

**Dr. Arun Kalra / Dr. Varun Gupta / Dr. M. Iliana Popescu / Dr. Henry Tsai
Hematology / Oncology**

39700 Bob Hope Drive
Bob Hope Classic
Medical Bldg. Ste. 108
Rancho Mirage, CA 92270
www.desertcancercare.com

**(760) 346-7655 Phone
(760) 346-7651 Fax**

PATIENT REGISTRATION FORM

Name _____ Today's Date _____
Last First Initial
Address _____
Street City State Zip
(Mailing Address if Different) _____
SS# _____ Birthdate _____ Age _____ Sex () Male () Female Marital Status S M W D
Occupation _____ Employer _____ Employee's Address _____
Home Phone (_____) _____ Bus. Phone (_____) _____ Cell phone (_____) _____

SPOUSE / RESPONSIBLE PARTY INFORMATION

Responsible Party/ Parent Name _____ Relationship _____
SS# _____ Birthdate _____ Marital Status S M W D
Occupation _____ Employer _____ Bus. Phone (_____) _____
Spouse's Full name _____ Birthdate _____
SS# _____ Home Phone (_____) _____ Bus. Phone (_____) _____
Occupation _____ Employer _____ Address _____

INSURANCE INFORMATION

Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payments. Many companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay deductible, co-insurance, and any other balance not paid for by your insurance, we will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

Primary Company _____ Address _____ Effective date _____
Policy Number _____ Group# _____ Phone Number (_____) _____
Subscriber _____ SubscriberSS# _____ Relationship to subscriber _____
Secondary Company _____ Address _____ Effective date _____
Policy Number _____ Group# _____ Phone Number (_____) _____
Subscriber _____ SubscriberSS# _____ Relationship to subscriber _____

OTHER INFORMATION

Nearest Relative not Living with you _____ Relationship _____ Phone _____
Referred To This Office By _____ Personal Physician _____

Your signature is necessary for us to process any insurance claim and to ensure payment of services rendered.

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and / surgical benefits, including major medical benefits to which I am entitled to Dr. Varun Gupta / Dr. M. Iliana Popescu / Dr. Arun Kalra. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient / responsible Party _____ Date _____

INITIAL PATIENT ASSESSMENT

Name: _____ Date: _____ Time Arrived: _____

1. What is your primary language? _____ Interpreter required? NO YES Name of interpreter: _____ language _____

2. Briefly describe the onset of your problem with dates: _____

3. Have you had any cancer? If yes, please describe the onset and treatment you have had so far: _____

4. MEDICAL HISTORY: (Please check No or Yes)

- | | | | | |
|--------------------------|----|--------------------------|-----|--------------------------|
| Heart Disease | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| High Blood Pressure | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Stroke | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Diabetes | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Lung Problems | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Digestion Problems | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Liver Problems | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Bone Disease | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Skin Problems | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Depression | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Mental Illness | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Chronic Pain | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Muscle or Joint Problems | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Asthma | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Bleeding Problems | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |

5. Please list all surgeries you have had in your life: _____

5a. Have you ever had a colonoscopy No Yes

If yes by whom and when _____

6. Family history of cancer No Yes

If yes, list who (blood related) and what type: _____

7. Do you have any allergies to:

- | | | | | |
|----------------|----|--------------------------|-----|--------------------------|
| Medicines? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Foods? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Environmental? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |

7a. If yes, please list and describe your allergic reaction(s): _____

8. LIFESTYLES HABITS: (Please check No or Yes)

Do you or have you ever smoked? No Yes

If yes, how many packs per day? _____ for _____ years.

If you have quit smoking, for how many years? _____

Do you, or have you used chewing tobacco? No Yes

Do you, or have you ever used recreational drugs? No Yes

Do you or have you ever used alcohol? No Yes

If yes, have you ever:

felt the need to cut down? No Yes

felt annoyed by criticism of your drinking? No Yes

had guilty feelings about drinking? No Yes

drink a morning "eye-opener?" No Yes

9. REVIEW OF SYMPTOMS: (Please check No or Yes)

- | | | | | |
|---------------------------------------|----|--------------------------|-----|--------------------------|
| Seizures | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Headaches | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Loss of Memory | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Dizziness | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Double vision or loss of vision | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Recent gain ___ or loss ___ of weight | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Night sweats | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Cough | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Breathing troubles | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Trouble with swallowing | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Easy bruising | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Bleeding | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Bowel changes | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Depression | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Nausea | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Burning with urination | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Change in skin area or mole? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Lump or thickening? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Difficulty Urinating | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Bowels Moving | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Fatigue or change in energy level | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |

Rate your fatigue, 4 being the worst, 0 being no fatigue: _____

Pain? No Yes

How would you rate your pain today? (Extreme, being worst possible pain or 10; Can not go to sleep because of pain or 8; Wake up because of pain or 6; None, meaning no pain or 0.)

0 1 2 3 4 5 6 7 8 9 10

Where? _____

What does it feel like? _____

Does it travel to another area? _____

10. Are you taking any medications? No Yes

If yes, please list all prescriptions. (Please include all herbal or over the counter medication(s):

11. Have you ever been exposed to:
- | | | | | |
|--------------------|----|--------------------------|-----|--------------------------|
| Harmful chemicals? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Hepatitis? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| HIV? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Tuberculosis? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |

12. **FOR WOMEN ONLY:**

Have you ever taken estrogen or birth control pill _____
 If so, for how long _____

Date of last menstrual period: _____
 Length of period: _____
 Age at first menses: _____
 Number of past pregnancies: _____
 Number of live births: _____
 Age at first birth: _____
 Number of living children: _____
 Have you ever had a breast biopsy? No Yes
 Results: _____

Last Mammogram _____

14. Which of the following items are difficult for you? (please check all that apply)

- | | | | | |
|-----------------------|----|--------------------------|-----|--------------------------|
| Nausea | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Sleep problems | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Getting around | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Bathing/dressing | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Dealing with children | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Housing | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Dealing with partner | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Insurance | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Work and/or school | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Child care | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |

15. On a scale of 1-10 Circle Number Indicating The Level of your Daily Activity:
 (Bedbound) 1 2 3 4 5 6 7 8 9 10 (Normal)

Nearest Friend or Relative & Phone _____

13. **PSYCHOSOCIAL:**

Marital status: (please circle one)
 Single Married Divorced Widowed Partner

Do you live alone? No Yes
 If no, who lives with you? _____

Who do you rely on for support or help? _____

Do you have transportation? No Yes
 Do you have a place to stay? No Yes
 Are you currently working? No Yes
 If yes, what type of work do you do?
 Please list any doctors that you are seeing:

16. Do you have a living will? No Yes
 A durable power of attorney? No Yes
 If yes, did you bring? No Yes

Have you talked with anyone about your wishes regarding life support measures if you quit breathing or your heart stopped? No Yes

Do you have a legal guardian No Yes

(someone appointed by the Court) to handle your affairs?

Have you arranged for anyone to No Yes

make decisions for you if needed?
 If yes, list person(s): _____

Signed: _____

Date: _____

Relationship to Patient:

To be completed by Nursing Staff / Physician

Chief Complaint: _____ Severity (Grade): _____

Onset of Dx: _____ Modifying Factors: _____

Associated s/s: _____

Misc Notes: _____

Nurse/Physician Signature: _____ Date: _____ Time Spent: _____

DESERT CANCER CARE, INC.

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TEL: (760) 346-7655

Fax: (760) 346-3037

Date: _____

Physician/Hospital: _____

Name

Phone#

Fax#

Address

City

State

Zip

I hereby give you authorization to release copies of the following information to:

Dr. Varun Gupta / Dr. M. Iliana Popescu / Dr. Henry Tsai / Dr. Arun Kalra

Reason Record Wanted

Records Needed

I understand authorizing the disclosure of the information identified above is voluntary. I need not sign this form in order to receive healthcare treatment. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Compliance Officer for Health Information Management. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date: _____. If I fail to specify an expiration date, this authorization will expire in 90 days from the date of signature.

I understand that I may inspect or obtain a copy of the information used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Compliance Officer for Health Information Management.

Date of Service: _____

Print Name: _____

Signature: _____

Date of Birth: _____

Witness: _____

I understand there may be a fee for copying records. _____ Initials

**DR. ARUN KALRA / DR. VARUN GUPTA
DR. M. ILIANA POPESCU / DR. HENRY TSAI**

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ACKNOWLEDGMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgment

I, _____ have received a copy of this office's
Notice of Privacy Practices,

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barrier prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify below)

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Tele (760) 346-7655

Patient Name: _____ DOB: _____

Address:

Telephone Home: _____ Cell: _____ Work: _____

ADVANCE DIRECTIVES

This is an acknowledgment that the physician, and one of his/her staff members, has provided me information concerning Advanced Directives.

1. I am 18 years or older. YES No (circle one)

2. I realize that I have the option of putting together Advance Directives for my healthcare. My physician has provided me written information concerning these Advance Directives. I understand that it is my responsibility to provide my doctors(s) with any documents that are required to carry out my Advance Directives.

3. I am aware that Advance Directives may be any one of the following:
 - a. A Durable Power of Attorney **for Healthcare.**
 - b. The Declaration in the Natural Death Act Example: A Living Will
 - c. I am writing down my wishes, on a piece of paper, so that my family may use the document I deciding my medical treatment I the event I am unable to do so.

Patient's Signature:

Date:

This document will become part of my medical record.

MAKING YOUR OWN HEALTH CARE DECISIONS: The Advance Directive

In recent years, patients have been urged by health care providers to take more responsibility in making personal health care decisions. An important aspect of such responsibility is forethought!

Because every person must face the possibility of becoming either seriously ill or injured in the future, it is never too early to think about the important decisions that may need to be made, often at the most difficult of times. Fortunately, residents of the State of California are able to provide advance instructions to their physicians and health care institutions regarding the kinds of care they do or do not want to receive under certain circumstances, or to delegate someone else to speak for them if they are unable.

Such "advance directives" have many benefits. They allow patients the right to make their own treatment decisions at a time when they are not under medical stress. They protect patients' loved ones from the emotional agony associated with making such decisions for another person. They allow physicians to treat patients in compliance with their stated wishes. In plain words, they take the guesswork out of the situation for all concerned. A copy of your advance directive should be in your file at both your physician's office and the hospital. The original should be kept with your own legal documents. It takes effect only when a person no longer has "capacity" (for instance, is comatose or unable to understand his or her medical condition).

The California Health Care Decisions Law, which became effective on July 1, 2000, allows persons, 18 years or older and of sound mind, to execute advance directives. The Law applies to health care decisions for adults who lack capacity to make such decisions for themselves. It does not affect the right of an individual to make decisions while he or she has the capacity to do so.

Under the Law, if you are an adult having capacity (able to understand his or her medical condition) you may use an Advance Health Care Directive (CHA Form 3-1) to give instruction covering possible future health care decisions; therefore, the designation "advance directive". Such a signed statement allows you to state exactly what kind of care you do or do not want to receive under certain conditions.

You may also, through the execution of a Durable Power of Attorney, (CHA Form 3-2) name another person (agent) to make treatment decisions for you in the event you lack capacity when a health care situation arises that had not previously been addressed by your own directive.

You may also write your own wishes on any piece of paper so that your doctor and your loved ones can be guided in making decisions about your treatment. However, such personal documents do not give much legal protection in the event that a disagreement should arise.

If you choose this option, your self-document must meet the following requirements of the California Health Care Decisions Law in order to ensure its legality:

Document maker must be age 18 years or older. Document maker must have legal "capacity", as described above.

Document must be in writing. (No oral statement applies, although the maker may give another person oral instructions for completion of a legal form, or the writing of a statement, before qualified witnesses.)

Document must be signed and dated by maker, in the presence of qualified witnesses.

Have you been putting off making an advance directive? Medical emergencies can and do happen without warning. Take this important step in ensuring that health care decisions affecting you will reflect your own wishes. Worried that you might change your mind later on, either about treatment or the designation of an agent? The new Law takes that concern into consideration and allows for advance directives to be changed, modified or entirely revoked at any time, by a maker with capacity.

If you have previously executed a similar advance directive under the state law that expired on June 30, 2000, please refer to your copy. Most forms do remain valid and do not need to be replaced.

There are, however, specific exceptions. Some previous Durable Power of Attorney for Health Care forms may no longer remain valid:

A form executed after January 1, 1992 remains valid indefinitely unless a limited duration was established in the form. If it was executed on or after January 1, 1992 and before July 1, 2000, and contains a warning statement that refers to a 7-year limit on duration, it will expire 7 years from the date of duration, unless a shorter period was specified.

If the document was executed after January 1, 1984 but before January 1, 1992, it expired 7 years from the date of execution, unless a shorter period was specified.

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NOTICE OF PRIVACY PRACTICES

DR. ARUN KALRA, DR. VARUN GUPTA, DR. M. ILIANA POPESCU, DR. HENRY TSAI
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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY:

This notice takes effect on 04-15-03 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at this organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

The Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are Permitted by Law.
2. Make the changes in our privacy practice and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other people who are taking care of you. We may also share medical information about you to other healthcare providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTHCARE OPERATIONS: We may use and disclose your medical information for our healthcare operations. This might include measuring and improving quality, evaluation the performance of an employee, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment and healthcare operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name, your location in our facility, your condition, described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your healthcare, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your healthcare. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with the coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of an inmate or other personal in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect, we may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to tract products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety to the health or safety of others. We may share medical information when necessary to help law enforcement official capture a person who has admitted to being part of a crime or has escaped for legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or to other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include, reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right To:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact listed at the end of this notice. If you request copies we will charge you \$2.00 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment and healthcare operations and other specified exceptions.
3. Request that we place additional restriction on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do will, we will abide by our Agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. You request that we communicate you medical information to you by different means or at different locations must be made in writing to the contract person listed at the end of this notice.
5. Request that we change you medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept you request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at your office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.