



Dear Patient and Family:

The Physicians and Staff of Children's Primary Care Medical Group (CPCMG) and Rady Children's Physician Management Services want to extend a warm thank you and welcome to you and your family.

In choosing our medical group, you will find that we are unique in our ability to offer you superior pediatric primary care services through over 100 providers practicing out of twenty-two (22) office locations throughout the San Diego and southern Riverside counties. Our access to Rady Children's Hospital and its many affiliated pediatric specialists provide us with a unique opportunity to work together to improve the health status of the children we serve. We are committed to the delivery of quality health care and quality services for all our patients.

Look for us in your neighborhood and know that we are committed to working with you to make the best health care decisions for your family.

If we can be of further assistance, please contact the CPCMG office of your choice or visit our website at [www.CPCMG.net](http://www.CPCMG.net).

Thank you for choosing us for your children's health care needs.

Sincerely,

A handwritten signature in blue ink, appearing to read "Thomas E. Page".

Thomas E. Page, M.D., F.A.A.P.  
President  
Children's Primary Care Medical Group, Inc.

A handwritten signature in blue ink, appearing to read "Cathy Romano".

Cathy Romano, C.M.P.E.  
President/Chief Executive Officer  
Rady Children's Physician Management Services, Inc.



## New Patient Checklist

As a reminder please bring the following items to your first appointment:

- Completed Forms
  - Patient History Questionnaire
  - Record Release Form
  - Acknowledgement of Receipt of Joint Notice of Privacy Practices
  
- Patient's Insurance card or military I.D.
  
- Immunization card (Yellow card)
  
- Hospital Discharge Summary – only for our Newborn patients
  
- Any previous medical history that may help in the continued care of the patient

Thank you,  
RCPMS Welcome Center Representatives

## Patient History Questionnaire

Affix Patient Label here

Patient name: \_\_\_\_\_

**Birth History:** (if child was born in last 12 months) Did your child receive Hepatitis B Vaccines at birth? No Yes - Date: \_\_\_\_\_

Birth Length \_\_\_\_\_ Birth Weight \_\_\_\_\_ Birth Hospital/Center: \_\_\_\_\_  
Gestational Age \_\_\_\_\_ Birth Place (City/Country): \_\_\_\_\_

List any problems at birth \_\_\_\_\_

**Medical History:** Has your child ever had any of these? Please circle Yes or No.

ADD/ADHD	Yes	No	Chicken Pox	Yes	No	Headaches	Yes	No	Pneumonia	Yes	No
Allergies	Yes	No	Congenital disease	Yes	No	Hearing Problems	Yes	No	Scoliosis	Yes	No
Anemia	Yes	No	Diabetes	Yes	No	HIV/AIDS	Yes	No	Seizures	Yes	No
Anxiety	Yes	No	Ear Infections	Yes	No	Jaundice	Yes	No	Sickle Cell	Yes	No
Asthma	Yes	No	Eating problems	Yes	No	Lead Poisoning	Yes	No	Tuberculosis	Yes	No
Bladder/ kidney Infection	Yes	No	Eczema	Yes	No	Meningitis	Yes	No	Vision Problems	Yes	No
Cancer	Yes	No	Colitis/ Bowel Disease	Yes	No	Heart Murmur	Yes	No	Strep Throat (recurrent/frequent)	Yes	No

List other medical problems \_\_\_\_\_

**Surgical History:** Has your child ever had any of these? Please circle Yes or No.

Appendectomy Yes No Eye surgery Yes No Lymph node biopsy Yes No  
Ear tubes Yes No Hernia repair Yes No Tonsillectomy Yes No

List other operations or procedures \_\_\_\_\_

**Family History:** Please place a check mark for any of these conditions:

Relative	Asthma	Birth Defects	Cancer	Diabetes	Early Death	Heart Disease (heart attack before 55, or any heart defect)	High Blood Pressure	High Cholesterol	Kidney or Bladder Disorder in childhood	Learning Disability	Mental Illness	Stroke (before 55)	Substance Abuse	OTHER: ADHD	OTHER: Allergy	OTHER: Blood Clots	OTHER: Ear or Sinus Infections (frequent)	OTHER: Eczema	OTHER: Stomach or Bowel Disorder	OTHER: Hip Disorder in childhood	OTHER: Migraines	OTHER: TB Test Positive	
Mother																							
Father																							
Sister																							
Brother																							
Mother's sister																							
Mother's brother																							
Father's sister																							
Father's brother																							
Mother's mother																							
Mother's father																							
Father's mother																							
Father's father																							

List other significant hereditary disorders \_\_\_\_\_

**Social History:**

Who lives at home? \_\_\_\_\_

Does anyone smoke around your child? Yes No Is there a pool or hot tub at home? Yes No

Are there any guns at home? Yes No Has there been any violence at home? Yes No

List pets at home \_\_\_\_\_

List other significant things about your family environment \_\_\_\_\_

Form completed by: Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Reviewed by provider: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature)

**Place Patient Label Here**

**Record Release Form**  
**Authorization for Use or Disclosure of Health Information**

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

**AUTHORIZATION:** I hereby authorize (name and address of physicians or facility)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

to furnish to (name and address of recipient)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

medical records and information pertaining to medical history, mental or physical condition, services rendered, or treatment for:

\_\_\_\_\_ DOB: \_\_\_\_\_ MR#: \_\_\_\_\_

(Print last, first, middle initial)

**Information to be released:** \_\_\_\_\_

**USES:** This information supplied is to be used for the following purpose(s): \_\_\_\_\_

**DURATION:** This authorization shall become effective immediately and remain in effect for 12 months from the date signed.

**SIGNATURE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

(Patient/Parent/or Legal Guardian)

Print name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Witness: \_\_\_\_\_ Verified ID: \_\_\_\_\_ Page 1 of 2

I **UNDERSTAND** that I have the right to revoke this authorization of any time. My revocation must be in writing, signed by me or by my legal representative and delivered to Children’s Primary Care Medical Group.

My revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have acted in reliance upon this Authorization. I have a right to receive a copy of this Authorization. I will not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits.

California law prohibits the requester from making the further disclosure of health information unless the requester obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

**Delivery Options:**

RELEASE RECORDS ON:  CD (Only EMR records)  Paper

RECORDS SHOULD BE:  Mailed

Hold for Pickup at Site / Pick up location: \_\_\_\_\_

Picked up by: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_

**\*Please note that there may be a charge for copying records.**

For translation please see the front desk staff.

**Special Authorization**

ALL MEDICAL INFORMATION, WITHOUT EXCEPTION, including information regarding AIDS testing, psychological or psychiatric treatment, and drug or alcohol abuse. I understand I am authorizing the release of sensitive/confidential information.

\_\_\_\_\_  
Sign

\_\_\_\_\_  
Time

\_\_\_\_\_  
Date



**AUTHORIZATION FOR THIRD PARTY TO CONSENT TO TREATMENT OF  
MINOR LACKING LEGAL CAPACITY TO CONSENT**

I am the  Parent  
 Guardian  
 Other person having legal custody \_\_\_\_\_  
*(describe legal relationship)*

of *(name of minor)* \_\_\_\_\_, a minor.

I hereby authorize the following individuals to act as my agent to consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis, immunization or treatment, and hospital care, which is recommended by, and to be rendered under the general or special supervision of any licensed doctor, whether such diagnosis or treatment is rendered at the doctor's office or at a hospital.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority to the above-named agent to give consent to any and all such diagnosis, treatment or hospital care, which a licensed doctor or dentist recommends.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**MEDICALLY RELEVANT INFORMATION**

Minor's Name: \_\_\_\_\_ Minor's Birthdate: \_\_\_\_\_

Allergies to Drugs or Food: \_\_\_\_\_

Conditions for which minor is currently being treated: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Mother's Address: \_\_\_\_\_

Mother's Telephone Numbers: Work \_\_\_\_\_ Home \_\_\_\_\_ Other \_\_\_\_\_

Father's Name: \_\_\_\_\_

Father's Address: \_\_\_\_\_

Father's Telephone Numbers: Work \_\_\_\_\_ Home \_\_\_\_\_ Other \_\_\_\_\_

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT REGISTRATION/ASSIGNMENT OF BENEFITS**

**NAME OF CHILD:**

(LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MIDDLE) \_\_\_\_\_ AKA \_\_\_\_\_

DOB \_\_\_\_\_ SEX \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PHONE \_\_\_\_\_ CONTACT EMAIL \_\_\_\_\_ LANGUAGE \_\_\_\_\_

MOTHER'S MAIDEN NAME \_\_\_\_\_ ETHNICITY \_\_\_\_\_ RACE \_\_\_\_\_

**PATIENT'S PRIMARY CARE PROVIDER:** \_\_\_\_\_

**PARENT OR LEGAL GUARDIAN:**

NAME (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MIDDLE) \_\_\_\_\_

IS ADDRESS SAME AS CHILD:  YES  NO (COMPLETE THE FOLLOWING IF DIFFERENT FROM THE CHILD)

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PH \_\_\_\_\_ WK PH \_\_\_\_\_ CELL PH \_\_\_\_\_

REL TO PT \_\_\_\_\_ LEGAL GUARDIAN \_\_\_\_\_

**NEXT OF KIN:**

NAME (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MIDDLE) \_\_\_\_\_

IS ADDRESS SAME AS CHILD:  YES  NO (COMPLETE THE FOLLOWING IF DIFFERENT FROM THE CHILD)

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PH \_\_\_\_\_ WK PH \_\_\_\_\_ CELL PH \_\_\_\_\_

REL TO PT \_\_\_\_\_ LEGAL GUARDIAN \_\_\_\_\_

**PERSON TO NOTIFY/CONTACT:** (NOT LIVING IN HOUSEHOLD)

NAME (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MIDDLE) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PH \_\_\_\_\_ WK PH \_\_\_\_\_ CELL PH \_\_\_\_\_

REL TO PT \_\_\_\_\_ LEGAL GUARDIAN \_\_\_\_\_

**GUARANTOR:** (PERSON FINANCIALLY RESPONSIBLE FOR CHILD)

NAME (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MIDDLE) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PHONE \_\_\_\_\_ SS # \_\_\_\_\_ DOB \_\_\_\_\_ REL TO PT \_\_\_\_\_

**GUARANTOR'S EMPLOYER INFO:**

NAME (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MIDDLE) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP CODE \_\_\_\_\_

WK PH \_\_\_\_\_ GUAR OCCUPATION \_\_\_\_\_ EMPLOYMENT STATUS \_\_\_\_\_

**PRIMARY INSURANCE:**

INSURANCE CO NAME \_\_\_\_\_ ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_ DOB \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

**SUBSCRIBER'S EMPLOYER INFO:**

NAME (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MIDDLE) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP CODE \_\_\_\_\_

WK PH \_\_\_\_\_ SUBSCRIBER'S OCCUPATION \_\_\_\_\_ EMPLOYMENT STATUS \_\_\_\_\_

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Witnessed: \_\_\_\_\_



**Terms and Conditions of Service:  
Medical Services and Financial Agreement**

- 1) **Medical Consent:** I consent to medical treatments or procedures, medications, injections, drawing blood for tests and ambulatory outpatient services rendered to my child(ren) under the general and special instructions of the physicians or other health care professionals assisting in my child(ren)'s medical care. I also consent to my child(ren)'s admission to the Rady Children's Hospital if this is necessary for my child(ren)'s medical care.
  
- 2) **Release of Medical Information:** CPCMG will obtain my written authorization to release information about my medical treatment, except in those circumstances when CPCMG is permitted or required by law to release information (see Notice to Privacy Practices for a description of the specific circumstances under which CPCMG may release this information). For example, CPCMG may release a copy of my patient record to health care providers, health plans, and government agencies. Additionally, I understand that if I am diagnosed with cancer, a reportable disease in California, CPCMG is required by law to report my diagnosis to the State Department of Health Services.
  
- 3) **Financial Agreement:** I understand that even if my child is covered by insurance, I may be financially responsible for some or all of my medical services. For instance, if I have a co-payment or deductible, I agree to pay the amounts I owe. Not all insurance plans cover all services. If I do not have insurance that covers the service I receive, I agree to pay CPCMG for professional and clinic services, including CPCMG provider services, in accordance with the regular rates and terms of CPCMG. I also agree to pay for the professional services provided at CPCMG by other health care providers. If I am unable to pay, I understand I may qualify for public assistance, special payment arrangements and/or charity care. I also understand that when this agreement is signed by me or my child(ren)'s guarantor, that individual is liable for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate.

If you made an appointment for a wellness visit/physical only and the doctor treats your child(ren) for an illness or counsels you regarding a medical condition during this visit there could be a separate co-payment that is your responsibility.

- 4) **Assignment of Benefits (Including Medicare Benefits):** I authorize and direct payment to CPCMG of any insurance benefits including hospital insurance and unemployment compensation disability benefits otherwise payable to or on my behalf for CPCMG services, including emergency services, at a rate not to exceed CPCMG actual charges. I understand that I am financially responsible for charges not paid pursuant to this agreement. I further agree that any credit balance resulting from payment of insurance or other sources may be applied to any other account owed to CPCMG by me.

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Signature of Parent or Guardian

Date





## **When You Need to Contact Your Child's Pediatrician After-Hours ...**

When contacting your pediatrician after hours, each office, with the help of either a recorded message, or answering service, will provide instructions on how to obtain medical care for your child. Please follow the guidelines listed below to receive advice.

### **Guidelines:**

- If you think your child is having a life or limb threatening emergency, call 911 immediately.
- If not a life threatening emergency, please call your pediatrician's office telephone number for direction. Medication refills should be done by your child's pediatrician during regular business hours.
- Over-the-counter medications should be used according to the information on the label.
- Please make only one phone call to the office and wait for a reply. Calls are returned based upon medical urgency.
- For additional medical/health tips please visit *Your Child's Health* on our website at: [www.rchsd.org](http://www.rchsd.org). Information is also available in Spanish.

### **Preparation:**

- Provide your child's name, date of birth, phone number where you can be reached and the name of your child's pediatrician and your insurance information.
- If your child has a fever, please take their temperature before you call.
- If you have a medication question, please have the bottle available so the nurse can verify the medication and dosing information.
- The nurse will ask you several questions about your child's illness, please be ready to discuss the symptoms of concern to you.
- Have a paper and pencil available to write down instructions.

### **Information:**

- Rady Children's Hospital After-Hours Pediatric Telephone Triage Service is staffed by California licensed Registered Nurses.
- The Registered Nurse uses standardized lists of questions that will help guide their advice and direction. Your answers will allow the nurse to decide the best way to help your child.
- The Registered Nurse will complete a full assessment to include past medical history, current medications and allergy information as the nurse does not have access to your child's office record.
- The Registered Nurses are not able to diagnose, prescribe medications or give laboratory results.
- The Registered Nurse will help you manage your child's symptoms and will help determine if your child requires immediate care, follow up or can be managed at home.

### **\*Rady Children's Health Pediatric Telephone Triage Service Hours of Operation:**

- 5 pm to 10 pm, Monday through Friday
- 12 noon to 10 pm, Saturday
- 8 am to 10 pm, Sunday
- 8 am to 10 pm, Holidays

***"The mission of Rady Children's Hospital and Health Center is to restore, sustain, and enhance the health and development potential of children through excellence in care, education, research and advocacy."***



PLACE PATIENT ID LABEL INSIDE BOX

**ACKNOWLEDGEMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES**

Rady Children’s Hospital San Diego and the Members of its Medical Staff, Children’s Specialists of San Diego, Children’s Primary Care Medical Group, Children’s Physicians Medical Group, and UCSD Pediatric Associates have the responsibility to:

- Maintain the privacy of an individual's medical information
- Provide a Joint Notice of Privacy Practices which describes our privacy practices
- Allow requests for restrictions on the use or disclosure of medical information and notify you if we are unable to accommodate a requested restriction
- Accommodate reasonable requests to communicate with you at an alternate address or location
- Facilitate your (or your child's) right to access and amend the medical record and obtain an accounting of certain disclosures of medical information

We will not use or disclose your (or your child's) medical information without your authorization, except as described in our Joint Notice of Privacy Practices. In addition, we reserve the right to change our privacy practices and to make the new provisions effective for the medical information we maintain. If our privacy practices change, a revised notice will be available at the registration areas and on our websites.

Please acknowledge that you received our Joint Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Name of Legal Representative (if applicable and relationship to patient)

Please Check the Box that applies if unable to obtain a signature:

Patient/Legal Representative received Joint Notice of Privacy Practices but refused to sign acknowledgement of receipt.

Patient/Legal Guardian unavailable to acknowledge receipt of Joint Notice of Privacy Practices.

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date



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## **PURPOSE OF THIS NOTICE**

The providers participating in this notice (referred to as “we”) are committed to protecting the privacy of medical information. This notice will tell you about the ways in which we may use and disclose medical information about you (if you are our patient) or your child (if your child is our patient), and describes your rights and our duties regarding the use and disclosure of medical information. This notice applies to all records of your/your child’s care generated by any of the Rady Children’s Hospital sites or medical groups listed on this notice.

We have a duty and responsibility to safeguard patient medical information. We are required by law to maintain the privacy of patient medical information and to give you this notice of our duties and our privacy practices. We must follow the terms of our current privacy notice.

## **HOW WE MAY USE AND DISCLOSE PATIENT MEDICAL INFORMATION**

The following categories describe different ways that we may use and disclose patient medical information. For each category of uses and disclosures, we will explain what we mean and give at least one example of how we may use or disclose patient medical information. Not every use or disclosure will be listed. However, all ways that we are permitted to use and disclose patient medical information will fall within one of the categories.

**Disclosure at Your Request** - We may disclose patient medical information when requested by you. This disclosure at your request may require a written authorization by you.

**For Treatment** - We may use and disclose medical information to provide medical treatment and services. For example, we may disclose medical information to doctors, nurses, technicians, students, residents, other healthcare providers, other hospitals or home health agencies so they can provide care or coordinate continuing care.

**For Payment** - We may use and disclose medical information so treatment and services received at or from our health care organizations may be billed and payment collected. For example, we may need to give medical information about surgery received at the Hospital so your health plan will pay us or reimburse you for the surgery.

We also may tell your health plan about a treatment you/your child will receive to obtain prior approval or to determine whether your health plan will cover the treatment.

**For Health Care Operations** - We use and disclose information to run our health care organizations and to make sure all of our patients receive quality care and comprehensive services. For example, we may use and disclose medical information for quality assurance activities such as post-discharge telephone calls to follow-up on a patient’s health status; conducting training programs in which students, trainees, or practitioners learn under supervision to practice or improve their skills as health care providers; training of non-health care professionals; granting medical staff privileges to physicians and non-physician practitioners; administrative activities, including financial and business planning and development, accreditation, certification, licensing, arranging for medical review, legal services, auditing functions, or to obtain or maintain insurance; patient service activities, including investigation of complaints; health education; and providing you with information about new or enhanced opportunities for care and service; or to tell you about or recommend possible treatment options or alternatives that may be of interest to you/your child.

**Among Participants** - We may also share information with each other, as necessary to carry out treatment, payment, or health care operations relating to our organized health care arrangement.

**For Appointment Reminders** - We may use and disclose medical information to contact you with a reminder about an appointment for treatment or medical care at our health care organizations.

**For Health Related Products or Services** - We may use and disclose medical information to tell you about our health related products or services that may be of interest to you.

**Directory Information** - We have a directory of information about hospitalized patients that includes your/your child’s: (1) name; (2) location or room number; (3) general condition (“serious, fair, good, etc.”); and (4) religious affiliation (available to clergy members only). Unless you specifically refuse to have this information in

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our directory, this information will be used to allow visitors to find your/your child's room, to allow florists to deliver flowers to you or to respond to questions about your/your child's general condition.

**Individuals Involved in Care or Payment for Care** - Unless you specifically tell us in advance not to do so, we may disclose medical information to a friend or family member who is involved in your/your child's care or who helps pay for care, or tell your family or friends your/your child's condition and that you are/your child is in the hospital. In addition, we may disclose medical information to organizations assisting in a disaster relief effort (such as the Red Cross) so that your family can be notified about your/your child's condition, status and location.

**Fundraising** - We may use medical information about you/your child to contact you to raise money for our health care organizations and their activities. If we do so, we will only release your name, address, telephone number and the dates you received services at the Hospital or medical group. If you receive a fundraising notice from us, you will be told how you can stop any future fundraising notices.

**Research** - Under certain circumstances, we may use and disclose medical information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another medication for the same condition. All research projects are subject to a special approval process. This process evaluates a proposed research project with special consideration of the protection of individual medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may disclose medical information about you/your child to people preparing to conduct a research project. For example, we may provide the researcher with information to help identify what types of patient problems might be appropriate to study as long as the medical information does not leave our facility or offices and the researcher agrees to protect the medical information.

**Marketing and Sale** - Uses and disclosures of medical information for marketing purposes and disclosures that constitute a sale of medical information require your authorization.

**As required by law** - We will disclose medical information about you/your child when required by federal, state or local laws.

**Organ and Tissue Donation** - We may release medical information without your permission to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank as necessary to arrange organ, eye or tissue donation and transplantation. This release of information is not a commitment by you to donate organs, eyes or tissues.

**Military Personnel** - If you are a member of the United States or foreign armed forces, we may release medical information about you as required by military command or government authorities.

**Worker's Compensation** - We may release medical information for worker's compensation or similar programs if you have a work related injury. These programs provide benefits for work related injuries.

**To Avert a Serious Threat to Health or Safety** - We may use and disclose medical information when necessary to prevent a serious threat to your/your child's health and safety or the health and safety of the public or another person. Any disclosure, however, would be to someone able to help prevent harm to the health or safety of you/your child, another person, or the public.

**Health Oversight Activities** - We may disclose medical information to a health oversight agency for activities authorized or required by law. For example, these oversight activities may include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights and other laws.

**Public Health Activities** - We may disclose medical information for public health activities. These generally include the following:

- To prevent or control disease, injury or disability.
  - To report births and deaths.
  - To report child abuse or neglect.
  - To report reactions to medications, problems with products or other adverse events.
  - To notify people of recalls of products they may be using.
-



- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse (including child abuse), neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Lawsuits and Disputes** - If you/your child is involved in a lawsuit or a legal dispute, we may disclose medical information in response to a court or administrative order. We may disclose medical information in response to a subpoena, discovery request or other lawful process by someone else involved in the legal dispute. We would only disclose this information if efforts have been made to tell you about the request (which may include written notice to you) to allow you/your child to obtain an order protecting the information requested or if we receive a court order protecting the information.

**Law Enforcement** - We may disclose medical information if asked to do so by law enforcement officials for the following reasons:

- As required by law to report certain types of injuries;
- In response to a court order or court-ordered warrant, subpoena or summons or similar process;
- To provide certain limited information to identify or locate a suspect, fugitive, material witness or missing person;
- About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of a criminal conduct;
- About criminal conduct at our facility; and
- In a medical emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who may have committed the crime.

**Coroners, Medical Examiners and Funeral Home Directors** - We may disclose medical information to a coroner or medical examiner for the purpose of identifying a deceased person, determining the cause of death of a person, or other duties as required by law. We may also release medical information about patients at our facility to funeral home directors as necessary to carry out their duties.

**National Security and Intelligence Activities** - We may disclose medical information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

**Protective Services for the President and Others** - We may disclose medical information to authorized federal officials so that they may provide protection to the President, other authorized persons, or foreign heads of state or to conduct special investigations.

**Inmates** - If you/your child is an inmate of a correctional facility or under the custody of a law enforcement official, we may disclose medical information about you/your child to the correctional facility or law enforcement official. We would only do so if the medical information is necessary for: providing health care; your/your child's health and safety or the health and safety of others; or safety and security of the correctional institution.

**Special Categories of Information** - In some circumstances, medical information may be subject to restrictions that may limit or preclude some uses or disclosures described in this notice. For example, there are special restrictions on the use or disclosure of certain categories of information, such as drug and alcohol abuse treatment, HIV and AIDS test results, and mental health treatment.

Most uses and disclosures of psychotherapy notes require your written authorization.

We may disclose medical information to a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child or the child's parents.

**Other Uses of Medical Information** - Other uses and disclosures of your/your child's medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us with authorization to use or disclose medical information, you may revoke that permission, in writing, at any time. If you revoke your authorization, this will stop any further use or disclosure of your/your child's medical information for the purposes covered by your written authorization, except if we have already acted in reliance on your authorization. We are unable to take back any disclosures we have already made with your permission.

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**YOUR RIGHTS REGARDING THE MEDICAL INFORMATION WE MAINTAIN ABOUT YOU/YOUR CHILD**

You have the right to:

1. Request a restriction on certain uses and disclosures of your/your child's medical information. You have the right to request a restriction or limitation on the medical information we use or disclose about you/your child for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose to someone who is involved in your/your child's care or the payment for care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you/your child had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. To request a restriction, you must make a request in writing to the Hospital's Health Information Management office or contact person of the medical groups. In the request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use or disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to a grandparent.
  2. Obtain a paper copy of this Joint Notice of Privacy Practices upon request. You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at any of our Web sites. To obtain a paper copy of this notice, contact the Hospital Privacy Officer or contact person of the medical groups.
  3. Inspect and request a copy of your/your medical record for a fee. You have the right to inspect and receive a copy of medical information that may be used to make decisions about your/your child's care. Usually, this includes health and billing records and may also include some mental health information. To inspect and copy your/your child's medical information, you must submit your request in writing to the Hospital's Health Information Management office or contact person of the medical group that maintains your/your child's record. If you request a copy of medical information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request under certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Hospital or medical group will review your request and denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of that review.
  4. Request an amendment to your/your child's health record if you feel the information is incorrect or incomplete. You have the right to request an amendment for as long as the information is kept by the Hospital or medical groups. To request an amendment, your request must be made in writing and submitted to the Hospital's Health Information Management office or contact person for the medical groups that have the record you want to amend and you must provide a reason that supports your request. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information: (1) not created by the Hospital or medical groups, unless you provide us with information that the person or entity who created the information is no longer available to make the amendment; (2) not part of the information kept by or for our facility; (3) not part of the information which you would be permitted to inspect and copy; or is accurate and complete. If we deny your request for amendment, you have the right to submit a written statement of disagreement about any item or statement in your record that you believe is incomplete or incorrect. We will include your written statement of disagreement or a summary of this information with any subsequent disclosure of your medical information. If you clearly indicate in writing that you want your request for amendment and our response to be part of your/your child's medical information, we will include this information or a summary of this information with any subsequent disclosure of your/your child's medical information.
  5. Obtain an accounting of disclosures of your/your child's medical information. You have the right to request a list of the disclosures we made of medical information about you/your child other than for
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treatment, payment or health care operations or as authorized by you or by law. To request this list or accounting of disclosures from the Hospital or one of the medical groups listed on this notice, you must submit your request in writing to the Hospital's Health Information Management office. Your request must state a time period, which may not be longer than six years prior to the request and may not include dates before April 14, 2003. The first list requested within a 12 month period is free. For additional lists within a 12 month period, we may charge you for the costs of providing the list. We will notify you in advance of the cost and provide you with an opportunity to withdraw or change your request.

We will notify you automatically following a breach of your/your child's unsecured medical information.

6. Request confidential communication by alternative means or locations. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Hospital's Health Information Management office or contact person of the medical groups. We will not ask you the reason for your request and will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
7. Restrict certain disclosures of medical information to a health plan when you pay out of pocket in full for the health care item or service, except as required by law.

### **MINORS AND PERSONAL REPRESENTATIVES**

In most situations, parents, guardians and/or others with legal responsibilities for minors (children under 18 years of age) may exercise the rights described in this Notice on behalf of the minor. However, there are situations in which minors independently may exercise the rights described in this Notice. Upon request, we will provide you with additional information on the minor's rights under state law.

### **CHANGES TO THIS NOTICE**

We reserve the right to change the terms of this notice and to make the revised terms effective for medical information we already have about you/your child as well as any information we receive in the future. A copy of the current notice will be posted at the Hospital, hospital sites and medical offices and on our Web sites. This notice will also be available at the registration area of the Hospital or medical offices.

### **COMPLAINTS**

If you believe your/your child's privacy rights have been violated, you may file a complaint with the Hospital or the medical groups by calling the Customer Service Center at 858-966-4950. Your/your child's care and treatment will not be affected and you will not be penalized for filing a complaint. You also have the right to complain to the Secretary of the United States Department of Health and Human Services.