Patient Information

Patient Name____ Date of Birth_____/_____/________

Patient Social Security #________-_______-_________Marital Status_____Ethnicity___________Sex M F

Mailing Address____

City____________________________________State__________Zip______________

Email____

Cell Phone _________-_________-____________Alternate Phone_________-_________-____________

Employment Status (circle one) Full time Part time Unemployed Student Retired

Employer____

Emergency Contact

Name (last, first):____Relationship:______________________

Emergency Contact Phone: ________-________-___________

Insurance Information

Primary Insurance Carrier_________________________ Policy #____________________ Group ____________

Name of Subscriber ____Subscriber D.O.B._____/_____/________

Patient Relationship to Subscriber: Self____ Spouse____ Child____

****IF PATIENT IS UNDER 18 YEARS OF AGE PLEASE FILL OUT THE FOLLOWING INFORMATION****

Financially Responsible Party____

Relationship to Patient______________ Financially Responsible D.O.B. ____/____/_____

Financially Responsible SSN _____-_____-_______ Primary Contact Phone Number _____-_____-_______

Billing Address____

City _____________________________ State_________ Zip Code ______________

Central Baldwin Physicians
INFIRMARY HEALTH

PRE-HISTORY INFORMATION

Name: ______________________________ Date: __________________

Date of Birth: _____________ Age: ___________

Referred By: _______________________

Communication	
Are there any vision problems that affect your communication?	☐Yes ☐ No
Are there any hearing problems that affect your communication?	☐Yes ☐ No
Are there any limitations to understanding or following instructions (either written or verbal)?	☐Yes ☐ No
What is your preferred language?	

1. State in your own words the major medical reason(s) for coming in today:
   ____
   ____
2. Please list any additional concerns you have:____
   ____
   ____
   ____

ALLERGIES: *List all allergies and the type of reaction*	
Drug	**Reaction**

CURRENT MEDICATIONS: *List all medications including over the counter and supplements. Please bring your medicine bottles to your appointment. Please attach a second sheet if more space is needed.*

Medicine	Dosage Taken	How often	Provider	Need Refill?
Example: Lasix	*20mg*	*Twice a day*	*Dr. Smith*	*Yes*

CURRENT MEDICAL HISTORY: ***Please check all that apply***

□ Addiction □ Anemia □ Anxiety □ Arthritis/Gout □ Asthma □ Bipolar □ Colon Disease □ Congestive Heart Failure □ COPD/Emphysema □ Dementia	□ Depression □ Diabetes □ Enlarged Prostate □ Heart Attack □ Hepatitis type: _____ □ High Cholesterol □ High Blood Pressure □ Irritable Bowel □ Kidney Disease □ Kidney Stones □ Liver Disease □ Migraines	□ Osteoporosis □ Reflux/GERD □ Blood Clot □ Parkinson's Disease □ Pulmonary Embolism □ Schizophrenia □ Skin Disease □ Stroke □ Thyroid Disease Other:	Have you fallen in the last 2 months? □ No □ Yes Have you fallen in the last 6 months? □ No □ Yes

Hospitalizations/Surgeries: ***Please list all surgeries and approximate dates***

WOMENS HEALTH HISTORY: ***Check and/or answer each question.***

Age at first period: _________ yrs old
Has menopause started/occurred? □ No □ Yes **at age** ______ yrs
Number of days between periods: ______ **Number of days period lasts:** _______
Flow is: □ light □ moderate □ heavy
Number of total Pregnancies: ______ **Full term births:** ______ **Premature births:** _____
Miscarriages: _____ **Abortions**: _____
Number of: Vaginal births: ______ C-Section: _______
Pregnancy Complications: □ No □ Yes □ High BP □ Diabetes □ Pre-eclampsia □ other: _____________
Birth Control: □ None □ Pill □ Depo-Provera □ IUD □ Partner-Vasectomy □ Tubal Ligation □ Other: _______________

ADVANCE DIRECTIVES: ***Please check all that apply***

Do you have a Power of Attorney for Healthcare? Yes No
Designated Person:
Do you have a living will/DNR? Yes No
Are you an organ donor? Yes No

PATIENT CARE TEAM: ***Please answer each question***

Specialty	**Name/Group**	**Last visit date**	**Specialty**	**Name/Group**	**Last visit date**
Cardiologist			**Pulmonologist**		
OB/Gyn			**Dermatologist**		
Neurologist			**Gastro**		
Eye Doctor			**Psychiatrist**		
Surgeon			**Nephrologist**		

SOCIAL HISTORY: Please check and/or answer each question.	
Tobacco Use	□ Current □ Former □ Packs/day: _____ □ Start Year □ Quit: _______ □ Types ________________________________
Alcohol Use	□ Never drink □ Occasional/social drinker □ ________# of drinks/day of alcohol
Illicit Drug Use	□ None □ Other use:
Sexually Active	□ No □ Yes with: □ Male □ Female □ Both
Marital Status	□ Married □ Divorced □ Widowed □ Single # of Children: __________ # of Grandchildren: __________ Spouse's Name: _________________________
Education Level	☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate /Prof.
Financial Resource Strain	**How hard is it for you to pay for the very basics like food, housing, medical care, and heating?** □ Not hard at all □ Not very hard □Somewhat hard □Hard □Very hard □ Patient refused
Caffeine	□ No □ Yes How Much: ___________________
Exercise	On average, how many days per week do you engage in moderate to strenuous exercise (like walking fast, running, jogging, dancing, swimming, biking, or other activities that cause a light or heavy sweat)? ____________ On average, how many minutes do you engage in exercise at this level? ___ □ Patient refused

Intimate Partner Violence	
Within the last year, have you been afraid of your partner or ex-partner?	**Yes / No**
Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	**Yes / No**
Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?	**Yes / No**
Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?	**Yes / No**

IMMUNIZATIONS: ***Please check all that apply*** ****Please bring a copy of your immunization records to your appointment****

Vaccine	Administered Date	Vaccine	Administered Date
Tetanus		**Meningitis**	
Shingles		**Hep B**	
Pneumonia		**Hep A**	
HPV		**Flu Shot**	
Covid 19			

PREVENTIVE CARE: ***Please list the dates of your last test, facility test was performed and the results if known***

Test	Date	Facility	Results
Mammogram			Normal / Abnormal
Pap Smear			Normal / Abnormal
Colonoscopy			Normal / Abnormal
Hemoccult/Cologuard			Normal / Abnormal
Dexa/Bone Density			Normal / Abnormal
PSA			Normal / Abnormal

Family Medical History: *Please check all that apply and address all family members that apply*			
Mother Alive Deceased Age at Death:_____ Cause of Death:_________	Alcoholism Anemia Asthma Cancer (type)_______ Stroke Dementia Diabetes	Heart Attack Heart Disease High Cholesterol High Blood Pressure Mental Illness	Kidney Disease Osteoporosis Seizures/Epilepsy Thyroid Disease Others: ______ _________________ _________________
Father Alive Deceased Age at Death:_____ Cause of Death:_________	Alcoholism Anemia Asthma Cancer (type)_______ Stroke Dementia Diabetes	Heart Attack Heart Disease High Cholesterol High Blood Pressure Mental Illness	Kidney Disease Osteoporosis Seizures/Epilepsy Thyroid Disease Others: ______ _________________ _________________
Maternal Grandmother Alive Deceased Age at Death:_____ Cause of Death:_________	Alcoholism Anemia Asthma Cancer (type)_______ Stroke Dementia Diabetes	Heart Attack Heart Disease High Cholesterol High Blood Pressure Mental Illness	Kidney Disease Osteoporosis Seizures/Epilepsy Thyroid Disease Others: ______ _________________ _________________
Maternal Grandfather Alive Deceased Age at Death:_____ Cause of Death:_________	Alcoholism Anemia Asthma Cancer (type)_______ Stroke Dementia Diabetes	Heart Attack Heart Disease High Cholesterol High Blood Pressure Mental Illness	Kidney Disease Osteoporosis Seizures/Epilepsy Thyroid Disease Others: ______ _________________ _________________
Paternal Grandmother Alive Deceased Age at Death:_____ Cause of Death:_________	Alcoholism Anemia Asthma Cancer (type)_______ Stroke Dementia Diabetes	Heart Attack Heart Disease High Cholesterol High Blood Pressure Mental Illness	Kidney Disease Osteoporosis Seizures/Epilepsy Thyroid Disease Others: ______ _________________ _________________

Paternal Grandfather Alive Deceased Age at Death:______ Cause of Death:__________	Alcoholism Anemia Asthma Cancer (type)________ Stroke Dementia Diabetes	Heart Attack Heart Disease High Cholesterol High Blood Pressure Mental Illness	Kidney Disease Osteoporosis Seizures/Epilepsy Thyroid Disease Others: _______ ____________________ ____________________
Sibling Alive Deceased Age at Death:______ Cause of Death:__________	Alcoholism Anemia Asthma Cancer (type)________ Stroke Dementia Diabetes	Heart Attack Heart Disease High Cholesterol High Blood Pressure Mental Illness	Kidney Disease Osteoporosis Seizures/Epilepsy Thyroid Disease Others: _______ ____________________ ____________________
Sibling Alive Deceased Age at Death:______ Cause of Death:__________	Alcoholism Anemia Asthma Cancer (type)________ Stroke Dementia Diabetes	Heart Attack Heart Disease High Cholesterol High Blood Pressure Mental Illness	Kidney Disease Osteoporosis Seizures/Epilepsy Thyroid Disease Others: _______ ____________________ ____________________
Child Alive Deceased Age at Death:______ Cause of Death:__________	Alcoholism Anemia Asthma Cancer (type)________ Stroke Dementia Diabetes	Heart Attack Heart Disease High Cholesterol High Blood Pressure Mental Illness	Kidney Disease Osteoporosis Seizures/Epilepsy Thyroid Disease Others: _______ ____________________ ____________________
Child Alive Deceased Age at Death:______ Cause of Death:__________	Alcoholism Anemia Asthma Cancer (type)________ Stroke Dementia Diabetes	Heart Attack Heart Disease High Cholesterol High Blood Pressure Mental Illness	Kidney Disease Osteoporosis Seizures/Epilepsy Thyroid Disease Others: _______ ____________________ ____________________

PATIENT HEALTH QUESTIONAIRE (PHQ-9)

NAME: ______________________ DATE: ______________

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people may have noticed. Or the opposite - being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns			
Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card	TOTAL			

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	______
Somewhat difficult	______
Very difficult	______
Extremely difficult	

AUTHORIZATION FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME____

DATE OF BIRTH____________________ SOCIAL SECURITY #_______________________

I HEREBY AUTHORIZE

NAME OF ORGANIZATION____

STREET ADDRESS____

CITY, STATE, ZIP ____

PHONE_________________________________ FAX_____________________________

TO RELEASE THE FOLLOWING MEDICAL RECORDS FOR THE LAST _______YEARS

ALL____ X-RAYS____ EKG____ DIAGNOSTICS TESTS____ OTHER____

TO

IMC CENTRAL BALDWIN PHYSICIANS

PO BOX 129

ROBERTSDALE, AL 36567

251-947-2000 251-947-5399

By signing below, I am giving authorization to release to IMC–Central Baldwin Physicians, P.C. my protected health information including medical, psychiatric, alcohol, HIV, drug abuse, and/or financial information contained in my records.
This authorization will expire 1 year from the date of signing below unless specified otherwise. (Date of expiration if different: ___/___/____). I understand that I can revoke this authorization at any time except to the extent that any action has been taken in reliance on this authorization. I can revoke this authorization by submitting a written request to the IMC-Central Baldwin Physicians, P.C. Release of Information Department.
I understand that I am not required to sign this form in order to receive treatment from IMC-Central Baldwin Physicians, P.C.

____ _______________

Signature of Patient Date

____ _______________

Signature of Authorized Representative Date

Records may be faxed to our office at 251-947-5399

IMC CENTRAL BALDWIN
PHYSICIANS, P.C.
251.947.2000

Central Baldwin Physicians
INFIRMARY HEALTH

18317 US Highway 90
Robertsdale, AL 36567

PATIENT RESPONSIBILITY AND CONSENT FORM

Patient Full Name:____ **Date of Birth:**______________

Primary Insurance:____ **Secondary:**_______________

Assignment of Benefits

I request that payment of authorized Medicare and/or Medicaid benefits to be or on my behalf for services in or by the IMC Medical Clinic shall be made to the Clinic, and I specifically assign such benefits to the Clinic. If applicable, I hereby assign and authorize payment directly to the Clinic of all medical benefits under any insurance or third-party plan payable to me or which I am otherwise entitled.

Release of Information

I authorize any holder of medical information about me to release to Medicare, Medicaid, and/or other health insurance or third-party plan and their respective agents any information needed to determine these benefits or benefits for related services.

Financial Responsibility

I understand that I am responsible for all charges not paid by my insurance plan except those amounts that the Clinic is contractually obligated to write off. I understand that I am responsible for all non-covered services and by signing this form I acknowledge I have been made aware of my obligation prior to receiving such services. I understand that if I do not pay for the charges for which I am responsible for the Clinic may turn my account over to a collection agency. I understand that should my account be turned over to a collection agency I may be charged a collection fee, not to exceed 25% of my account, and I accept these fees charged by the Clinic as a legal and lawful debt and agree to pay such fee if charged.

Telephone and Alternative Communication Consent

I understand the Clinic or its agents may use prerecorded/artificial voice messages and/or text messages to remind me about appointments or notify me of other information and I expressly consent to the Clinic or its agents' use of any number associated with my account including any wireless numbers, including contact by means of prerecorded/artificial voice or text messages and/or automatic dialing devices, for the purpose of collecting on my account. I also authorize the Clinic to communicate with me using any email address I provide to the Clinic.

No Show for an Appointment

I understand when I make an appointment, time is reserved for me that can not be scheduled for someone else. Recognizing this I will, exempting unforeseen emergencies, notify the Clinic no later than 24 hours or 1 business day before my appointment should I not be able to keep my appointment. If I do not, I understand the Clinic has the right to charge me a no-show fee and I acknowledge such a charge would be a legal and lawful debt and agree to pay such fee charged.

Minors

I understand that I am responsible for this child's account and any agreement otherwise by means of a court decree or other valid agreement is between me and another party.

____ ______________________

Patient or responsible party signature Date

Prescription Agreement

Patient Name:____ DOB_______________

PHARMACY My preferred pharmacy is:

NAME ____

LOCATION ____

PRESCRIPTION INSURANCE INFORMATION: ***IF DIFFERENT FROM HEALTH INSURANCE***

Prescription Insurance Information ***IF DIFFERENT FROM HEALTH INSURANCE CARD***		
BIN #:	PCN #:	ID #:
Group#		Phone:

When Requesting Refills:

1. Refills will only be made during regular office hours—Monday through Thursday, 8:00AM-4:00PM and Friday 8:00AM-11:00AM
2. Refill requests cannot be accepted on nights, holidays, or weekends.
3. Please allow **three (3) business days (M-F)** for your refill request to be processed.
4. If your insurance company requires us to submit a prior authorization request for the medication we are prescribing you, it can take up to 2 weeks for the insurance company to give us a determination.
5. Formularies change often and the only way to know for sure if a medication is covered by your insurance or will require prior authorization is for you to call your insurance company.
6. If you have not yet made your annual visit, or if you missed your annual appointment you may run out of refills. You will need to make an appointment and see your doctor in order to get a new prescription.
7. If you are requesting a medication that is not a maintenance medication (those are medications that you take daily all the time), you will need to make an appointment to see your doctor first. The doctors will not send in prescriptions for things like antibiotics, muscle relaxers or any type of pain medication without seeing the patient in the office first. This policy is in place for patient safety.
8. **There are no refills on narcotic medications without a visit with your provider.**
9. By signing below, you are stating that you understand and agree to this process for requesting medication refills

____ ___________________

Patient's signature Date

Central Baldwin Physicians
INFIRMARY HEALTH

Cancellation Policy

Failing to show for or an appointment or cancelling at the last minute hinders our ability to care for you as well as our other patients because we lose an appointment time that could have been used to help another patient in need. Our employees also waste valuable time preparing for your visit. For these reasons our office charges a no-show fee for the following situations:

If you fail to arrive for your scheduled appointment without calling to cancel/reschedule it will be considered a no show

OR

If you cancel or reschedule your appointment less than 24 hours before your appointment day and time it will be considered a no show

An invoice for the no show fee will be mailed to you

No show fees are charged as follows:

1st instance $25

2nd instance $50

3rd instance No opportunity to schedule again

Patient Name (Print)____

Patient Signature ____

Date ____

Clinic Policies

- Our office is open Monday through Thursday 7:15am to 11am and 12:30pm to 4:00pm, and 7:15am to 11am on Fridays.
- Our providers request that you bring all of your medications with you to each visit
- Patients more than **15** minutes late for a scheduled appointment will be asked to reschedule that appointment
- A $25 fee will be assessed for any appointments cancelled/re-scheduled less than 24 hours (one business day) in advance, as well as for missing a scheduled appointment (no show)
- We are contractually obligated by your insurance company to collect your office copayment at the time of service. If you are not able to make your copayment when you arrive, we will be happy to reschedule your appointment
- If you have any tests performed at our office you will be notified of the results by mail within 1 week of the date the tests were done. We will make every effort to contact you immediately for abnormalities that need emergent attention. Please make sure with the front desk that we have your correct address and phone number
- All lab work drawn by our office is sent to Quest for processing. Please check with your insurance to insure they will cover any billed services from Quest
- Please make an appointment with your provider if you need them to fill out/sign forms for you (insurance, FMLA, Social Security, Disability) Our providers will only fill these out during an appointment with the patient
- All records request will be fulfilled within seven (7) business days
- Photo ID and physical insurance card is required for all new patients
- Photo ID is also required for picking up any written prescriptions
- Please allow 3 business days for all refill requests to be processed and then check with your pharmacy for availability

Thank you for letting us take care of you!

Patient Signature:____

Date:_________________________

Effective Date: 9/23/13

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE: This notice describes the privacy practices of our network of providers who may share medical information about you as a patient, and that of 1) any health care professional authorized to enter information into your medical chart, 2) any healthcare providers and employees that make up our Organized Health Care Arrangement (OHCA) as listed at www.infirmaryhealth.org/patients/forms (see OHCA), 3) all members of a volunteer group we allow to help you while a patient in an identified hospital.

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 each of our health care facilities. 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 by our health care providers, whether made by our personnel or your personal doctor. If your doctor is not a member of one of our medical clinics, he/she may have different policies or notices regarding the use and disclosure of your medical information created in the doctor's office or clinic. 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
- Provide you this notice of our legal duties and privacy practices with respect to medical information about you
- Follow the terms of the notice that is currently in effect

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that we may 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:

FOR TREATMENT: We may use your medical information to provide you with medical treatment or services. WE may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. 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. Companies that are a part of our organization may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work, x-rays, home care, medical supplies or equipment for home, and hospice care. We also may disclose medical information about you to people outside the organization who may be involved in your treatment, such as family members, clergy or others we use to provide services that are part of your care.

FOR PAYMENT: We may use and disclose medical information about you so that the treatment and services you receive from our providers may be billed to and payment may be collected from you, and insurance company, or a third party. For example, we may need to tell your health plan certain information about an office visit, surgery, or nursing care you received at one of our providers so your health plan will pay us or reimburse you for the eservice. We may also tell your health plan about home medical equipment or a treatment you are going to receive to obtain prior approval or to determine whether you plan will cover the treatment or equipment.

FOR HEALTH CARE OPERATIONS: Any medical information about you that is maintained by our health care providers may be used and disclosed for health care operations. These uses and disclosures are necessary to run the business of each entity and make sure that 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 medical patients to decide what additional. Service we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other health care personnel for review and learning purposes. We may remove information that identifies you from this set to medical information so others may use it to study health care and health care delivered without learning who the specific patients are.

APPOINTMENT REMINDERS: We may contact you as a reminder that you have an appointment for treatment at one of our providers.

TREATMENT ALTERNATIVES: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

HEALTH-RELATED BENEFITS AND SERVICES: We may tell you about health-related benefits or services that may be of interest to you such as disease-specific support groups or childbirth education services and classes.

HOSPITAL DIRECTORY: We may include certain limited information about you in our hospital directory while you are a patient at a hospital. This information may include your name, location in the hospital, 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, rabbi, or minister even if they don't ask for you by name. This is so your family friends and clergy can visit you in the hospital and generally k now how you are doing. You may make a request to be excluded from the hospital directory by contacting the Admission Department at any time during your stay.

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 or who may help pay for your care. We may also tell your family or friends your condition and that you are in one of our hospitals. In addition, we may disclose medical information about you to an organization 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 strict approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' needs for privacy of their medical information. Before we use or disclose medical information for research, the project will be approved through this research-approval process. We may, however, disclose medical information about you to our clinical research staff, as long as the medical information they review is limited to use by our facility, in preparation for a research project. This helps them look for patients with specific medical needs who may benefit from new treatments or procedure. We may release information that reveals who you are to researchers or others involved in your care at the facility. If a research project is identified that my benefit you, your physician will be contacted to advise him/her of the e availability of the study. This information will be discussed only with your physician and the researcher.

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 TRHEAT 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.

SPECIAL SITUATIONS

ORGAN AND TISSUE DONATION: If you are an organ or tissue donor, we may release medical information to organization 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 according to applicable law.

PUBLIC HEALTH ISSUES: We may disclose medical information about you for public health activities. The reasons we may disclose information would be in order to: 1) prevent or control disease, injury or disability; 2)report births and deaths; 3) report child abuse or neglect; 4) report reactions to medications or problems with products; 5) notify people of recalls of products they may be using; 6) notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; 7) notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

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.

FUNDRAISING ACTIVITIES: Limited information may be provided to a related foundation or business associate in an effort to raise money for our hospitals. Funds raised will be used to expand and support our effort to provide health care and related services to the community. You have a right to opt out of receiving such notices with each communication.

LAWSUITS AND DISPUTES: If you are involved in a lawsuit or a dispute, we will disclose medical information about you, where required, in response to a court or administrative order. We will also, where required, disclose medical information about you in response to a subpoena, discover request, or other lawful process by someone else involved in the dispute, but only after efforts have been made through the judicial process to tell you about the request or to obtain an order protecting the information requested.

LAW ENFORCEMENT: We reserve the right to release medical information to a law enforcement official or other governmental representative: 1) for a non-binding administrative request; 2)to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5)about criminal conduct at a provider; 6)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

CORONOERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS: We may release medical information to coroners, medical examiners, or funeral directors consistent with applicable law 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: 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; 3)for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU: With regard to your medical information that we maintain, you have the right to: 1) Inspect and obtain a copy of your medical information from the provider that has your records as provided for in 45 CFR 164.524. Usually this includes medical and billing records, but does not include psychotherapy notes. We may charge a fee for the cost of copying, mailing, or other supplies associated with your request. Please contact the provider that treated you for assistance; 2) Request an amendment of your medical information as provided for in CFR 164.526. The request must be in writing and submitted to the Health Information Management Department at the Infirmary Health facility at which care was provided for the Privacy Officer to make arrangements; 3) Request restrictions on certain uses and disclosure of protected health information as provided for in 45 CFR 162.522(a): A) We will comply if the request relates to services paid for out-of-pocket and in full before the service is provided, the request is for nondisclosure to a health plan related solely to such services, and the request is submitted in writing prior to, or at the time of scheduling/registering for the service. Otherwise we are not required to agree to your request; B) For other requests for restrictions, if we do agree; we will comply with your request unless the information is needed to provide you with emergency treatment. For requests (other than described in section A), you must make your request in writing to HIPAA Privacy Office for consideration. If possible, the request will be accommodated; 3) Request confidential communications by alternative means or at alternative locations as provided for in 45 CFR 164.522(b). To request confidential communications, you must make your request in writing to the Privacy Office; 4) Receive notice of any breach of your unsecured personal health information; 5) receive a copy of this notice upon request. You may obtain a copy of this notice at our website www.infirmaryhealth.org/patients/forms (see Notice of Privacy Practices), at the Registration/Admission desk, or in the Medical Records Release of Information Office at any of our provide locations.

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 in each of our health care provider companies. The notice will contain the effective date in the top right hand corner the 1st page. In addition, each time your register at or are admitted to a facility for treatment or health care services as an inpatient our outpatient, a copy of the current notice in effect will be available upon request.

TO REPORT A PROBLEM: If you believe your privacy rights have been violated, you may file a complaint with your health care provider as identified at www.infirmaryhealth.org/patients/forms or with the Secretary of the Department of Health and Human Services. To file a complaint with your provider, contact the Privacy Officer or call the HIPAA Hotline at 251-435-3900. There will be no retaliation for filing a complaint.

RELATIONSHIPS: The relationship represented by this Joint Notice of Privacy Practices is for the sole purpose of sharing medical information about you as appropriate medical care is provided. No Joint Venture, financial or similar liability related relationship is implied, expressed or intended by this notice. This notice covers our hospitals, outpatient diagnostic services, medical clinics, and other medical-related services available through other providers as Infirmary Health (IHS) locations in Mobile and Baldwin County. You may review the list of entities covered by this Joint Notice of Privacy Practices on our website at www.infirmatyhealth.org/patients/forms (see OHCA).

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. Examples of uses or disclosures requiring your authorization include most disclosures of psychotherapy notes, uses and disclosures for marketing activities, and disclosures that constitute a sale of protected health information. 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 you.

Submit written requests to the following address:

Infirmary Health System, Inc.
Attention: Privacy Office
PO Box 2226 Mobile Alabama 36652

If you have questions about this notice, please call: 251-435-3900

Central Baldwin Physicians
INFIRMARY HEALTH

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

You acknowledge that you were offered a copy of our Notice of Privacy Practices. If you would like to receive a paper copy at any time in the future, you can call (251)947-2000.

Name:____

Signature:____ **Date:**______________________

Individual was unable to sign due to the following reason:

_____ Admitted directly to treatment area

_____ Left AMA or without being seen

_____ Not competent

_____ Refused to sign

Signature of facility representative:____

Date:_________________________

Please list anyone with whom we can discuss your medical issues

Name	Relationship	Phone Number
_____________________________	_____________________	___________________
_____________________________	______________________	___________________
_____________________________	______________________	___________________