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PEDIATRIC PATIENT REGISTRATION

Note: This form may be completed manually or on your computer. To complete it on your computer: *1. Type your answer in each field. 2. Save your work often on your computer or device. 3. Print the completed form and bring it with you to your first appointment.*

How did you hear about us?
- ☐ Newspaper
- ☐ Social media/Web search
- ☐ Insurance directory/referral
- ☐ Family/Friend

PATIENT'S NAME AND ADDRESS

LAST	FIRST	MI	CURRENT GENDER ☐ MALE ☐ FEMALE ☐ UNDIFFERENTIATED
SOC. SEC. # XXX-XX-XXXX	BIRTHDATE mm/dd/yy	AGE	PRIMARY DOCTOR
STREET ADDRESS	APT#	CITY	STATE / ZIP
PHONE ◯ CELL ◯ HOME ◯ DAY	EMAIL		
RACE	ETHNICITY	LANGUAGE	

EMERGENCY CONTACT INFORMATION

NAME	PHONE ◯ CELL ◯ HOME ◯ DAY
RELATIONSHIP TO PATIENT	

PATIENT'S INSURANCE

PRIMARY INSURANCE COMPANY NAME AND ADDRESS	POLICY #
GROUP #	POLICYHOLDER'S NAME
SOC. SEC. # XXX-XX-XXXX	POLICYHOLDER'S BIRTHDATE mm/dd/yy / RELATIONSHIP TO PATIENT
SECONDARY INSURANCE COMPANY NAME AND ADDRESS	POLICY #
GROUP #	POLICYHOLDER'S NAME
SOC. SEC. # XXX-XX-XXXX	POLICYHOLDER'S BIRTHDATE mm/dd/yy / RELATIONSHIP TO PATIENT

PARENTS' INFORMATION

MOTHER'S NAME	MAIDEN NAME
BIRTHDATE mm/dd/yy	SOC. SEC. # XXX-XX-XXXX
STREET ADDRESS / APT# / CITY / STATE / ZIP	
CELL PHONE ( )	HOME PHONE ( )
EMPLOYER NAME / DAY PHONE ( ) / EMAIL example@test.com	
MARITAL STATUS ◯ MARRIED ◯ DIVORCED ◯ SINGLE ◯ WIDOWED ◯ OTHER_____	
FATHER'S NAME	
BIRTHDATE mm/dd/yy	SOC. SEC. # XXX-XX-XXXX
STREET ADDRESS / APT# / CITY / STATE / ZIP	
CELL PHONE	HOME PHONE
EMPLOYER NAME / DAY PHONE / EMAIL example@test.com	
MARITAL STATUS ◯ MARRIED ◯ DIVORCED ◯ SINGLE ◯ WIDOWED ◯ OTHER_____	

CUSTODIAL INFORMATION

CUSTODIAL PARENT IS ◯ MOTHER ◯ FATHER ◯ OTHER _____

FINANCIAL POLICY: Payment in full or co-payment is expected at the time of service. Services provided that are not a covered benefit of your health plan will be your responsibility.

CONSENT TO TREATMENT/RELEASE OF INFORMATION: I grant Graybill Medical Group, Inc. to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the insurer's agents to process my payments for service. To the best of my knowledge, all of the information above is true and correct.

ASSIGNMENT OF BENEFITS: I thereby assign all benefits payable by my insurance company to Graybill Medical Group.

TREATMENT IF PARENT OR GUARDIAN IS NOT PRESENT: Child MUST have a note from a parent or guardian giving permission for Graybill Pediatrics to examine child. Please include in this note the date of visit, any known allergies, the name of the person bringing in the child and his or her relationship to the child, and reason for visit. Forms are available if you'd like to have one for reference. Please ask the Receptionist for details.

_____ _____ _____

PARENT/GUARDIAN SIGNATURE | DATE | RELATIONSHIP TO PATIENT

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PATIENT FINANCIAL AGREEMENT

- **Co-Payments:** Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit.
- **Deductible Payments:** If your insurance requires you to meet a deductible before services are covered, payment must be made at the time of service. A $100.00 payment will be due at the time of service. Please note the $100.00 payment does not constitute payment in full and any additional balance must be paid upon receiving notification from our practice.
- **Claims Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Payment from your insurance company is expected within 45 days. After 45 days, we will look to you for payment in full. You will be responsible for all non-covered services according to Medicare guidelines. We must have a copy of your most recent cards and any secondary insurance or supplement you may have. Accounts that are 90 days past due are subject to being sent to a collection agency or small claims court for the unpaid bills. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.
- **Preventive Care Services:** Routine exams are not always covered by your insurance. Please be aware that if an additional problem is addressed at the time of your visit, a co-pay, deductible or office visit fee may be charged. If services are denied for payment by your insurance or you have failed to provide us with your correct insurance information, you will be responsible to pay for these services.
- **Cash Pay Patients:** The amount you pay for today's scheduled office visit may not be your final payment. Other costs that may be accrued for today's appointment are including, but not limited to, laboratory tests, x-ray tests, any injections, special procedures or additional office visit charges.
- **Laboratory Bills:** Any laboratory procedures that are ordered during today's visit will be billed to you directly by the laboratory. Please contact your laboratory directly for any questions regarding your lab bill.
- **Missed Appointments:** Please note a $25.00 cancellation fee will apply for missed appointments or failure to cancel within 24 hours prior to your scheduled appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
- If at any time you should experience financial hardship and need to make special payment plan arrangements, please contact our billing office.

Assignment of Benefits: Authorization is hereby granted to release information as may be necessary to process and complete my insurance claim, and payment of medical benefit is to be paid directly to Graybill Medical Group for all services rendered. *Initials:* _____

I have read and understand the above statements. I agree to comply with the financial policies of the office and I am financially responsible for my account.

Patient or Guardian Signature: _____ *Date:* _____

Patient Name (please print) _____ *Date of Birth:* _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

GRAYBILL MEDICAL GROUP, INC.

Privacy Officer (760) 291-6696

I hereby acknowledge that I have been offered a copy of Graybill Medical Group's Notice of Privacy Practices. I have been advised that a copy of the current notice will be posted in the reception area, and that any amended Notice of Privacy Practices will be available at each appointment.

_____ _____
PATIENT NAME (please print) PATIENT DATE OF BIRTH

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

(_____)_____ _____
PATIENT PHONE NAME OF PHYSICIAN (please print)

If not signed by the patient, please indicate relationship:

- ○ Parent or guardian of minor patient
- ○ Guardian or conservator of an incompetent patient
- ○ Beneficiary or personal representative of deceased patient

☐ I would like to receive a copy of any amended Notice of Privacy Practices via e-mail.

My email address is (example@test.com): _____

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Parent/Legal Guardian Request to Access Minor Patient's NextGen® Portal Account

Parents and legal guardians may request proxy access to their child's protected health information (PHI) through the Graybill Medical Group patient portal, NextGen®. The scope of access may vary based on your child's age.

- *Children ages 0-11 years: You will be granted **full access** to your child's NextGen record, including immunizations, allergy information, and growth charts.*
- *Children ages 12-17 years: You will be granted **partial access** to your child's NextGen record, in accordance with California and Federal privacy laws. **For full access**, **Special Authorization and Patient Signature** are required (see below).*
- *Adults ages 18 and older: You will **no longer have access** to your child's NextGen account.*

The parent/legal guardian who is granted proxy access to NextGen will be required to accept and abide by the NextGen Terms and Conditions. In addition, Graybill Medical Group may terminate the proxy access at any time without notice.

PATIENT INFORMATION (REQUIRED)

Name (Last, First, MI)	Date of Birth (MM/DD/YY)

Provide ONE of the following:

☐ Last 4 digits of Social Security Number: _____ ☐ Medical Record Number: _____

Street Address	Apt #	City	State	Zip

Phone (XXX-XXX-XXXX)	Email (EXAMPLE@TEST.COM)

PARENT/LEGAL GUARDIAN INFORMATION (REQUIRED)

Name (Last, First, MI)	Date of Birth (MM/DD/YY)

Provide ONE of the following

☐ Last 4 digits of Social Security Number: _____ ☐ Medical Record Number: _____

Street Address	Apt #	City	State	Zip

Phone (XXX-XXX-XXXX)	Email (EXAMPLE@TEST.COM)

SPECIAL AUTHORIZATION FOR FULL ACCESS TO NEXTGEN (PATIENTS 12 YEARS OR OLDER)

By signing below, I acknowledge that I am choosing to designate the person named above as my NextGen proxy, thereby allowing him/her access to my complete medical record through NextGen. I understand that I may revoke this authorization at any time.

Patient Signature _____ Date (MM/DD/YY) _____

Proxy Relationship to Patient:

◯ Parent ◯ Legal Guardian ◯ Power of Attorney ◯ Other _____

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PARENTS' QUESTIONNAIRE

Date _____

CHILD'S BIRTH HISTORY

PROVIDER: Write additional information in this column

During your pregnancy with this child did you:

Have high blood pressure?	◯ Yes ◯ No	Have diabetes or sugar in your urine?	◯ Yes ◯ No
Have a urine or kidney infection?	◯ Yes ◯ No	Have any other infections?	◯ Yes ◯ No
Have a venereal disease such as gonorrhea or syphilis?	◯ Yes ◯ No	Take any medications, drugs or alcohol?	◯ Yes ◯ No
Have any problems with labor or delivery?	◯ Yes ◯ No	Was the pregnancy planned?	◯ Yes ◯ No
How long was the pregnancy? _____ months		How much did the baby weigh? ____lbs ____oz	

Did your child have any problems after birth? ◯ Yes* ◯ No

*if yes please describe: _____

_____

Did the mother and child come home from the hospital together? ◯ Yes ◯ No

How many days did the mother and child stay in the hospital? Mother _____ days Child _____ days

In which hospital was your child born?_____

SOCIAL HISTORY

Child lives with: ◯ Mother ◯ Father ◯ Both Parents ◯ Other Relatives ◯ Foster Parents

WHO LIVES IN THE HOME WITH YOUR CHILD? (Please print clearly):

NAME	RELATIONSHIP TO CHILD
1.	
2.	
3.	
4.	
5.	
6.	

Does your child spend time regularly with a babysitter? ◯ Yes ◯ No

If yes, how many times per week? _____

Does your child spend time at a day care center? ◯ Yes ◯ No

If yes, how many times per week? _____ How many hours per day? _____

FAMILY HISTORY (check any that apply)

	Father	Mother	Father's Family	Mother's Family	Child's Brothers	Child's Sisters
Asthma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart attack at age less than 50 years	☐	☐	☐	☐	☐	☐
Seizures (epilepsy)	☐	☐	☐	☐	☐	☐
Sickle Cell Disease	☐	☐	☐	☐	☐	☐

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PARENTS' QUESTIONNAIRE

Date _____

PROVIDER: Write additional information in this column

CHILD'S MEDICAL HISTORY

Has the child ever stayed overnight in a hospital? ◯Yes ◯No

YEAR	NAME OF HOSPITAL	REASON
1.		
2.		
3.		

Has the child ever had:

Eczema (allergic skin rash?)	◯Yes ◯No	Asthma?	◯Yes ◯No
Chicken Pox	◯Yes ◯No	Rheumatic Fever?	◯Yes ◯No
Anemia (low blood)?	◯Yes ◯No	Seizure, convulsions, fits?	◯Yes ◯No

Has the child ever experienced:

Eye or vision problems?	◯Yes ◯No	Ear or hearing problems?	◯Yes ◯No
Frequent ear infections?	◯Yes ◯No	Heart problems?	◯Yes ◯No
Stomach or bowel problems?	◯Yes ◯No	Broken or fractured bones?	◯Yes ◯No
Problems with urinating?	◯Yes ◯No	Ate paint, clay or plaster?	◯Yes ◯No

Do you give the child vitamins, iron or fluoride dietary supplements? ◯Yes ◯No

*If yes, please describe:

CHILD'S DEVELOPMENT

Has your child developed (for example, started sitting, walking, talking) at the same rate as his or her brothers, sisters, relatives or friends? ◯Yes ◯No*

*If no, please explain:

CHILD'S SCHOOL HISTORY

If school age, name of school currently attending: Grade level _____

Has your child ever failed a class?	◯Yes ◯No	Attended a special class?	◯Yes ◯No
Had behavior problems in school?	◯Yes ◯No		

If yes to any of the above, please explain:

CHILD'S BEHAVIOR

Has your child had frequent nightmares?	◯Yes ◯No	Had problems being overly shy?	◯Yes ◯No
Been overly clinging to parents or friend?	◯Yes ◯No	Been easily upset?	◯Yes ◯No
Been overly nervous?	◯Yes ◯No	Been unreasonably jealous?	◯Yes ◯No
Does your child lie a lot?	◯Yes ◯No	Does your child fight a lot	◯Yes ◯No
Does your child steal?	◯Yes ◯No		

HOW WOULD YOU DESCRIBE THE CHILD AND HIS/HER BEHAVIOR?

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TB EXPOSURE RISK ASSESSMENT FOR CHILDREN

Today's Date _____

Has the Mother ever tested positive for active TB? ○ Yes ○ No

Has the Father ever tested positive for active TB? ○ Yes ○ No

Has any family member/person whom your child sees regularly been diagnosed or suspected of being sick with active TB? ○ Yes ○ No

Does your child have family members/frequent visitors who were born in high TB-prevalent areas (Asia, Africa, Latin America, Mexico, parts of Eastern Europe)? ○ Yes ○ No

Was your child born in, or has your child traveled to, high TB-prevalent areas (Asia, Africa, Latin America, Mexico, parts of Eastern Europe)? ○ Yes ○ No

Has your child lived in out-of-home placements such as foster care or residential facilities or been incarcerated in the last 5 years? ○ Yes ○ No

Does your child have HIV infection or any other immunosuppressive condition? ○ Yes ○ No

Has your child lived among or frequently been around individuals who are homeless, have a history of incarceration, migrant workers, users of street drugs, residents in nursing homes, or have HIV infection? ○ Yes ○ No

Does your child have close contact with a person who has a positive TB skin test? ○ Yes ○ No

Has your child ever consumed raw milk or unpasteurized cheese? ○ Yes ○ No

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PEDIATRIC HISTORY

Today's Date _____

MOTHER'S NAME_____ DOB_____

FATHER'S NAME_____ DOB_____

SIBLING(S)/AGE(S)_____

Are there any special cultural or religious beliefs that might affect your child's healthcare?

_____

HISTORY

Complications w/pregnancy ◯Yes ◯ No Birth: ◯Vaginal ◯C-section Birth weight ____ Birth length_____

Special diet? ◯Yes ◯ No Medications: _____

Drug/medication allergies? ◯Yes* ◯ No *If yes, describe: _____

Surgeries (age, diagnosis): _____

Hospitalizations (age, diagnosis): _____

Any problems at school? ◯ Yes* ◯ No *If yes, describe: _____

Other problems: _____

FAMILY HISTORY

☐ Cystic fibrosis	☐ High blood pressure	☐ TB	☐ Seizures
☐ Sickle cell disease	☐ Scoliosis	☐ Kidney disease	☐ Lazy eye
☐ Diabetes	☐ Melanoma/Skin cancer	☐ Anemia/bleeding	☐ Allergies/Asthma/Eczema
☐ Hip problems	☐ Recurrent ear infections	☐ Deafness	☐ Attention Deficit Disorder

IMMUNIZATION DATES (Please bring copy of immunization record)

DATE	DATE	DATE	DATE
DPT 1 _____/_____/_____	OPV 1 _____/_____/_____	Rotovirus 1 _____/_____/_____	HIB 1 _____/_____/_____
DPT 2 _____/_____/_____	OPV 2 _____/_____/_____	Rotovirus 2 _____/_____/_____	HIB 2 _____/_____/_____
DPT 3 _____/_____/_____	OPV 3 _____/_____/_____	Rotovirus 3 _____/_____/_____	HIB 3 _____/_____/_____
DPT 4 _____/_____/_____	OPV 4 _____/_____/_____	Rotovirus 4 _____/_____/_____	HIB 4 _____/_____/_____
DPT 5 _____/_____/_____	MMR 1 _____/_____/_____	DT _____/_____/_____	HEPB 1 _____/_____/_____
Prevnar 1 _____	MMR 2 _____/_____/_____	TB _____/_____/_____	HEPB 2 _____/_____/_____
Prevnar 2 _____	Chicken Pox ____/____/_____	TB _____/_____/_____	HEPB 3 _____/_____/_____
Prevnar 3 _____			
Prevnar 4 _____			

DO YOU HAVE ANY OTHER QUESTIONS OR CONCERNS REGARDING YOUR CHILD'S HEALTH OR DEVELOPMENT?_____

_____

_____

_____

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NOTICE OF PRIVACY PRACTICES

Privacy Officer 760-291-6696

Effective Date: September 23, 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How Graybill Medical Group May Use or Disclose Your Health Information

The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. *Treatment*. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or following your death.
2. *Payment.* We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. *Health Care Operations.* We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. Although federal law does not protect health

information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law.

We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

4. *Appointment Reminders.* We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. *Sign-in Sheet.* We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. *Notification and Communication with Family.* We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. *Marketing*. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in. We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life-threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. *Sale of Health Information.* We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. *Required by Law.* As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. *Public Health.* We may, and are sometimes required by law to, disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. *Health Oversight Activities.* We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
12. *Judicial and Administrative Proceedings.* We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. *Law Enforcement.* We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. *Coroners.* We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. *Organ or Tissue Donation.* We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. *Public Safety.* We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. *Proof of Immunization.* We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.
18. *Specialized Government Functions.* We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. *Worker's Compensation.* We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. *Change of Ownership.* In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. *Breach Notification.* In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.
22. *Research.* We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When Graybill Medical Group May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. *Right to Request Special Privacy Protections.* You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. *Right to Request Confidential Communications.* You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. *Right to Inspect and Copy.* You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's

records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. *Right to Amend or Supplement.* You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
5. *Right to an Accounting of Disclosures.* You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX - Office of Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 (fax)
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.