

Patient Information: <i>Last Name</i>		<i>First Name</i>		<i>Social Security No.</i>	
<i>Physical Address</i>		<i>City</i>	<i>State</i>	<i>Zip</i>	<i>County</i>
<i>Mailing Address</i>		<i>City</i>	<i>State</i>	<i>Zip</i>	<i>County</i>
<i>Home Phone</i>	<i>Cell Phone</i>	<i>Email Address</i>		<i>Date of Birth</i>	
Household Size	Head of Household Name	Income Level	<input type="checkbox"/> Monthly <input type="checkbox"/> Annual		

Primary Insurance	ID #	Group #	Name of Insured Party		
Responsible Party: <i>Last Name</i>		<i>First Name</i>		<i>Social Security No.</i>	
<i>Physical Address</i>		<i>City</i>	<i>State</i>	<i>Zip</i>	<i>County</i>
<i>Mailing Address</i>		<i>City</i>	<i>State</i>	<i>Zip</i>	<i>County</i>
<i>Home Phone</i>	<i>Work Phone</i>	<i>Email Address</i>		<i>Date of Birth</i>	
<i>Employer Name</i>		<i>Employer Address</i>			
Relationship to Responsible Party		Marital Status		Primary Language	
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		_____	

Race <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White	Are you Hispanic/Latino? <input type="checkbox"/> YES <input type="checkbox"/> NO Are you a veteran? <input type="checkbox"/> YES <input type="checkbox"/> NO Do you smoke? <input type="checkbox"/> YES <input type="checkbox"/> NO	Pharmacy Information Medication Allergies <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please list: _____ _____
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Some of the following questions may be uncomfortable for you to answer; however, your honest responses will assist Desert Senita in providing the best services for you as an individual. By answering the following questions, you will help us to qualify the resources that support the services we provide for you.

Sexual Orientation: <input type="checkbox"/> Lesbian/Gay/Homosexual <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Something Else/Other <input type="checkbox"/> Don't Know/Questioning <input type="checkbox"/> Choose Not To Disclose	Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other/Gender Variant/Inter-sex <input type="checkbox"/> Transgender Male/Female-to-Male <input type="checkbox"/> Transgender Female/Male-to-Female <input type="checkbox"/> Choose Not To Disclose	Sex Assigned At Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Choose Not To Disclose
What pronoun do you prefer to be addressed by? <input type="checkbox"/> She/Her <input type="checkbox"/> He/Him <input type="checkbox"/> They <input type="checkbox"/> Zie/Hir <input type="checkbox"/> Other: _____		

Emergency Contact: <i>Name</i>	<i>Relationship</i>	<i>Home Phone</i>	<i>Work Phone</i>
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AUTHORIZATION AND ASSIGNMENT
 I voluntarily consent to outpatient care with Desert Senita Community Health Center and/or Dental Center (DSCHC/DSDC), encompassing routine, minor surgical, diagnostic and/or dental procedures. I understand the insurance company I have listed above will be billed for my services. I assign claim payments from the insurance company to be made payable to DSCHC and/or DSDC. I understand that all services may not be covered and I will be financially responsible for balances not covered by my insurance. I understand that any overpayment on my account will be refunded in a timely manner. The attending provider (Doctor, Certified Physician's Assistant, Advanced Registered Nurse Practitioner or Dentist) may disclose any necessary information to Medicare, Medicaid and any third party payer. This authorization and assignment may be revoked by me at any time by written notice.

Signature _____	Date _____
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Patient Name _____ Social Security # _____
 Address _____ Medical Record # _____
 City _____ State _____ Zip _____ Date of Birth _____ M / F _____ Marital Status _____
 Occupation/Employer _____
 Phone #: _____ Work Phone #: _____
 Insurance Name: _____ ID# _____ Group # _____ Phone #: _____

Hospital Admissions and Chronic illnesses:

Year	Illness or Operation	Year	Illness or Operation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Vaccine	Year of Last	Vaccine	Year of Last	Test/Exam	Year of Last	Test/Exam	Year of Last
Tetanus/Td	_____	Hepatitis A	_____	PSA	_____	Dental	_____
Rectal/Stool	_____	TB Skin Test	_____	Colonoscopy	_____	Eye	_____
Influenza (flu)	_____	Hepatitis B	_____	Cholesterol	_____	Other	_____
Pneumonia	_____	Other	_____				

List all medications you are currently taking: (Please include any over the counter medication, vitamins, or herbal supplements)

List Allergies:

Medical History: (Please check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Decreased hearing | <input type="checkbox"/> Sexually transmitted diseases | <input type="checkbox"/> Stress incontinence - urine leakage with exercise / movement |
| <input type="checkbox"/> Ringing in ear | <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Ear infections – frequent | <input type="checkbox"/> Weight-loss | <input type="checkbox"/> Urine infections – frequent |
| <input type="checkbox"/> Dizzy spells <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Anemia | <input type="checkbox"/> Please fill in daily amount |
| <input type="checkbox"/> Failing vision <input type="checkbox"/> Eye pain | <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Alcohol _____ <input type="checkbox"/> Coffee _____ |
| <input type="checkbox"/> Double or blurred vision | <input type="checkbox"/> Cancer | <input type="checkbox"/> Smoking _____ packs per day _____ years |
| <input type="checkbox"/> Nose bleeds - recurrent | <input type="checkbox"/> Diabetes | <input type="checkbox"/> years quit _____ |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Seizures | <input type="checkbox"/> Exercise _____ |
| <input type="checkbox"/> Sore throats - frequent | <input type="checkbox"/> Tremor / hands shaking | <input type="checkbox"/> Street Drugs _____ |
| <input type="checkbox"/> Hoarseness - prolonged | <input type="checkbox"/> Numbness / tingling sensations | <input type="checkbox"/> Tattoos <input type="checkbox"/> Piercing |
| <input type="checkbox"/> Hay fever / allergies | <input type="checkbox"/> Headaches – frequent | <input type="checkbox"/> Hair loss <input type="checkbox"/> Progressive <input type="checkbox"/> Recent |
| <input type="checkbox"/> Pneumonia / pleurisy | <input type="checkbox"/> Arthritis / Rheumatism | Females - Please complete |
| <input type="checkbox"/> Bronchitis / chronic cough | <input type="checkbox"/> Back pain – recurrent | Menstrual flow: |
| <input type="checkbox"/> Asthma / Wheezing | <input type="checkbox"/> Bone fracture / joint injury | <input type="checkbox"/> Reg <input type="checkbox"/> Irreg <input type="checkbox"/> Pain / Cramps |
| <input type="checkbox"/> Shortness of breath: | <input type="checkbox"/> Osteoporosis | Days of flow _____ length of cycle _____ |
| <input type="checkbox"/> On exertion <input type="checkbox"/> Lying flat | <input type="checkbox"/> Foot pain | <input type="checkbox"/> Pain / bleeding during or after sex |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Rashes | Number of pregnancies: |
| <input type="checkbox"/> Heart murmur <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Pregnancies _____ <input type="checkbox"/> Abortions _____ |
| <input type="checkbox"/> Irregular pulse <input type="checkbox"/> Palpitations | <input type="checkbox"/> Sleeping or concentration difficulty | <input type="checkbox"/> Miscarriages _____ <input type="checkbox"/> Live births _____ |
| <input type="checkbox"/> Leg pain - when walking | <input type="checkbox"/> Depression | Birth control method: _____ |
| <input type="checkbox"/> Varicose veins / phlebitis | <input type="checkbox"/> Agitation | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Cold numb feet | <input type="checkbox"/> Moodiness | <input type="checkbox"/> Menopause onset _____ |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Phobias | <input type="checkbox"/> Date of last PAP test _____ |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Feelings of worthlessness | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> Heartburn <input type="checkbox"/> Peptic ulcer | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Breast exam |
| <input type="checkbox"/> Abdominal pain - chronic | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Self breast exam teaching |
| <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Measles | Date of last Mammogram _____ |
| <input type="checkbox"/> Jaundice <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Hepatitis A, B, C or other | |

- Diarrhea Constipation
- Diverticulitis Crohn's / Colitis
- Bloody or tarry stools
- Hemorrhoids Hernia
- Victim of abuse

- Urination Problems**
- Overnight > than twice
 - More than 8 times / 24 hours
 - Urgency to urinate - with leakage
 - Decrease in force / flow - painful

- Normal Abnormal
- Males - Please complete
- Last testicular exam _____
 - Self testicular exam teaching
 - Penile discharge

Family History: Place the relationship of the family member on the line to the right of the medical term.

- | | | | |
|--------------------------|-------------------------|-------------------------|------------------------|
| 1. Epilepsy _____ | 7. Hay fever _____ | 13. Heart disease _____ | 19. Cancer(type) _____ |
| 2. Migraine _____ | 8. Asthma _____ | 14. Stroke _____ | 20. Alzheimer's _____ |
| 3. Mental Illness _____ | 9. Anemia _____ | 15. Hypertension _____ | 21. Lupus _____ |
| 4. Glaucoma _____ | 10. Bleeds easily _____ | 16. Cholesterol _____ | 22. Other _____ |
| 5. Diabetes _____ | 11. Osteoporosis _____ | 17. Alcoholism _____ | |
| 6. Thyroid disease _____ | 12. Arthritis _____ | 18. Hepatitis _____ | |

Please add any additional information that will help your provider with your medical treatment.

Please circle one

Do you have a Living Will?YES NO

Would you like information on Living Will?YES NO

Provider Signature _____ Date _____

Provider Signature _____ Date _____

Provider Signature _____ Date _____

Patient Signature _____ Date _____

Provider Signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices
Acknowledgement of Receipt of Health Information Practices

I have received a copy of the **Notice of Privacy Practices** and **Notice of Health Information Practices** from Desert Senita Community Health Center.

Printed Patient Name: _____ DOB: _____

X _____ Date _____
(Patient/Guardian Signature)

OR

In lieu of patient signature, I, _____,
(Printed Employee Name)

employee of Desert Senita Community Health Center, state that

(Printed Patient/Guardian Name)

has been given a current **Notice of Privacy Practices** and **Health Information Practices**.

X _____ Date _____
(Employee Signature)

Patient Rights and Responsibilities

As a patient you have the right to:

- To be treated with respect, dignity, and consideration including the recognition of personal beliefs and values.
- To receive care in a setting and environment committed to patient safety.
- To privacy and confidentiality.
- To coordination and continuity of your healthcare.
- To know the identity of providers, nurses and others involved in your care.
- To information presented in terms you can understand, including treatment and care options.
- To be involved in decisions regarding your health care plan.
- To reasonable access to healthcare.
- To access health care records according to the health center's policy and procedure.
- To be heard if problems, complaints or grievances arise and not be subjected to retaliation.
- To be informed of charges for services as well as payment options.
- To change your provider if other qualified providers are available.
- To not be subjected to abuse, neglect, exploitation, coercion, manipulation, sexual abuse, sexual assault, or restraint or seclusion (except as allowed in AZDHS Rule R9-10-1012(B)).
- To not be subjected to misappropriation of personal and private property by personnel members, employees, volunteers, or students.

As a patient you have the responsibility to:

- To provide complete medical information to your health care providers and report any changes in your health.
- To ask questions so that you have a clear understanding.
- To make informed decisions.
- To understand your health problems and follow agreed upon plans and instructions for your care.
- To recognize the impact of your lifestyle choices on your personal health.
- To keep scheduled appointments, reschedule in a timely manner or cancel your appointment within 24 hours of appointment time.
- To respect the rights, privacy and confidentiality of other patients and clinic personnel.
- To accept financial obligations and understand your health insurance benefits.
- To inform your provider about any living will, medical power of attorney or other directive that could affect your care.
- To be photographed one time and have that photo placed in your chart for identification purposes OR:
- To be prepared to show photo identification at each visit for patients 18 years or older.

Patient Signature

Date

Your signature indicates you have received a copy of your rights/responsibilities.

PRIVACY NOTICE

(THIS NOTICE DESCRIBES HOW MEDICAL, DENTAL, AND MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.) Effective date September 23, 2013 (Revised May 1, 2014)

PLEASE REVIEW CAREFULLY

WHO WILL FOLLOW THIS NOTICE

This notice describes the practices of Desert Senita Community Health Center (DSCHC) regarding the use of your health information and that of:

- any of our healthcare professionals authorized to enter information into your medical, dental or behavioral health record
- all departments and units of Desert Senita Community Health Center, any member of a volunteer/student group we allow to help you while you are in our facility
- all employees, contracted staff and other DSCHC personnel
- all affiliates, sites and locations of the Desert Senita Community Health Center will follow the terms of this notice. In addition, these affiliates, sites and
- locations may share health information with each other for the treatment, payment or health care purposes described in this notice.

OUR PLEDGE REGARDING YOUR HEALTH CARE INFORMATION

We understand that medical information about you and your health is personal. Protecting medical information about you is important. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated at Desert Senita Community Health Center whether made by health care professionals or other personnel.

This notice will tell you about the ways in which we may use and disclose healthcare information about you. Disclosure, as appropriate, may be verbal communication, electronic transmission, paper record, or by fax. We also describe your rights and certain obligations we have regarding the use and disclosure of healthcare information.

We are required by law to:

- Keep personal healthcare information private;
- Give you this notice of our legal duties and privacy practices with respect to your healthcare information; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTHCARE INFORMATION ABOUT YOU

The following are examples of the types of permitted uses and disclosures of your protected healthcare information. These examples are not meant to be all inclusive, but rather to describe the types of uses and disclosures that may be made by our office once you have provided consent.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

- **For Treatment** Information obtained by a nurse, provider, or other member of your healthcare team will be recorded in your healthcare record and used to determine the course of treatment that should work best for you. We may disclose your health information to others who will need this information in order to treat you, for example another DSCHC provider, nurse practitioners, pharmacists, or others involved in your care. We may also disclose your protected health information to another healthcare provider (e.g., a specialist or laboratory) who, at the request of your DSCHC provider, becomes involved in your care by providing assistance with our healthcare diagnosis or treatment.
- **For Payment** We may use and disclose your protected health information for billing and collection purposes. For example, we may need to give your 3rd party payor/Health Plan information about your care so that they will pay us or reimburse you for this

care. We may also provide information to your Health Plan or 3rd party payer about a treatment/service that has been ordered by your healthcare provider in order to obtain prior approval or to determine whether your plan will cover the treatment/service.

- **For Healthcare Operations.** We may use or disclose, as needed, your personal health information in order to support our business activities. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.

Other examples of healthcare operations might include:

- Use of a sign-in sheet at the front desk where you will be asked to sign your name.
- Calling you by name in the waiting room when your healthcare provider is ready to see you.
- We may contact you (by telephone or mail) to remind you about your appointment.

We will share your personal health information with 3rd party “business associates” that perform various activities for DSCHC. Whenever an arrangement between our office and a business associate involves the use or disclosure of your personal health information, we will have a written contract that contains terms that will protect the privacy of your health information. Some examples of our business associates would include X-ray interpretation services, contracted laboratory testing, medical transcription services, record copy service and record storage facilities.

II. OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT. We may use and disclose your personal health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your personal health information.

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object in advance, we may release protected health information about you to a friend or family member who is involved in your medical care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may also give information to someone who helps pay for your care. In addition, we may disclose personal health information about you to an authorized entity assisting with disaster relief efforts. We may allow family or friends to act on your behalf to pick up filled prescriptions, medical supplies, x-rays, and similar forms of personal health information, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.
- **Emergencies.** We may use or disclose your protected health information in an emergency treatment situation should you be unable to consent prior to treatment. If this happens, we shall try to obtain your consent as soon as reasonably practicable after the treatment. If we are required by law to treat you and are unable to obtain your consent, we may still use or disclose your protected health information to treat you.
- **Treatment Alternatives.** We may use or disclose your personal health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services, that are available from DSCHC, that may be of interest to you. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.
- **Fundraising Activities.** We may use or disclose your demographic information in order to contact you for fundraising activities supported by our clinic. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

III. OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT.

- **As Required By Law.** We will disclose your personal health information when required to do so by federal, state or local law.
- **Research.** We may disclose your personal health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your personal health information. For example, we may conduct a research project involving the review of healthcare records for all patients with specific types of medical conditions.
- **Public Health Risks.** We may disclose your personal health information for public health activities. These activities generally include the following:
 - To prevent or control disease, injury or disability
 - To report deaths
 - To report child abuse or neglect
 - To report reactions to medications or problems with products
 - To notify people about 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 authority if we believe a patient has been the victim of abuse, neglect or domestic violence
- **Worker’s Compensation.** We may release your personal health information for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Coroners, Funeral Directors, and Organ Donation.** We may release your personal health information to a coroner or medical examiner to assist with identifying the deceased or determining the cause of death. We may release your personal health information to a funeral director as necessary to carry out their duties. If you are an organ donor, we may release your personal

health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

- **Military and Veterans.** If you are a member of the armed forces, we may release your personal medical information as required by military command authorities.
- **Health Oversight Activities.** We may disclose your personal health information to a health oversight agency for activities authorized by law. Examples of oversight activities 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 laws.
- **Legal Proceedings.** We may release your personal health information in response to a subpoena, discovery request, or other lawful orders from a court or administrative tribunal (to the extent such disclosure is expressly authorized).
- **Law Enforcement.** We may release your health information if asked to do so by a law enforcement official as part of law enforcement activities; in investigations of criminal conduct or of victims of crime; in response to court orders; in emergency circumstances; or whenever required to do so by law.
- **Inmate.** We may use or disclose your personal health information if you are an inmate of a correctional facility and your healthcare provider created or received your personal health information in the course of providing care to you.
- **Protected Services for the President, National Security and Intelligence Activities.** We may release your personal health information to authorized federal officials so they may provide protection to the President, other authorized persons of foreign heads of state or conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law.

IV. USES AND DISCLOSURES OF PERSONAL HEALTH INFORMATION BASED UPON YOUR WRITTEN

AUTHORIZATION. Other uses and disclosures of your personal health 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 permission to use or disclose your personal health information, you may revoke this authorization, at any time, in writing. If you revoke your permission, thereafter we will no longer use or disclose your personal health information for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

Authorization is required for: most uses and disclosures of psychotherapy notes, uses and disclosures of Protected Health Information for marketing purposes, and disclosures that constitute a sale of Protected Health Information.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Although your healthcare record is the physical property of the Desert Senita Community Health Center, the information belongs to you. You have the following rights regarding the healthcare information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and obtain a copy of healthcare information that may be used to make decisions about your care. Usually, this includes medical, dental, prescription, and billing records, but does not include psychotherapy notes.
To inspect and obtain a copy of healthcare information that may be used to make decisions about you, you must submit a written request to our Medical Records 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 obtain a copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Desert Senita Community 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 the health 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. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. 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;
 - Is not part of the medical information kept by the Desert Senita Community 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 the disclosures we made of health information about you. To request this list or accounting of disclosures, you must submit your

request in writing to our Privacy Officer. Your request must state a time period that 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 personal health 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 personal health 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. We are not required to agree to your request, with one exception*. 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 our Privacy Officer at the address below. In your request, you must tell us:
 - What information you want to limit;
 - Whether you want to limit our use of your information, disclosure to outside entities or both; and
 - To whom you want the limits to apply.

* Exception: When you are paying for a service out of pocket and request we not provide it to the Health Plan, we must comply with the request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about health 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 our Privacy Officer. 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 at any time. You may request a copy of our most current privacy notice from our Registration Office or from the Privacy Officer.
- **Breach Notification.** A breach is, generally, an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the protected health information (PHI) such that the use or disclosure poses a significant risk of financial, reputational, or other harm to the affected individual. If a breach occurs, you will be notified the Breach occurred no later than 60 days after the occurrence.

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 health 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. The notice will contain the effective date at the top of the first page.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the Desert Senita Community Health Center or with the Secretary of the Department of Health and Human Services toll free at 1-877-696-6775. To file a complaint with the Desert Senita Community Health Center, contact our Privacy Officer at the address and phone number below. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

If you have any questions about this notice, please contact:
Desert Senita Community Health Center
Privacy Officer
410 Malacate Street
Ajo, Arizona 85321
(520) 387-5651

Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?

In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?

The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?

People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning, payment for your treatment, conducting quality assessment and improvement activities, developing clinical guidelines and protocols, conducting patient safety activities, and population health services. Medical examiners, public health authorities, organ procurement organizations, and others may also access health information for certain approved purposes, such as conducting death investigations, public health investigations and organ, eye or tissue donation and transplantation, as permitted by applicable law.

Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

You also may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.

Does Health Current receive behavioral health information and if so, who can access it? Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from some substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share these protected substance abuse treatment records it receives from these programs in twocases. One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?

Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not

authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing

You have the right to:

1. Ask for a copy of your health information that is available through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider.
2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.
3. Ask for a list of people who have viewed your information through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. Except as otherwise provided by state or federal law, you may “opt out” of having your information shared through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. Your information will not be available for sharing through Health Current within 30 days of Health Current receiving your Opt Out Form from your healthcare provider.
Caution: If you opt out, your health information will NOT be available to your healthcare providers—even in an emergency.
2. If you opt out today, you can change your mind at any time by completing an Opt Back In Form and returning it to your healthcare provider.
3. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.