MEDICAL HISTORY FORM

NAME_____BIRTHDATE_____

Have you ever been told you had one of the following? Please check Yes if you have now, or have had in the past.

	YES	NO		YES	NO
Anxiety	☐	☐	Aortic Aneurysm	☐	☐
Arthritis	☐	☐	Arrhythmias	☐	☐
Asthma	☐	☐	Atrial Flutter	☐	☐
Coronary Artery Disease	☐	☐	Bradycardia	☐	☐
Congestive Heart Failure	☐	☐	Brain Aneurysm	☐	☐
COPD	☐	☐	Cardiomyopathy	☐	☐
Cancer	☐	☐	Carotid Disease	☐	☐
Depression	☐	☐	Chronic Venous Insufficiency	☐	☐
Diabetes Type 1	☐	☐	Claudication	☐	☐
Diabetes Type 2	☐	☐	DVT	☐	☐
Heart Disease	☐	☐	Endocarditis	☐	☐
Hypertension	☐	☐	Myocardial Infarction	☐	☐
Hyperlipidemia	☐	☐	Palpitations	☐	☐
Kidney Disease/Stones	☐	☐	Peripheral Vascular Disease	☐	☐
Liver Disease/Hepatitis	☐	☐	Pseudoaneurysm	☐	☐
Lung Disease	☐	☐	Pulmonary Embolism	☐	☐
Overweight/Obesity	☐	☐	Renal Artery Stenosis	☐	☐
Pneumonia	☐	☐	Valvular Heart Disease	☐	☐
Stroke/TIA	☐	☐	Varicose Veins	☐	☐
Thyroid Disease	☐	☐	Other:		
Atrial Fibrillation	☐	☐			

PAST SURGICAL HISTORY

	SURGERY	REASON	YEAR	HOSPITAL
1.				
2.				
3.				
4.				
5.				

MEDICATIONS

	DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.			
2.			
3.			
4.			
5.			
6.			

ALLERGIES/SENSITIVITIES TO MEDICATIONS/REACTIONS

	Allergy/Sensitivity to Medication	Reaction
1.		
2.		
3.		

FAMILY HEALTH HISTORY

	RELATION	HEALTH PROBLEM	AGE AT DEATH	CAUSE OF DEATH
1.				
2.				
3.				
4.				
5.				

SOCIAL HISTORY

Occupation	
Marital Status	☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐ Domestic Partner
Number of Children	
Diet	☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Carbohydrate ☐ Cardiac ☐ Diabetic
Exercise Level	☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Tobacco	Do you currently use tobacco? ☐ Yes ☐ No Did you use tobacco in your past? ☐ Yes ☐ No How Long:_____ Year Quit:_____ ☐ Cigarettes - _____/day ☐ Chew - _____/day ☐ Cigars - _____/day
Alcohol intake	Do you drink alcohol? ☐ Yes ☐ No If so, how often? ☐ Occasionally ☐ <3 times/week ☐ >3 times/week How Many drinks per week? _____
Caffeine intake	☐ None ☐ Occasional ☐ Moderate ☐ Heavy # of cups/cans per day?_____
Drug use/abuse?	☐ Never ☐ Current ☐ Former Type:_____ Route: _____
Advance Directive	☐Yes ☐No

REVIEW OF SYSTEMS

Please check (X) any current problems you have on the list below:

		CARDIAC
☐ NO	☐ YES	Chest Pain/Pressure
☐ NO	☐ YES	Excessive perspiration
☐ NO	☐ YES	Palpitation/Fluttering
☐ NO	☐ YES	Loss of consciousness
☐ NO	☐ YES	Trouble breathing at night
☐ NO	☐ YES	Syncope
		VASCULAR
☐ NO	☐ YES	Leg pain/Claudication
☐ NO	☐ YES	Swelling
☐ NO	☐ YES	Varicose Veins
☐ NO	☐ YES	Ulcer/Leg ulcer/Non-healing sore
☐ NO	☐ YES	Cool extremity
		CONSTITUTIONAL
☐ NO	☐ YES	Weight gain
☐ NO	☐ YES	Weight loss
☐ NO	☐ YES	Fever
☐ NO	☐ YES	Fatigue
☐ NO	☐ YES	Weakness
		HEENT
☐ NO	☐ YES	Vision Changes
☐ NO	☐ YES	Hearing Loss
☐ NO	☐ YES	Redness
☐ NO	☐ YES	Burning
☐ NO	☐ YES	Nasal congestion
		RESPIRATORY
☐ NO	☐ YES	Snoring
☐ NO	☐ YES	Coughing up blood
☐ NO	☐ YES	Shortness of breath
☐ NO	☐ YES	Cough
☐ NO	☐ YES	COPD
☐ NO	☐ YES	Wheezing
		GASTROINTESTINAL
☐ NO	☐ YES	Nausea
☐ NO	☐ YES	Reflux
☐ NO	☐ YES	Bleeding
☐ NO	☐ YES	Distention
☐ NO	☐ YES	Constipation
		GENITOURINARY
☐ NO	☐ YES	Blood in urine
☐ NO	☐ YES	Getting up at night to urinate
☐ NO	☐ YES	Difficulty urinating
☐ NO	☐ YES	Frequent urination
☐ NO	☐ YES	Incontinence

		NEUROLOGY
☐ NO	☐ YES	Dizziness
☐ NO	☐ YES	Memory loss
☐ NO	☐ YES	Seizures
☐ NO	☐ YES	Headache
☐ NO	☐ YES	Weakness
☐ NO	☐ YES	Gait disturbance
☐ NO	☐ YES	Numbness in extremities
☐ NO	☐ YES	Confusion
☐ NO	☐ YES	Balance disturbance
		PSYCHIATRY
☐ NO	☐ YES	Depression
☐ NO	☐ YES	Hallucinations
☐ NO	☐ YES	Anxiety
☐ NO	☐ YES	Nervousness
☐ NO	☐ YES	Suicidal
☐ NO	☐ YES	Sleep Disturbances
		HEMATOLOGY
☐ NO	☐ YES	Anemia
☐ NO	☐ YES	Easy Bruising
☐ NO	☐ YES	Thrombocytopenia
☐ NO	☐ YES	Easy Bleeding
		Endocrine
☐ NO	☐ YES	Goiter
☐ NO	☐ YES	Tremors
☐ NO	☐ YES	Hair loss
☐ NO	☐ YES	
		SKIN
☐ NO	☐ YES	Rash
☐ NO	☐ YES	Blisters
☐ NO	☐ YES	Sores
☐ NO	☐ YES	Irritation
		MUSCULOSKELETAL
☐ NO	☐ YES	Joint pain
☐ NO	☐ YES	Muscle pain
☐ NO	☐ YES	Back pain
☐ NO	☐ YES	Muscle cramps
		IMMUNE SYSTEM
☐ NO	☐ YES	Asthma
☐ NO	☐ YES	Eczema
☐ NO	☐ YES	Food allergies

PATIENT REGISTRATION FORM

Today's Date:

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Sex: ____Male ____ Female Date of Birth: _____ SS#: _____ Home phone: _____

Street Address _____ City: _____ State: _____ Zip Code: _____

Work Phone: _____ Mobile Phone: _____ Patient Referred By: _____

Race: (check one) ___American Indian/Alaska Native ___Asian/Oriental ___Black/African American ___Native Hawaiian/Other Pacific Islander ___White ___Other ___Declined

Ethnicity: (check one) ___Central America ___Cuban ___Dominican ___Hispanic/Latino/Spanish ___Mexican ___Not Hispanic or Latino ___Puerto Rican ___South American ___Spaniard ___Other ___Declined

Marital Status: ___Single ___Married ___Other (widow, divorced, separated) Patient PCP: _____

Spouse's Name: _____ Spouse's Employer: _____ Spouse's Employer Phone: _____

Email address: _____

Preferred Pharmacy (location and phone # if available) _____

Guardian Information (If Applicable):

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ Date of Birth: _____ SS#: _____ Employer: _____

Employer Address: _____ Employer Phone: _____

Emergency Contact Information:

Last Name: _____ Frist Name: _____ Phone: _____ Relationship: _____

Employer Information:

Employer Name: _____ Employer Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Guarantor Information:

Last Name: _____ Frist Name: _____ MI: _____ Phone: _____

Street Address _____ City: _____ State: _____ Zip Code: _____

SS# _____ DOB: _____ Employer Name: _____

Employer Address: _____ Employer Phone: _____

Insurance Information:

Insurance Plan Name: _____ Insurance Phone Number: _____ Policy ID#: _____

Street Address for Claims: _____ City:_____ State: _____ Zip:_____

Patient's Relationship to Policy Holder: _____Policy Group #: _____ Effective Date: _____

Policy Holder Last Name:_____ First Name: _____ MI: _____ Sex: ___Male ___Female

Policy Holder Address: _____ City: _____ State_____ Zip_____

Policy Holder SSN: _____ DOB: _____ Employer Name: _____

Policy Holder Employer Address: _____ Phone: _____

Insurance Information:

Is injury related to ___Work ___Auto Accident ___Other Date of Injury: _____ Work Comp Claim #: _____

Case Manager/Adjuster Name: _____ Case Manager/Adjuster Phone: _____

Abrazo
Arizona Heart Institute

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients and explains: (1) how your Protected Health Information (PHI) may be used or shared; (2) your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI; (3) your rights to complain if you believe your privacy rights have been violated; and (4) our responsibilities for maintaining the privacy of your PHI.

- I acknowledge that I have read the foregoing and received a copy of the "Notice of Privacy Practices" (effective 05/26/16) that explains when, where, and why my Protected Health Information (PHI) may be used or shared.
- I authorize VHS Outpatient Clinics, Inc / Abrazo Medical Group to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. I hereby authorize my insurance carrier to furnish to VHS Outpatient Clinics, Inc / Abrazo Medical Group any information obtained in the adjudication of any claim for services furnished to me by Abrazo Medical Group.
- I acknowledge that Abrazo Medical Group, the physicians, the nurses, and other staff may obtain and share any or all of my Protected Health Information, including prescription history, with other health care professionals in order to treat me, coordinate my care, and/or in order to arrange for payment of my bill and respond to any issues related to my care.
- I acknowledge that I have the right to request additional restrictions on the use and disclosure of my PHI if I so choose.
- I acknowledge receipt, and have read and understand the Notice of Health Information Practices regarding my Providers' participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

Printed Name of Patient:_____ Date of Birth:_____

Signature of Patient/Guardian: _____ Date: _____

Printed Name of Guardian: _____ Relationship to Patient: _____

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: _____

Abrazo™
Arizona Heart Institute

PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care, appointments, test results, referrals, or any other reason. This is to acknowledge that you authorize VHS Outpatient Clinics, Inc / Abrazo Medical Group to contact you and how you wish to be contacted (check all that apply):

	ORDER OF PREFERENCE:	OK TO LEAVE VOICEMAIL?	PHONE NUMBER:
HOME PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
CELL PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
WORK PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
ALTERNATE PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
PATIENT PORTAL &SECURE EMAIL	❒1 ❒2 ❒3 ❒4 ❒5	EMAIL ADDRESS:	
☐None of the above			

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize VHS Outpatient Clinics, Inc / Abrazo Medical Group to disclose your PHI to the following individuals (check all that apply):

Name:____Relationship to Patient:_________________________
Telephone: (________)__________________Email:____Types of Information:❒ Appointment Reminders ❒ Results (lab test, X-Ray, etc) ❒ Financial ❒ Other: ___________
Okay to contact via:❒ Telephone❒Leave a Voice Mail ❒Patient Portal & Secure Email ❒ Other: ________________

Name:____Relationship to Patient:_________________________
Telephone: (________)__________________Email:____Types of Information:❒ Appointment Reminders ❒ Results (lab test, X-Ray, etc) ❒ Financial ❒ Other: ___________
Okay to contact via:❒ Telephone❒Leave a Voice Mail ❒Patient Portal & Secure Email ❒ Other: ________________

Name:____Relationship to Patient:_________________________
Telephone: (________)__________________Email:____Types of Information:❒ Appointment Reminders ❒ Results (lab test, X-Ray, etc) ❒ Financial ❒ Other: ___________
Okay to contact via:❒ Telephone❒Leave a Voice Mail ❒Patient Portal & Secure Email ❒ Other: ________________

☐None of the above Signature: ____

A federal law was passed in 2014 and became effective on September 30, 2014, governing how we may contact you via telephone, text, and email. Listed below are some of the reasons we may need to contact you via telephone, text, or email:

- Appointment reminders
- Follow up with test results
- Reminder calls about annual preventive care due
- Email or fax with patient forms to complete prior to your appointment
- Notification of medication renewals
- Notification of surgery time and date
- Notification of prepayments for surgeries and procedures
- Follow up calls after surgeries or procedures

Consent to Contact

By providing a telephone number, I expressly consent and authorize the physician practice, any practitioner or clinical provider as well as any of their related entities, agents, or contractors, including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with me and obtained through any source including, but not limited to, any number I am providing today, have provided previously or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with, me and obtained through any source including, but not limited to, any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical and educational information including exchange news, changes to health care law, health care coverage, care follow up, and other healthcare opportunities, goods and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C.§ 7701, et seq. By providing an email address, I represent I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a phone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt–out method that will be identified in the applicable communication.

I have read and understand the above and consent to contact as described:

Patient Name: _____Date of Birth: _____

Signature: _____ Date:_____

*Minors or Users Requiring Caregivers – Acknowledgement of Consent to Contact

Name: _____Relationship to Patient: _____

Signature: _____ Date:_____

VHS Outpatient Clinics, Inc / Abrazo Medical Group Financial Policy and Authorizations

We are happy that you selected VHS Outpatient Clinics, Inc / Abrazo Medical Group for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

Patients are expected to provide identification and if insured, a current insurance card(s) at time of service. Patients are financially responsible for all services provided and are expected to pay for services at time of service, including any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship. Returned checks will be subject to fees.

Medicare: The office will bill the Medicare intermediary. Patients are responsible for the following:

- Annual Medicare deductible
- All applicable co-pays of the allowed charge
- Any non-covered services
- Any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN).

Medicare Supplemental and Secondary Insurances: The Practice will bill both Medicare and secondary insurances.

Medicaid: Patients must provide the Practice with a current Medicaid card at each visit. Medicaid patients are responsible for applicable co-pays and for all non-covered services. Medicaid patients are responsible for securing necessary referrals from their primary care physicians.

HMOs and PPOs, Commercial Insurance Plans: Patients are responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the Practice. Patients are responsible for the balance in full if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

Self-Pay: Patients are responsible for payment in full at the time of services for all services rendered.

Worker's Compensation: Employer authorization must be obtained before treatment is rendered or the patient will be responsible for payment in full at the time of services for all services rendered. Once authorized, patients are not responsible for any charges unless the workers compensation case is dismissed or denied.

Personal Injury/Motor Vehicle Accidents and Other Third Party Liability: The patient is responsible for the balance in full at the time of service. Any settlement you receive from your insurance company or other third party will be handled by you, your insurance company, and/or your attorney.

Out of State Insurance: If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out-of-state or out-of-network benefits. The patient may be required to make payment in full or pay any co-pay, co-insurance or deductible.

Authorizations and Consent

ASSIGNMENT AND RELEASE: I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

ELECTRONIC CHECK CONVERSION: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

NO SHOW POLICY: I understand if I fail to come for a scheduled appointment or cancel at least 24 hours prior to the appointment, I will be considered a "no show" and may be subject to a "no show" charge per occurrence. Ongoing occurrences of no shows may result in dismissal from the Practice.

CONSENT FOR TREATMENT: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

ADVANCED DIRECTIVE: Do you have an Advanced Directive (Living Will and/or Medical Power of Attorney)?
❒Yes ❒No If yes, please provide a copy for our records.

I understand the Financial and No Show Policies, Authorizations and Consent for Treatment, and hereby agree to them:

_____ _____ _____

Patient or Parent/Guardian if Minor | Date of Birth | Date

VHS Outpatient Clinics, Inc.

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.

We are committed to protecting the confidentiality of your medical information, and are required by law to do so. This notice describes how we may use your medical information within the Practice and how we may disclose it to others outside the Practice. This notice also describes the rights you have concerning your own medical information. Please review it carefully and let us know if you have questions.

HOW WILL WE USE AND DISCLOSE YOUR MEDICAL INFORMATION?

Treatment: We may use your medical information to provide you with medical services and supplies. We may also disclose your medical information to others who need that information to treat you, such as doctors, physician assistants, nurses, medical and nursing students, technicians, therapists, emergency service and medical transportation providers, medical equipment providers, and others involved in your care.

For example, we will allow other physicians treating you to have access to your Practice medical record. To assure that your other treatment providers have quick access to your latest health information, we may participate in a community-based electronic health information exchange. We also may use and disclose your medical information to contact you to remind you of an upcoming appointment, to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you, or to perform follow-up calls to monitor your care experience.

Family Members and Others Involved in Your Care: We may disclose your medical information to a family member or friend who is involved in your medical care, or to someone who helps to pay for your care. We also may disclose your medical information to disaster relief organizations to help locate a family member or friend in a disaster. During visits with family members and other visitors, let your physician and Practice personnel know if you do not want them to disclose your medical information during the visit.

Payment: We may use and disclose your medical information to get paid for the medical services and supplies we provide to you. For example, your health plan or Health Insurance Company may ask to see parts of your medical record before they will pay us for your treatment.

Practice Operations: We may use and disclose your medical information if it is necessary to improve the quality of care we provide to patients or to run the Practice. We may use your medical information to conduct quality improvement activities, to obtain audit, accounting or legal services, or to conduct business management and planning. For example, we may look at your medical record to evaluate the care provided by Practice personnel, your doctors, or other health care professionals.

Health Information Exchange: 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 The Network, operated by Arizona Health-e Connection (AzHeC). For example, information about your past medical care and current medical conditions and medications can be available to other primary care physicians or hospitals, if they participate in The (AzHeC) Exchange. 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 (AzHeC) Exchange 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 Arizona Health-e Connection (AzHeC) by completing and submitting an Opt-Out Form to a staff member at the front desk.

Research: We may use or disclose your medical information for research projects, such as studying the effectiveness of a treatment you received. These research projects must go through a special process that protects the confidentiality of your medical information.

Required by Law: Federal, state, or local laws sometimes require us to disclose patients' medical information. For instance, we are required to report child abuse or neglect and must provide certain in- formation to law enforcement officials in domestic violence cases. We also are required to give information to the State Workers' Compensation Program for work-related injuries.

Public Health: We also may report certain medical information for public health purposes. For instance, we are required to report births, deaths, and communicable diseases to the State. We also may need to report patient problems with medications or medical products to the FDA, or may notify patients of recalls of products they are using.

Public Safety: We may disclose medical information for public safety purposes in limited circumstances. We may disclose medical information to law enforcement officials in response to a search war- rant or a grand jury subpoena. We also may disclose medical information to assist law enforcement officials in identifying or locating a person, to prosecute a crime of violence, to report deaths that may have resulted from criminal conduct, and to report criminal conduct at the Hospital. We also may disclose your medical information to law enforcement officials and others to prevent a serious threat to health or safety.

Health Oversight Activities: We may disclose medical information to a government agency that oversees the Practice or its personnel, such as the State Department of Health, the federal agencies that oversee Medicare, the Board of Medical Examiners or the Board of Nursing. These agencies need medical information to monitor the Practice's compliance with state and federal laws.

Coroners, Medical Examiners and Funeral Directors:

Organ and Tissue Donation: We may disclose medical information to organizations that handle organ, eye or tissue donation or transplantation.

Military, Veterans, National Security and Other Government Purposes: If you are a member of the armed forces, we may release your medical information as required by military command authorities or to the Department of Veterans Affairs. The Practice Hospital may also disclose medical

information to federal officials for intelligence and national security purposes, or for presidential Protective Services.

Judicial Proceedings: The Practice may disclose medical information if the Practice is ordered to do so by a court or if the Practice receives a subpoena or a search warrant. You will receive advance notice about this disclosure in most situations so that you will have a chance to object to sharing your medical information.

Information with Additional Protection: Certain types of medical information have additional protection under state or federal law. For instance, medical information about communicable disease and HIV/AIDS, and evaluation and treatment for a serious mental illness is treated differently than other types of medical information. For those types of information, the Practice is required to get your permission before disclosing that information to others in many circumstances.

Uses and Disclosures for Which Your Authorization is Required: With limited exceptions, the Practice must obtain your written authorization before it may disclose your medical information in the following circumstances: (1) to disclose psychotherapy notes, (2) to conduct marketing activities, or (3) to sell your medical information to a third party.

Other Uses and Disclosures Requiring Authorization: If the Practice wishes to use or disclose your medical information for a purpose that is not discussed in this Notice, the Practice will seek your written authorization. If you give your authorization to the Practice, you may take back that authorization any time, unless we have already relied on your authorization to use or disclose the information. If you ever would like to revoke your authorization, please notify the Privacy Official in writing.

WHAT ARE YOUR RIGHTS?

Right to Request Your Medical Information: You have the right to look at your own medical information and to get a copy of that information. (The law requires us to keep the original record.) This includes your medical record, your billing record, and other records we use to make decisions about your care. To request your medical information, write to the Privacy Official. If you request a copy of your information, we will charge you for our costs to copy the information. We will tell you in advance what this copying will cost. You can look at your record at no cost.

Right to Request Amendment of Medical Information You Believe Is Erroneous or Incomplete: If you examine your medical information and believe that some of the information is wrong or in- complete, you may ask us to amend your record. To ask us to amend your medical information, write to the Privacy Official.

Right to Get a List of Certain Disclosures of Your Medical Information: You have the right to request a list of many of the disclosures we make of your medical information. If you would like to receive such a list, write to the Privacy Official. We will provide the first list to you free, but we may charge you for any additional lists you request during the same year. We will tell you in advance what this list will cost.

Right to Request Restrictions on How the Practice Will Use or Disclose Your Medical Information for Treatment, Payment, or Health Care Operations: You have the right to request the Practice from making uses or disclosures of your medical information to treat you, to seek payment for care, or to operate the Practice. In many cases, the Practice is not required to agree to your request for restriction, but if we do agree, we will comply with that agreement. However, the Practice must agree to your request not to disclose to your health plan any medical information about items or services for which you have paid in full, unless such disclosure is required for treatment or by law. If you do not want the practice to notify your health plan, you must notify us at the time of your registration as well as make immediate arrangements to pay in full for your treatment or visit.

Right to Request Confidential Communications: You have the right to ask us to communicate with you in a way that you feel is more confidential. For example, you can ask us not to call your home, but to communicate only by mail. To do this, write to the Privacy Official. At your request, you can also ask to speak with your health care providers in private outside the presence of other patients or family.

Right to a Paper Copy: If you have received this notice electronically, you have the right to a paper copy at any time. You may download a paper copy of the notice from our Web site, at **[www.abrazohealth.com]**, or you may obtain a paper copy of the notice from the Privacy Official.

DUTIES OF THE PRACTICE

The Practice is required by law to protect the privacy of your medical information, give you this Notice of Privacy Practices, and follow the terms of the Notice that is currently in effect. The Practice is also required to notify you if there is a breach of your unsecured medical information.

WHICH HEALTH CARE PROVIDERS ARE COVERED BY THIS NOTICE?

This Notice of Privacy Practices applies to the Practice and its personnel, volunteers, students, and trainees.

CHANGES TO THIS NOTICE

From time to time, we may change our practices concerning how we use or disclose patient medical information, or how we will implement patient rights concerning their information. We reserve the right to change this Notice and to make the provisions in our new Notice effective for all medical information we maintain. If we change these practices, we will publish a revised Notice of Privacy Practices. You can get a copy of our current notice of Privacy Practices at any time by contacting the Privacy Official.

DO YOU HAVE CONCERNS OR COMPLAINTS

Please tell us about any problems or concerns you have with your privacy rights or how the Practice uses or discloses your medical information. If you have a concern, please contact the Practice's confidential Compliance Hotline at 1-877-893-8363 extension 2009

If for some reason the Practice cannot resolve your concern, you may also file a complaint with the federal government at the OCR/DHHS regional office. We will not penalize you or retaliate against you in any way for filing a complaint with the federal government.

PRACTICE PRIVACY OFFICIAL CONTACT INFORMATION

Mailing Address: 10020 N. 25th Ave, Phoenix AZ 85021
Phone 1-877- 893- 8363 extension 2009
Email: privacysecurityoffice@tenethealth.com

Notice of Health Information Practices

You are receiving this notice because your health care provider participates in an electronic information service offered by The Network, a nonprofit 501(c)(3) non-governmental organization operated by Arizona Health-e Connection (AzHeC). This service does not cost you anything and can help your doctor and health care providers better coordinate your care by *securely sharing your health information.* This notice explains how electronic information sharing works and will help you understand your rights regarding this service under Arizona law.

If you would like your doctor and other health care providers to electronically and securely share your health information to better coordinate your care, YOU DO NOT NEED TO DO ANYTHING.

Your information will automatically be shared with your health care providers, unless you decide to "Opt-Out." (**See *Your Rights Regarding Electronic Information Sharing***)

What does it mean to securely share information and how can it help you get better care?
In a paper-based medical system, your medical tests or lab results are either mailed or faxed to your primary care doctor. But sometimes paper or faxed records are lost or don't arrive in time for your doctor visit. With electronic information sharing, your doctors and other health providers are able to securely share your health information with each other in a safe and timely manner.

What medical information is available to be securely shared?
Authorized medical practices will be able to share several types of health information about you, including but not limited to:

- Hospital: Admission and discharge information from hospitals that use the service
- Medical history
- Medicines you take
- Allergies – including allergies to medicines
- Lab test results and radiology reports
- Doctor visit information
- Health plan enrollment and eligibility

Who can view your medical information electronically?
Only people involved in your care have access to your information. This may include doctors, nurses, and other care providers who are providing and coordinating your care. Your health insurer may also view your information to help coordinate or manage your care.

How is your medical information protected?
The Network is required to follow federal law – the Health Insurance Portability and Accountability Act or "HIPAA" – to protect your private health information. People with access have a unique username and password and get training before they can see your information, so that they know how to protect it. In addition, the system records every time someone looks at your medical information, and you can ask for a list of who has viewed your information and when.

Are there additional security measures?
Information is shared using secure, encrypted transmission.

Your Rights Regarding Secure Electronic Information Sharing

If you do nothing, your information may be securely shared with your health care providers.

You have the right to:

1. Ask for a copy of your medical information that is available to be shared. Just ask your health care provider and you can get a copy within 30 days or sooner.

2. Request to have any information corrected. If any information in the system is incorrect, you can ask that provider to correct the information.

3. Ask for a list of providers who have viewed your information. Contact The Network for a list of people who have viewed your information in the system. Please let The Network know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution to keep your medical information from being shared electronically through The Network. Specifically, you may:

1. "Opt-Out" of having your information available for sharing. To Opt-Out, you must ask your provider for the Options Change Form. After you submit the form, your information will not be available for sharing. Caution: There are risks in preventing your health care providers from sharing your health care information, especially in an emergency.

2. It may be possible, to choose to exclude some information from being shared. For example, if you see a clinician and you do not want that information shared, and the system supports the exclusion, you may request that information not be shared with that provider. On the Options Change Form, fill in the information and name of the provider for the information that you do not want shared. Caution: If that provider works for an organization (like a hospital or a group of physicians), all your information from that hospital or group of physicians may be blocked from view.

3. Change your mind at any time. If you say no today, you can change your mind at any time. If you do nothing today and allow your health records to be shared, you may "Opt-Out" in the future.

For questions or further information:

Call (602) 688-7200 | Email: thenetwork@azhec.org | Visit www.azhec.org

3877 N. 7th Street, Suite 130 | Phoenix, Arizona 85014