Dear Patient and Family:

Thank you so much for allowing Rio Bravo Cancer Center to participate in the care of your health. We are dedicated to providing warm and compassionate care to all of our patients and their families. Being diagnosed with cancer is a life changing event. We understand the confusion and emotions that our patients may experience. Rio Bravo Cancer Center was founded on the one simple goal of providing honesty and guidance to all our patients and their families.

We always take the extra time to get to know our patients, as our patients eventually become just like family. All of our staff have only one objective and that is to make every single encounter enjoyable. If you have any questions, feel free to reach out to any one of our team members at Rio Bravo Cancer Center.

Remember, you are not alone and we are here to support and advocate for you and your family. We thank you for allowing us to be part of this journey towards improved health and wellness.

Dr. Ricardo Salas
Director of Hematology/Oncology

Dr. Jekwon Yeh
Director of Radiation Oncology

PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Name: ______________________ DOB: ______ / ______ / ______ Age: ______

Address: ____
Street City State Zip

SS#: ______ - ______ - ______ Male / Female Marital Status: (Circle) Single Married Divorced Widowed

Home Phone: (______) ______ - ______ Mobile Phone: (______) ______ - ______

Email: ______________________

Attention: We will use the address above and all phone numbers listed to contact you, mail copy of office visit notes and/or leave messages regarding your care. Please see the Office Manager if you wish to place a restriction on the use of this information for these purposes.

REFERRING PHYSICIAN:

Name: ______________________ ☐ Oncologist ☐ Urologist ☐ Ear, Nose, & Throat ☐ GYN

Office Phone: (______) ______ - ______ Office Fax: (______) ______ - ______

Street Address: ______________________ Suite #: ______

City: ______________________ State: ______ Zip: ______

PRIMARY CARE PHYSICIAN:

Name: ______________________

Office Phone: (______) ______ - ______ Office Fax: (______) ______ - ______

Street Address: ______________________ Suite #: ______

City: ______________________ State: ______ Zip: ______

We will send records automatically to the physicians listed aboove.
Would you like us to send records to any other doctor participating in your care? ☐ YES ☐ NO

OTHER PHYSICIAN:

Name: ______________________

Office Phone: (______) ______ - ______ Office Fax: (______) ______ - ______

Street Address: ______________________ Suite #: ______

City: ______________________ State: ______ Zip: ______

PATIENT REGISTRATION FORM

RELATIVE INFORMATION (Spouse/Significant Other):

Name: ______________________ DOB: ______ / ______ / ______ Male / Female

Phone: (________) ________ - ______________ Cell: (________) ________ - ______________

Work: (________) ________ - ______________ Email: ______________________

Address: ____

ALTERNATIVE/EMERGENCY CONTACT INFORMATION (Other than your Spouse/Significant Other):

Name: ______________________ Relationship: ______________________

Phone: (________) ________ - ______________ Cell: (________) ________ - ______________

Work: (________) ________ - ______________ Email: ______________________

Address: ____

Are you a patient in a skilled nursing home? ☐ YES ☐ NO If YES, where: ______________________

Employed: ☐ YES ☐ NO

Employer Name: ______________________ Occupation: ______________________

Ethnicity: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White
☐ Native Hawaiian or other Pacific Islander ☐ Decline to Answer
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Spoken Language: ______________________ Preferred Language: ______________________

RESPONSIBLE PARTY INFORMATION

Responsible Party Name: ______________________ Relationship to Patient: ______________________
Person responsible for payment if other than patient

Address: ____
Street City State Zip

Phone: (________) ________ - ______________

PRIMARY INSURANCE INFORMATION

Name of Insurance: ______________________ Subscriber: ______________________

DOB: ______ / ______ / ______ Member ID#: ______________________ Group #: ______________

Effective Date: ______ / ______ / ______

SECONDARY INSURANCE INFORMATION

Name of Insurance: ______________________ Subscriber: ______________________

DOB: ______ / ______ / ______ Member ID#: ______________________ Group #: ______________

Effective Date: ______ / ______ / ______

PATIENT REGISTRATION FORM

HOW DID YOU CHOOSE RIO BRAVO CANCER CENTER?

☐ Friend ☐ TV Commercial ☐ Newspaper Ad ☐ Doctor Referral

☐ Other: ____

Release of Medical Records, Medical Information and Assignment of Insurance Benefits

I, the undersigned patient and/or responsible party, hereby authorize this office and its agent and employees, to release and disclose all or any part of the above named patient's medical records to any entity which is, or may be liable for all or part of the provider's charges. I authorize the release of records necessary to assist in the reimbursement of benefits to which the patient be entitled on a continuing basis.

I request and authorize that payment/insurance benefits be made directly to Rio Bravo Cancer Center for any services furnished to the above named patient by Rio Bravo Cancer Center. The signature below shall suffice for all insurance forms on a continuing basis.

I agree to pay Rio Bravo Cancer Center for all charges for services not covered by insurance payor. I acknowledge that Rio Bravo Cancer Center does not bill third party insurance on behalf of the above named patient.

____ ____________________

Signature of Patient or Representative Date

MEDICAL HISTORY

Please complete prior to your appointment so we may have up-to-date information.

Name: ______________________________

DIAGNOSIS INFORMATION:

What type of medical problem were you referred for? ______________________________

Have you ever received Radiation Therapy (X-Ray therapy, UV treatments) in the past? ______________________________

Have you ever received chemotherapy in the past? ______________________________

HISTORY OF MEDICAL PROBLEMS:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

HISTORY OF SURGERIES:

Procedure: ______________________________ Date: ______________

Procedure: ______________________________ Date: ______________

Procedure: ______________________________ Date: ______________

Procedure: ______________________________ Date: ______________

MEDICATION HISTORY:

	NAME OF MEDICATION	STRENGTH (i.e. mg)	TAKEN HOW OFTEN (i.e. once a day)
1.			
2.			
3.			
4.			

Pharmacy Name: ______________________________

Phone: (________) ________ - ______________ City: ______________________________

DRUG ALLERGIES: ☐ YES ☐ NO

	NAME OF DRUG	REACTION
1.		
2.		
3.		

RIO BRAVO CANCER CENTER

MEDICAL HISTORY

FAMILY HISTORY OF CANCER:

RELATIONSHIP	TYPE OF CANCER	IS THIS PERSON ALIVE?
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO

GENERAL HEALTH:

Whom do you live with? ______ ☐ I live alone

Do you have children? ☐ YES ☐ NO # of Male Children ______ # of Female Children ______

What type of work do you do? ______

Do you need transportation? ☐ YES ☐ NO Do you climb stairs at home? ☐ YES ☐ NO If YES, how many stairs? ______

Do you smoke? ☐ YES ☐ NO How many per day? ______ How many years? ______

If you quit smoking, when? ______ How many did you smoke per day? ______

How many years? ______

Do you drink alcohol? ☐ YES ☐ NO How much per day? ______ How many years? ______

If you quit drinking, when did you quit? ______

Do you use drugs? (answers are confidential) ______

ARE YOU EXPERIENCING:	Y/N		COMMENTS
GENERAL:			
Fevers or Night Sweats	YES	NO	
Unusual Weight Change	YES	NO	
Change in Energy Level	YES	NO	
SKIN:			
Infections	YES	NO	Where?
Rash	YES	NO	Where?
Change in Skin Color	YES	NO	Where?
HEAD:			
Headache	YES	NO	How many days?
Head Injury	YES	NO	When?
EYES:			
Eye Problems	YES	NO	

Rio Bravo Cancer Center

MEDICAL HISTORY

EAR/NOSE/THROAT:			
Bleeding	YES	NO	
Hearing Problems	YES	NO	
Dizziness	YES	NO	
Loss of Consciousness	YES	NO	
Throat Problems	YES	NO	
LUNGS:			
Cough	YES	NO	
Bloody Sputum	YES	NO	
Breathing Problems	YES	NO	
NECK:			
Thyroid Problems	YES	NO	
Neck Masses	YES	NO	
HEART:			
Angina/Chest Pain	YES	NO	
Trouble Breathing when Moving/ Laying Down	YES	NO	
Heart Problems/Attacks	YES	NO	
Swelling of Limbs	YES	NO	
BREAST/CHEST:			
Breast/Chest Size Changes	YES	NO	
Fluid from Nipples	YES	NO	
INTESTINES:			
Last Colonoscopy			Date:
Trouble Swallowing	YES	NO	
Intestinal Ulcers	YES	NO	
Liver Problems	YES	NO	
Abdominal Pain	YES	NO	
Bleeding in Stool	YES	NO	
Constipation	YES	NO	
Diarrhea	YES	NO	
Change in Stool Color	YES	NO	
GENITOURINARY:			
Problems Urinating	YES	NO	
Blood in Urine	YES	NO	

Frequent Urination	YES	NO	
Male: Problem with Erections	YES	NO	
MUSCULOSKELETAL:			
Muscle or Bone Pain?	YES	NO	
Muscle or Bone Injury?	YES	NO	
NEUROLOGIC:			
Seizures	YES	NO	
Paralysis or Weakness	YES	NO	Where?
Head Injury	YES	NO	
Fainting	YES	NO	
Strokes	YES	NO	When?
HEMATOLOGIC:			
Wound Healing Problems	YES	NO	Where?
Bleeding/Bruising Problems	YES	NO	Where?
Recurring Infection Problems	YES	NO	
PSYCHIATRIC:			
Psychiatric Issues?	YES	NO	
HORMONES:			
Hormonal Problems	YES	NO	

FEMALES ONLY - ANSWER THE REMAINING QUESTIONS:

ARE YOU EXPERIENCING:	Y/N		COMMENTS
Change in Breasts	YES	NO	
Pain in Breasts	YES	NO	
Change in Breast Skin	YES	NO	
Blood from Nipples	YES	NO	
Vaginal Bleeding	YES	NO	
Vaginal Discharge	YES	NO	
HAVE YOU HAD ANY:			
Mammograms	YES	NO	Date of Last Mammogram:
Pap Smears	YES	NO	Date of Last Pap Test:
Periods	YES	NO	Date of Last Period
Pregnancies	YES	NO	How Many: Date of 1st:
Miscarriages	YES	NO	How Many:
Abortions	YES	NO	How Many:

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Rio Bravo Cancer Center
4500 Morning Drive Suite 105
Bakersfield, CA 93306
Tel: (661) 491-5060
Fax: (844) 742-2324

This form is used so that Rio Bravo Cancer Center can request records from your other physicians that are participating in your care.

RELEASE INFORMATION FROM:

Please specify organization names/addresses:

____

____

____

____

____

RELEASE INFORMATION TO:

Organization Name:
Rio Bravo Cancer Center

Address:
4500 Morning Drive Suite 105
Bakersfield, CA 93306

Phone: **(661) 491-5060**

Fax: **(844) 742-2324**

By signing this Authorization, I authorize my Health Care Provider to disclose my protected health information.

IDENTIFYING INFORMATION AT TIME OF SERVICE:

Patient's Full Name: ______________________________

Maiden or Other Name(s) Used: ______________________________

DOB: ______ / ______ / ______ Medical Record #: ______________________________

Address: ______________________________
Street City State Zip

Covering the period(s) of healthcare:

From (Date): ______ / ______ / ______ To (Date): ______ / ______ / ______

1. **Information authorized for disclosure,** *if included in my records:*

☐ Radiology & Diagnostic Imaging & Reports ☐ Pathology Reports ☐ Laboratory Tests

☐ Other: ______________________________ ☐ All

Include the following if indicated:

☐ Complete Health Record ☐ Visit/Discharge Summary ☐ Clinical Documentation of Consultation

☐ Immunization Records ☐ Progress Reports ☐ Photos, Videos, Digital or Other Imaging

2. **If applicable,** I also give my permission for the following **"Sensitive Protected Health Information"** to be disclosed **(please initial below)**

☐ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)

☐ Behavioral Health Services/Psychiatric Care ☐ Treatment for Alcohol and/or Drug Abuse

☐ Sexually Transmitted Diseases (STD) ☐ Genetic Counseling/Testing

I understand *that the information disclosed pursuant to this Authorization* ***except*** *information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable.*

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Rio Bravo Cancer Center
4500 Morning Drive Suite 105
Bakersfield, CA 93306
Tel: (661) 491-5060
Fax: (844) 742-2324

3. **The purpose for which disclosure is authorized** *(check where applicable)*

☐ Medical Care ☐ Insurance ☐ Benefit Eligibility ☐ Immunization

☐ Other: ____

I understand that I have a right to revoke this authorization at any time.

I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care.

I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event, or condition

(Date): ________ / ________ / ________ *(OK TO LEAVE BLANK)* ☐ Unlimited

If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as unlimited, (Initial here ________) it is the responsibility of the individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.

4. **I understand** that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

5. **This facility, its employees, officers, and physicians** are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

____ ______________________________

Signed: Patient- (or Parent, Legal Guardian or Legal Representative) (Relationship if not patient)

ID Provided: ____ Date: ________ / ________ / ________

____

Witness or Notary (This Authorization must be notarized if information is being released to an attorney and or court.

NOTICE OF PRIVACY PRACTICES & PATIENT CONSENT

FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Rio Bravo Cancer Center
4500 Morning Drive Suite 105
Bakersfield, CA 93306
Tel: (661) 491-5060
Fax: (844) 742-2324

Patient's Full Name: ______________________________ Date: ______ / ______ / ______

Account #: ______________________________

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Rio Bravo Cancer Center may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Rio Bravo Cancer Center has a detailed document called the 'Notice of Privacy Practices'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Rio Bravo Cancer Center will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Rio Bravo Cancer Center to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Rio Bravo Cancer Center has taken action relying on this consent.

____
Signature

If not signed by the patient, please indicate relationship:

- ☐ Parent or Guardian of Minor Patient
- ☐ Guardian or Conservator of an Incompetent Patient

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at any time by contacting: Rio Bravo Cancer Center Attn: HIPAA Privacy Coordinator at the above address

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For Office Use Only:

Complete the following only if the Patient refuses to sign the Acknowledgment:

Efforts to obtain: ______________________________

Reasons for refusal: ______________________________

RIO BRAVO
CANCER CENTER

NOTICE OF PRIVACY PRACTICES

Effective Date: July 15, 2016

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: Kim Taylor
Phone Number: 661-491-5060

Section A: Who Will Follow This Notice?

This Notice describes Rio Bravo Cancer Center (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.kernradiology.com

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.

Original Effective Date: July 15, 2016