being marked personal and confidential, and addressed to the patient**
12. * ☐ **Via Telephone, if the patient contacts the practice and provides the appropriate information (name, SSN, Birth Date)**
13. The Practice may refuse to treat the patient if he/she (or authorized representative) does not sign this consent form. If the patient (or an authorized representative) signs this consent form, and then revolkes it, the practice has the right to refuse to provide further treatment to the patients as of the time of revocation (except as the practice is required by law to treat individuals).
14. **I have read and understand the information in this consent. I have received a copy of this consent and I am the patient, or am authorized to act on behalf of the patient to sign this document verifying consent of the above stated terms.**

_____ _____

***Signature of patient or patient representative** ***Date**

MEDICAL RECORDS REQUEST FORM

1st Attempt 2nd Attempt 3rd Attempt

210 Jupiter Lakes Blvd, Building 3000, Suite 106, Jupiter, FL 33458
Phone: 561-619-7620 | Fax: 561-619-7864 | HISP Email: nreddy@pbgi.emadirect.md

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: **Date of Birth:**

Maiden Name: Social Security #:

(FOR OFFICE USE ONLY)

I request and authorize _____

P:_____

F:_____

DR. NAVEEN REDDY, MD
210 Jupiter Lakes Blvd, Building 3000, Suite 106, Jupiter, FL 33458

to release healthcare information of the patient named above to:

(FOR OFFICE USE)

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 simplex, human papillomavirus, warts, genital warts, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, 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.

Date signed:_____

***Patient Signature:** _____

HIPPA PRIVACY NOTICE

Palm Beach GI
Naveen Reddy, MD
210 Jupiter Lakes Blvd.
Building 3000, Suite 106
Jupiter, FL 33458

A Notice of Privacy Practices (NPP) is provided to all Patients. This Notice of Privacy identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been been violated; and 4) Our responsibilities for maintaining the privacy of your medical information.

The undersigned certified that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the Patient, or the Patient's Personal Representative.

_____ _____
Name of Patient Signature of Patient

_____ _____
Name of Patient's Personal Representative Signature of Patient's Personal Representative

For Internal Use Only

_____ _____
Name of Employee Signature of Employee

If applicable, reason Patient's written acknowledgment could not be obtained:

___ Patient was unable to sign

___ Patient refused to sign

Other: _____

Signature _____ Date: _____

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210 Jupiter Lakes Blvd. Bldg 3000, Suite 106
Jupiter, FL 33458

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 INFORMATON. PLEASE REVIEW IT CAREFULLY.

Who Presents this Notice

The references to "Facility" and "Health Professionals" in this notice refer to the members of the Tenet Healthcare Affiliated Covered Entity. An Affiliated Covered Entity (ACE) is a group of organizations under common ownership or control who designate themselves as a single Affiliated Covered Entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The Facility, its employees, workforce members and members of the ACE who are involved in providing and coordinating health care are all bound to follow the terms of this Notice of Privacy Practices ("Notice"). The members of the ACE will share PHI with each other for the treatment, payment and health care operations of the ACE and as permitted by HIPAA and this Notice. For a complete list of the members of the ACE, please contact the Privacy & Security Compliance Office.

Privacy Obligations

Each Facility is required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of legal duties and privacy practices with respect to your Protected Health Information. The Facility uses computerized systems that may subject your Protected Health Information to electronic disclosure for purposes of treatment, payment and/or health care operations as described below. When the Facility uses or discloses your Protected Health Information, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

Notifications

The Facility is required by law to protect the privacy of your medical information, distribute this Notice of Privacy Practices to you, and follow the terms of this Notice. The Facility is also required to notify you if there is a breach or impermissible access, use or disclosure of your medical information.

Permissible Uses and Disclosures Without Your Written Authorization

In certain situations your written authorization must be obtained in order to use and/or disclose your PHI. However, the Facility and Health Professionals do not need any type of authorization from you for the following uses and disclosures:

Uses and Disclosures for Treatment, Payment and Health Care Operations. Your PHI may be used and disclosed to treat you, obtain payment for services provided to you and conduct "health care operations" as detailed below:

Treatment. Your PHI may be used and disclosed to provide treatment and other services to you--for example, to diagnose and treat your injury or illness. In addition, you may be contacted to provide you appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your PHI may also be disclosed to other providers involved in your treatment. For example, a doctor treating you for a broken leg may need to know if you have diabetes because if you do, this may impact your recovery.

Payment. Your PHI may be used and disclosed to obtain payment for services provided to you--for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care ("Your Payor") to verify that Your Payor will pay for health care. The physician who reads your x-ray may need to bill you or your Payor for reading of your x-ray therefore your billing information may be shared with the physician who read your x-ray.

Health Care Operations. Your PHI may be used and disclosed for health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care delivered to you. For example, PHI may be used to evaluate the quality and competence of physicians, nurses and other health care workers. PHI may be disclosed to the Privacy & Security Compliance Office in order to resolve any complaints you may have and ensure that you have a comfortable visit. Your PHI may be provided to various governmental or accreditation entities such as the Joint Commission on Accreditation of Healthcare Organizations to maintain our license and accreditation. In addition, PHI may be shared with business associates who perform treatment, payment and health care operations services on behalf of the Facility and Health Professionals.

Additionally, your PHI may be used or disclosed for the purpose of allowing students, residents, nurses, physicians and others who are interested in healthcare, pursuing careers in the medical field or desire an opportunity for an educational experience to tour, shadow employees and/or physician faculty members or engage in a clinical Practicum.

Health Information Organizations. Your PHI may be used and disclosed with other health care providers or other health care entities for treatment, payment and health care operations purposes, as permitted by law, through a Health Information Organization. A list of Health Information Organizations in which this facility participates may be obtained upon request or found on our website at www.tenethealth.com.

For example, information about your past medical care and current medical conditions and medications can be available to other primary care physicians if they participate in the Health Information Organization. Exchange of health information can provide faster access, better coordination of care and assist providers and public health officials in making more informed treatment decisions. You may opt out of the Health Information Organization and prevent providers from being able to search for your information through the exchange. You may opt out and prevent your medical information from being searched through the Health Information Organization by completing and submitting an Opt-Out Form to registration.

Use or Disclosure for Directory of Individuals in the Facility. Facility may include your name, location in the Facility, general health condition and religious affiliation in a patient directory without obtaining your authorization unless you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or minister, even if they do not ask for you by name. If you do not wish to be included in the facility directory, you will be given an opportunity to object at the time of admission.

Disclosure to Relatives, Close Friends and Other Caregivers. Your PHI may be disclosed to a family member, other relative, a close personal friend or any other person identified by you who is involved in your health care or helps pay for your care. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, the Facility and/or Health Professionals may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, the Facility and/or Health Professionals would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care. Your PHI also may be disclosed in order to notify (or assist in notifying) such persons of your location or general condition.

Public Health Activities. Your PHI may be disclosed for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

Victims of Abuse, Neglect or Domestic Violence. Your PHI may be disclosed to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if there is a reasonable belief that you are a victim of abuse, neglect or domestic violence.

Health Oversight Activities. Your PHI may be disclosed to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

Judicial and Administrative Proceedings. Your PHI may be disclosed in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

Law Enforcement Officials. Your PHI may be disclosed to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. For example, your PHI may be disclosed to identify or locate a suspect, fugitive, material witness, or missing person or to report a crime or criminal conduct at the facility.

Correctional Institution. You PHI may be disclosed to a correctional institution if you are an inmate in a correctional institution and if the correctional institution or law enforcement authority makes certain requests to us.

Organ and Tissue Procurement. Your PHI may be disclosed to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Research. Your PHI may be used or disclosed without your consent or authorization if an Institutional Review Board approves a waiver of authorization for disclosure.

Health or Safety. Your PHI may be used or disclosed to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

U.S. Military. Your PHI may be use or disclosed to U. S. Military Commanders for assuring proper execution of the military mission. Military command authorities receiving protected health information are not covered entities subject to the HIPAA Privacy Rule, but they are subject to the Privacy Act of 1974 and DoD 5400.11-R , "DoD Privacy Program," May 14, 2007.

Other Specialized Government Functions. Your PHI may be disclosed to units of the government with special functions, such as the U.S. Department of State under certain circumstances for example the Secret Service or NSA to protect the country or the President.

Workers' Compensation. Your PHI may be disclosed as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

As Required by Law. Your PHI may be used and disclosed when required to do so by any other law not already referred to in the preceding

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categories, such as required by the FDA, to monitor the safety of a medical device.

Appointment Reminders. Your PHI may be used to tell or remind you about appointments.

Fundraising. Your PHI may be used to contact you as a part of fundraising efforts, unless you elect not to receive this type of information.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Use or Disclosure with Your Authorization. For any purpose other than the ones described above, your PHI may be used or disclosed only when you provide your written authorization on an authorization form ("Your Authorization"). For instance, you will need to execute an authorization form before your PHI can be sent to your life insurance company or to the attorney representing the other party in litigation in which you are involved.

Marketing. Your written authorization ("Your Marketing Authorization") also must be obtained prior to using your PHI to send you any marketing materials. (However, marketing materials can be provided to you in a face-to-face encounter without obtaining Your Marketing Authorization. The Facility and/or Health Professionals are also permitted to give you a promotional gift of nominal value, if they so choose, without obtaining Your Marketing Authorization). The Facility and/or Health Professionals may communicate with you in a face-to-face encounter about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings without Your Marketing Authorization.

In addition, the Facility and/or Health Professionals may send you treatment communications, unless you elect not to receive this type of communication, for which the Facility and/or Health Professionals may receive financial remuneration.

Sale of PHI. The Facility and Health Professionals will not disclose your PHI without your authorization in exchange for direct or indirect payment except in limited circumstances permitted by law. These circumstances include public health activities; research; treatment of the individual; sale, transfer, merger or consolidation of the Facility; services provided by a business associate, pursuant to a business associate agreement; providing an individual with a copy of their PHI; and other purposes deemed necessary and appropriate by the U.S. Department of Health and Human Services (HHS).

Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental illness, mental retardation and developmental disabilities; (3) is about alcohol or drug abuse or addiction; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about communicable disease(s), including venereal disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (8) is about domestic abuse of an adult; or (9) is about sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Right to Request Additional Restrictions. You may request restrictions on the use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While all requests for additional restrictions will be carefully considered, the Facility and Health Professionals are not required to agree to these requested restrictions.

You may also request to restrict disclosures of your PHI to your health plan for payment and healthcare operations purposes (and not for treatment) if the disclosure pertains to a healthcare item or service for which you paid out-of-pocket in full. The Facility and Health Professionals must agree to abide by the restriction to your health plan EXCEPT when the disclosure is required by law.

If you wish to request additional restrictions, please obtain a request form from the Health Information Management Office and submit the completed form to the Health Information Management Office. A written response will be sent to you.

Right to Receive Confidential Communications. You may request, and the Facility and Health Professionals will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

Right to Revoke Your Authorization. You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your PHI, except to the extent that the Facility and/or Health Professionals have taken action in reliance upon it, by delivering a written revocation statement to the Facility Health Information Management Office identified below.

Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by the Facility and Health Professionals in order to inspect and request copies of the records. Under limited circumstances, you may be denied access to a portion of your records. If you desire access to your records, please obtain a record request form from the Facility Health

nformation Management Office and submit the completed form to the Facility Health Information Management Office. If you request copies of paper records, you will be charged in accordance with federal and state law. To the extent the request for records includes portions of records which are not in paper form (e.g., x-ray films), you will be charge the reasonable cost of the copies. You also will be charged for the postage costs, if you request that the copies be mailed to you. However, you will not be charged for copies that are requested in order to make or complete an application for a federal or state disability benefits program.

Right to Amend Your Records. You have the right to request that PHI maintained in your medical record file or billing records be amended. f you desire to amend your records, please obtain an amendment request form from the Facility Health Information Management Office and submit the completed form to the Facility Health Information Management Office. Your request will be accommodated unless the Facility and/or Health Professionals believe that the information that would be amended is accurate and complete or other special circumstances apply.

Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, you will be charged for the accounting statement.

Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

For Further Information or Complaints. If you desire further information about your privacy rights, are concerned that your privacy rights have been violated or disagree with a decision made about access to your PHI, you may contact the Privacy & Security Compliance Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy & Security Compliance Office will provide you with the correct address for the Director. The Facility and Health Professionals will not retaliate against you if you file a complaint with the Privacy & Security Compliance Office or the Director.

Effective Date and Duration of This Notice

Effective Date. This Notice is effective on March 1, 2021.

Right to Change Terms of this Notice. The terms of this Notice may be changed at any time. If this Notice is changed, the new notice terms may be made effective for all PHI that the Facility and Health Professionals maintain, including any information created or received prior to issuing the new notice. If this Notice is changed, the new notice will be posted in waiting areas around the Facility and on our Internet site at www.tenethealth.com. You also may obtain any new notice by contacting the Privacy & Security Compliance Office.

FACILITY CONTACTS

Privacy & Security Compliance Office

4201 N Dallas Pky
Dallas, Texas 75254
E-mail:PrivacySecurityOffice@tenethealth.com
Ethics Action Line (EAL) 1-800-8-ETHICS