TRI-CITY HealthCenter
Our Community. Your Health.

REGISTRATION FORM

MR#: ______

*Please print all information

PATIENT INFORMATION

Last Name: ______ First Name: ______ M. Initial: ______

Social Security#: ______ Birthdate: ______

Gender:
- ☐ Male
- ☐ Female
- ☐ Transgender Male / Female - to- Male
- ☐ Transgender Female / Male -to- Female
- ☐ Other
- ☐ Chose not to disclose

Sexual Orientation:
- ☐ Lesbian or Gay
- ☐ Straight (not lesbian or gay)
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know
- ☐ Chose not to disclose

Home Address: ______ City: ______ Zip Code: ______

Home Phone: ______ Cell Phone: ______ Work Phone: ______

Email Address: ______ Specify preferred contact method Such as Home Phone, Cell Phone, Work Phone, or Email ______

Interpreter needed/Language Barrier: Yes ☐ No ☐ If yes, what language? ______
Is the patient a minor, (<18): Yes ☐ No ☐

Marital Status: ______ Mother's Maiden Name: ______

EMERGENCY CONTACT

First Name: ______ Primary Phone: ______

Relationship to Patient: ______ Address: ______

Ethnicity

- ☐ Afghani
- ☐ African
- ☐ American
- ☐ Asian
- ☐ East Indian
- ☐ European
- ☐ Filipino
- ☐ Hawaiian Native
- ☐ Hispanic/Latino
- ☐ Indochinese
- ☐ Middle Eastern
- ☐ Native American
- ☐ Pakistani
- ☐ Pacific Islander
- ☐ Undeclared
- ☐ Other / Specify Below:

____
____
____

Race

- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific islander
- ☐ African American / Black
- ☐ American Indian / Alaska native
- ☐ White
- ☐ More than one race
- ☐ Unreported/Refuse to report race

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REGISTRATION FORM

HOW DID YOU HEAR ABOUT US?

- ☐ A Better Way
- ☐ Advertisement (Bus, Mall, Movie)
- ☐ Flyer / Postcard / Poster
- ☐ Health Fair
- ☐ Newspaper / TV
- ☐ Other Unknown
- ☐ Outreach
- ☐ Presentation by TCHC Staff
- ☐ Radio
- ☐ Referral from Other Agency
- ☐ Street medicine
- ☐ Teen Clinic Cards
- ☐ Web Search
- ☐ Website / Online
- ☐ Word of Mouth
- ☐ Yellow Pages

EMPLOYMENT

Employer: ____________ Employer Address: ____________

Employer Phone: ____________ Occupation: ____________

MONTHLY INCOME

Is the Patient the Head of the Household: Yes ☐ No ☐ Head of the Household Name: ____________

Monthly Income: $ ____________ Family Size: ______ Head of the Household Birthday: ____________

Homeless Status:
- ☐ Doubling up
- ☐ Not Homeless
- ☐ Shelter
- ☐ Street
- ☐ Transitional
- ☐ Unknown/unreported

Are you a resident of Public Housing? Yes ☐ No ☐

Are you a Migrant Worker? Yes ☐ No ☐

Veteran: Yes ☐ No ☐

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Authorization to Release Medical Information

You are authorizing the disclosure of your personal information, which may include health information, to persons or organizations outside of Tri-City Health Center (TCHC). Your privacy is protected by state and federal privacy laws. As such, we need your explicit permission to make the requested disclosure. Please complete each section of this form.

Patient Name: ______________________________ Date of Birth: ____________________

Address: ____

City: _______________________________ State: ___________ Zip Code: ______________

Telephone: (____) ___________________ Email: ___________________________________

I authorize the following person(s) to have access to my medical records. Check all that apply.

☐ Spouse / Partner: ____

☐ Children: ____

☐ Representative: ____

☐ Other: _____________________________________ Relation to Patient: ______________

I give permission for my medical provider to:

- ☐ Share test results
- ☐ Share my medical condition
- ☐ Discuss or send messages about appointments

I understand that to insure that privacy is maintained, Tri-City Health Center will be verifying the identity of the person(s) who has access to my medical records and information.

I understand that information disclosed to any of the above person(s) is no longer protected by federal or state law and may be subject to disclosure by the above named person(s).

I understand I have the right to revoke this authorization at any time. I have the right to revoke this consent in writing.

Signature: ____ Date: ___________________

LABEL

TRI-CITY HealthCenter
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ADULT HEALTH HISTORY QUESTIONNAIRE

Reason for Visit: List in order of importance to you	**Medicines:** List all meds, herbs, vitamins, nutritional supplements	**Allergies:** List any allergies to medications and/or foods

Past Medical History:

Do you have, or have you ever had in the past, any of the following conditions? Check (✓) YES or NO; no straight lines please. Complete both columns.

	NO	YES	COMMENTS		NO	YES	COMMENTS
High blood pressure				Kidney / Urine problems			
High cholesterol				Stroke			
Diabetes				Cancer			Specify:
Heart problem Chest pain				Prostate problems			
Thyroid problems				Arthritis / Joint problems			
Lung problems / asthma				Back problems			
Breast problems				Serious injuries			
Eye / visual problems			△ Corrective lenses	Severe headaches			
Ear / hearing problems				Convulsions / seizures			
Seasonal allergies				Anxiety / nervousness			
Stomach problems / ulcers				Blood clots (leg / lung)			
Hepatitis / liver problems				Skin problems			
Bowel problems / colon polyp				Depression			
Hemorrhoids				Other issues (please list)			
Anemia / blood problems				Surgeries			
Blood transfusions							

Surgeries and Hospitalizations:

YEAR	ILLNESS / INJURY / SURGERY	HOSPITAL

Females Only

Age of first period?
First day of last NORMAL period (LNMP):
Length of cycle? ______ Days of flow? _____
Periods are: ☐ Regular ☐ Irregular
Maximum # pads / tampons used in 1 hour? ______
Menstrual cramps: ☐ None ☐ Mild ☐ Moderate ☐ Severe
Date of last Pap Smear: __________ Was it normal? ☐ Yes ☐ No
No
Ever had an abnormal Pap Smear? ☐ Yes ☐ No
Date of last Mammogram: ___________
Was it normal? ☐ Yes ☐ No
Did your mother take DEC (a hormone) when she was pregnant with you?
☐ Yes ☐ No ☐Unknown

Reproductive History

Have you ever been pregnant? ☐ No ☐ Yes
Total number of pregnancies: ______
a) # live births: d) # still births:
b) # full term: e) # miscarriages / abortions:
c) # premature: f) # ectopic / tubal pregnancies:

Last Delivery Date: _____ Any problems? ☐ Yes ☐

Number of children living? ______
Are you breastfeeding now? ☐ Yes ☐ No

Symptoms

Do you currently have any of the following symptoms? Please complete BOTH columns.
Check (✓) YES or NO; no straight lines please. Complete both columns.

	NO (-)	YES (✓)	COMMENTS		NO (-)	YES (✓)	COMMENTS
Unusual heartbeat				Problems / pain with sex			
Chest pains				Trouble sleeping			
Night sweats				Little interest / pleasure doing things?			
Trouble breathing				Feeling down, depressed, hopeless?			
Frequent cough				Very often feel moody, agitated			
Indigestion				Overwhelmed			
Constipation / diarrhea							
Trouble with urination							
Blood in stools / rectum							
Unusual weight gain/ loss							
Lightheaded / dizzy / faint abdominal pain							
Female-hot flashes							

Has anyone hurt or abused you? ☐ Never ☐ Recently ☐ In the past

If yes, how? ☐ Physically ☐ Mentally ☐Sexually ☐ Verbal

Do you currently feel sale at home? ☐ Yes ☐ No ☐ Sometimes

Have you ever been placed in a girls / boys home, foster home, group home? ☐ Yes ☐ No History of domestic violence? ☐ Yes ☐ No

Have you ever been convicted of a sexual offense? ☐ Yes ☐ No

Family History:

Have any of your family / blood relatives ever had any of the following conditions? Complete BOTH columns.

	NO (-)	YES (✓)	COMMENTS		NO (-)	YES (✓)	COMMENTS
High blood pressure				Gastrointestinal problem			
Diabetes or high sugar				Hepatitis / liver problem			
Heart problems				Alcohol / drug problem			
Stroke				Psychiatric / emotional problem			
Cancer				Inherited disorders			
TB or lung problems				Thalassemia or sickle cell			
Kidney or urine problems				Any other problems in the family?			

Habits

Do you need assistance for *daily activities?* ☐ No ☐ Yes If yes, please check from the following needs:
☐ Cooking ☐ Grocery Shopping ☐ Dressing ☐ Bed ☐ Using toilet ☐ Getting up from chair ☐Taking medication

Do you *now* use, **or have you ever used,** the following:
Tobacco ☐ Yes ☐ No Type? ____________ # Packs/day: ______ # years ______ Age started: ______ years
Alcohol Use: Age started: ____ years. Sought treatment for alcohol abuse: ☐ Yes ☐ No
Involved in rehabilitation program i.e., 12 step program? ☐ Yes ☐ No Family history of alcoholism: ☐ Yes ☐ No

Drug Use / Abuse
Use drugs? ☐ Yes ☐ No ☐ Formerly Type of drug? ____________________ Frequency _______________
Type of drug? ____________________ Frequency _______________
Type of drug? ____________________ Frequency _______________
Sought treatment for drug abuse: ☐ Yes ☐ No
Involved in a rehabilitation program i.e., 12 step program ☐ Yes ☐ No
Family history of drug abuse: ☐ Yes ☐ No

Sexual History

☐ No sexual experience ever before ☐ Virgin (no previous intercourse) ☐ Not sexually active at this time
☐ Sexually active with (check all that apply): ☐ Men ☐ Women ☐Both
Number of current partners: ______ Number of lifetime partners: ______
Most recent sexual relations was ______ days / months / years ago
Practice safe sex: ☐ Yes ☐ No ☐ Sometimes Most recent unprotected encounter: ______ weeks / months / years ago

Does your sexual partner have other sexual partners? ☐ No ☐ Yes ☐ I don't know / maybe

Have you had a sexual partner who has sex with: ☐ an IV drug user ☐prostitute / paid for sex ☐ person of the same sex

Have you OR your sexual partner(s) had any infections related to sex? ☐ No ☐ Yes (If yes., please specify):

History of STI's: ☐ Chlamydia ☐ Gonorrhea ☐ Genital warts ☐ Herpes ☐ Other (specify):

Birth Control Methods

How important is it for you to avoid pregnancy now? ☐ Very ☐ Somewhat ☐ Not at all

Are you and/or your partner panning to get pregnant in the next two years? ☐ Yes ☐ No ☐ Maybe

Would you like any information on how to plan for a healthy pregnancy? ☐ Yes ☐ No

What method of birth control are you using currently? ☐ None ☐ Condoms ☐ Pills ☐ Injection ☐ IUD ☐ tubal ligation ☐ Other:

Have any birth control methods cause you problems? ☐ No ☐ Yes, explain:

What birth control method have you used in the past? (Check all that apply)
Men answer the first line, women any that apply.

☐None ☐ Abstinence ☐ Rhythm method ☐ Withdrawal ☐ Condom ☐ Vasectomy

☐Pill ☐ Patch ☐ DMPA (Depo) ☐ Norplant ☐ Diaphragm ☐ IUD
☐Tubal Ligation ☐ Foam / vaginal insert ☐ Other (specify): _________________

Exercise

Do you exercise regularly? ☐ No ☐ Yes If yes, what type? _________________ How many minutes per session? ____________

Diet

Do you have, or have you ever had, an eating disorder or special eating problems? ☐ No ☐ Yes, explain

Current Dietary Intake:	**High**	**Medium**	**Low**	**Comments:**
Fat	☐	☐	☐	
Fiber (Fruit / Vegetables)	☐	☐	☐	
Caffeine	☐	☐	☐	
Salt	☐	☐	☐	
Sugar	☐	☐	☐	
Water / Fluids	☐	☐	☐	

Immunizations & Tests

What vaccinations do you know you have received in the past *as an adult or child?* (Please check)

☐ Td / Tetanus ☐ Polio ☐ MMR ☐ Rubella ☐ Pneumovax
☐ Influenza ☐ Hepatitis A ☐ Hepatitis B ☐ Varicella
☐ Check here if you received your childhood vaccinations in the U.S.
☐ Check here if you have NOT had any vaccinations

Most recent TB skin test? ________________

Have you ever had a positive TB skin test? ☐ No ☐ Yes If yes, Chest x-ray result: ☐ Normal ☐ Abnormal
Have you ever been treated for TB? ☐ No ☐ Yes
If yes, please answer the following:
Date of treatment: ______________________ Name of medication: ____________________ Length of treatment: ______ months

LABEL

Consent for General Medical Services

I, ____, give my consent to Tri-City Health Center for any diagnostic procedures or medical treatment, including immunizations, considered to be necessary by the physician, nurse practitioner, physician assistant, or other medical providers of the clinic.

I authorize my insurance benefit to be paid directly to Tri-City Health Center. I understand I will be responsible for any services that are not covered under my insurance benefit.

I also authorize the release of any information necessary in the processing of any claims.

____ ____________________
Print Name of Patient Date

____
Signature

If you are parent or legal guardian of patient

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I acknowledge that I have received a copy of Tri-City Health Center's Notice of Privacy Practices.

Reconozco que recibi una copia del Aviso sobre las Practicas de Privacidad del Centro Medico Tri-City Health Center.

我承认我已收到三城健康中心隐私条例通知书.

ਮੈਂ ਇਹ ਸਵੀਕਾਰ ਕਰਦਾ / ਕਰਦੀ ਹਾਂ ਕਿ ਮੈਨੂੰ ਟ੍ਰਾਈ-ਸਿਟੀ ਹੈਲਥ ਸੈਂਟਰ ਦੀ ਨਿਜਤਾ ਪ੍ਰੈਕਟਿਸਾਂ ਦੇ ਨੋਟਿਸ ਦੀ ਇੱਕ ਕਾਪੀ ਮਿਲੀ ਹੈ.

मैं स्वीकार करता हूं कि मुझे त्रि-सिटी हेल्थ सेंटर की **निजता** प्रथाओं के नोटिस की एक कॉपी प्राप्त हुई है।.

Tôi thừa nhận rằng tôi đã nhận được một bản sao của Thông báo về Thực tiễn Bảo mật Cá nhân của Tri-City Health Center.

من اذعان می کنم که من یک کپی از اعلامیه های حریم خصوصی مراکز بهداشتی سه شهره دریافت کرده ام.

_______________________________ _______________________
Signature Date

_______________________________ _______________________
Print Name Relationship to patient

Comments:

____
____
____

Effective Date: April 14, 2003

TRI-CITY HEALTH CENTER
NOTICE OF PRIVACY PRACTICES

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

This notice contains a summary of our health information privacy practices and of your rights relating to your health information. In the absence of an express statement to the contrary, this notice is not intended to preclude or restrict uses or disclosures of health information that are otherwise permitted by law, or to give you rights that we are not required by law to give.

If you have any questions about this notice, please contact the privacy officer at 510.770.8133 ext. 290.

Who Will Follow This Notice:

This notice describes our health center's practices and that of:

- All employees, staff, and other health center personnel.
- All departments and units of the health center.
- Any independent health care professional who provides services to you within our facilities
- Any member of a volunteer group we allow to help you while you are in the health center.

All these individuals, sites and locations follow the terms of this notice. In addition, these individuals, sites and locations may share medical information with each other for treatment, payment, or health center operations purposes described in this notice.

Our Pledge Regarding Medical Information:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the health center. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all records of your care maintained by the health center; whether made by the health center personnel or your personal doctor.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of this notice, as currently in effect.

How we May Use and Disclose Medical Information about You:

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and try to give examples. Not every use or disclosure in a category will be listed.

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 health center personnel who are involved in taking care of you at the health center. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the health center also may share medical information about you in order to coordinate the different services you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the health center who may be involved in your medical care after you leave the health center, such as family members, social service agencies, health care facilities, and providers that we use to provide services for part of your care.

For Payment: We may use and disclose medical information about you to bill and collect payment from you or another source, such as an insurance company or a relative who has financial responsibility for you. For example, we may need to give your health plan information about medical care you received at the health center so your health plan will pay us or reimburse you for the medical care. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose medical information about you for health center operations, and in limited circumstances, to enable the recipient of the information to carry out this operations. These uses and disclosures are necessary to run the health center and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many health center patients to decide what additional services the health center should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other health center personnel for review and learning purposes.

Quality of Care Improvement Activities We may use and disclose medical information about your for reviews of the quality of care we are providing. For example, our health center works with the Community Health Center Network, a local group who has reviewed the quality of diabetes care being provided to patients in our area.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the health center.

Treatment Alternatives: We may use and disclose medical information to tell you about our recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose medical information to tell you about health-related benefits of services that we provide and may be of interest to you.

Fundraising Activities: We may use medical information about you to contact you in an effort to raise money for the health center and its operation. We may disclose medical information to a foundation related to the health center so that the foundation may contact you in raising money for the health center. We would only release contact information, such as name, address and phone number. If you do not want the health center to contact you for fundraising efforts, you must notify the privacy officer in writing.

Payment for Your Care: We may also give information to someone who helps pay for your care.

Contractors: We may disclose your health information to our contractors who assist us with our operations. Our contractors agree in writing to keep the health information provided to them confidential and secure, and not to use it except to assist us.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. Where feasible, research information will not include information that could identify you as an individual. If research project can identify you, those projects are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we disclose medical information for research, the project will have been approved through this research approval process.

As Requested by Law: We will disclose medical information about you when required to do so by federal, state, or local law.

For Public Health Activities: We may disclose health information about you for public health purposes, if we are required or permitted to do so by law. The following are examples of circumstances in which we may be mandated or permitted by law to make a report:

- To prevent or control disease, injury or disability;
- To report births and deaths;

- To report the abuse or neglect of children, elders, and dependent adults;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To public health registries such as breast cancer registry;
- 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, and;
- To notify the appropriate authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

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

Special Situations

In addition to the practices described above, there are other situations in which we may be required or permitted to disclose our patients' health information. These include the following:

Disasters: We may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

Organ and Tissue Donation: If you are an organ donor or a prospective donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces or a veteran, we may release medical information about you as required by military command authorities or to assist in determining your eligibility for veteran's benefits. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Health Oversight Activities: We may disclose information to a health oversight agency for activities authorized by law. These oversight activities include, for example, Medi-Cal audits,

investigations of Medicare claims, inspections, and licensure. We may disclose to these government programs, with compliance to civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you).

Law Enforcement: We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons, or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the health center; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the health center to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. We may also disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary; (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

De-Identified Information: We may remove information that identifies you from your health information, so others may use it without learning who you are. Once your health information has been de-identified, we may use or disclose it.

Limitations: In some circumstances, your health information may be subject to restrictions that may limit or preclude some uses or disclosures described above. For example, government health benefit programs may limit the disclosure of members' health information for purposes unrelated to the program. In addition there are special restrictions on the disclosure of health information relating to HIV/AIDS status, mental health treatment, developmental disabilities, and drug and alcohol abuse treatment. We comply with these restrictions in our use of your health information.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but may not include some mental health information. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the medical record department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain and very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed eHealth care professional chosen by the health center will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the health center.

To request an amendment, your request must be made in writing and submitted to the medical record department. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment 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 that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the health center;

- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of disclosures we made of medical information about you other than your own uses for treatment, payment and health care operations, and disclosure you have authorized.

To request this list of accounting of disclosures, you must submit your request in writing to the medical record department. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a test you 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 you emergency treatment.

To request restrictions, you must make your request in writing to the privacy officer. In your request you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply; For example disclosures to your spouse.

Right to Request Confidential Communications: 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 at the time of registration. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the 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 have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Changes to This Notice: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for all medical information we already have about you as well as any

information we receive in the future. We will post a copy of the current notice in the health center. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the health center or with the Secretary of the Department of Health and Human Services. To file a complaint with the health center, contact the privacy officer at **510-770-5133 ext. 290.** All complaints must be submitted in writing.

We will not retaliate against you for filing a complaint.

Other uses and disclosures of medical information not covered by this notice or otherwise permitted by the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose medical information about you, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are not able to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

Advanced Health Care Directive (AHCD)?
An AHCD is a way to make your health care wishes known if you are unable to speak for yourself or prefer someone else to speak for you. An AHCD can serve one or both of these functions:

- Power of Attorney for Health Care (to appoint an agent)
- Instructions for Health Care (to indicate your wishes)

Is the AHCD different from a Durable Power of Attorney for Health Care (DPAHC)?
The AHCD was enacted by July 2000 legislation and replaced the DPAHC and the Natural Death Act Declaration. However, if you ha already completed one of these forms that was valid before July 1, 2000, it is still valid now. The only advanced directive form that didn't change was the Pre-Hospital Do-Not-Resuscitate form.

"Pre-Hospital Do-Not Resuscitate form?" Never heard of it!
The special form allows persons to indicate that they do not want CPR started if something happens to them outside a hospital. Normally, emergency medical personnel are required to start CPR for all persons; having this form protects people from CPR if they choose to forego it. This is the only form that must be signed in advance by your doctor.

I've never completed an "advanced health care directive" before. Why should I?
Persons of all ages may unexpectedly be in a position where they cannot speak for themselves, such as an accident or severe illness. In these situations, having an "advanced health care directive" assures that your doctor knows your wishes about the kind of care you want and/or who the person is that you want to make decisions on your behalf.

Does this mean only one person can decide for me? What if I want others involved too?
Often many family members are involved in decision-making, and most of the time that works well. But occasionally, people will disagree about best course of action, so it is usually best to name just one person as the agent (with a back up, if you want). You can also indicate if there is someone who you do NOT want to make your decisions for you.

But I though the doctors make all those life-and-death decisions anyway?
Actually, doctors tell you about your medical condition, the different treatment options that are available to you and what may happen with each type of treatment. Through doctors provide guidance, the decision to have a treatment, refuse a treatment or stop a treatment is yours.

What if something happens to me and no form has been completed?
If you are not able to speak for yourself, the doctor and health care team will turn to one or more family members or friends. The most appropriate decision-maker is the one with a close, caring relationship with you, is aware of your values and beliefs and is willing and able to make the needed decision.

My "values and beliefs?" But I haven't talked with anyone about these!
That is a good idea to talk with family or close friends about the things that are important to you regarding quality of life and how you would want to spend your last days and weeks. Knowing the things that are important to you will help your loved ones make the best decision.