Riverwood Medical Associates
PATIENT REGISTRATION

PATIENT INFORMATION:	**MRN:**	**ORG MRN**
Patient's Legal Name (Last, First, Middle):		
Date of Birth:	**Sex: M F**	**Social Security Number:**
Marital Status (*circle one*):	**Single Married Divorced Widowed Separated**	
Home Phone Number:		
Cell Phone Number:		
Street Address:		
City:	**State:**	**Zip:**
Email Address:		
Employer Information:		
Employer Name:		
Employer Address:		
Work Phone Number:		
City:	**State:**	**Zip:**
Parent/Guardian Name (if different):		
Date of Birth:	**Sex:**	**SSN:**
Street Address:		
City:	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Work Phone:**
Email Address:		
Employer Name:		
Employer Address:		
City:	**State:**	**Zip:**

Race: (Ancestral/Genetic Lineage with which you associate yourself) (*check appropriate box*)

□ **Black or African American** □ **Asian** □ **Caucasian**
□ **Hispanic/Latino** □ **Multi-Racial** □ **Native American**
□ **Other** □ **Unknown** □ **Decline**

Preferred Language: (*check appropriate box*)

□ **English** □ **Arabic** □ **Chinese** □ **French** □ **German** □ **Italian** □ **Japanese**
□ **Korean** □ **Portuguese** □ **Russian** □ **Spanish** □ **Vietnamese** □ **Sign Language**
□ **Other: _____**

Do we have permission to leave a voice message for routine matters such as appointments, pick-ups, and normal lab results:
□**Yes** □**No**

How would you prefer to receive appointment reminders? (Please choose one)
□ **Home Telephone** □ **Mobile Telephone** □ **Mobile Text**

□**Email_____**

PLEASE COMPLETE BACK OF FORM

EMERGENCY CONTACT:		
Name: (Last, First, Middle)	**Relationship to Patient:**	
Home Phone:	**Work Phone:**	**Cell Phone:**

Person Responsible for bill/co-payment:

Name: _____ Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Subscriber Name:	**Subscriber Name:**
Subscriber Date of Birth:	**Subscriber Date of Birth:**
Subscriber Social Security #:	**Subscriber Social Security #:**
Subscriber Employer:	**Subscriber Employer:**
Policy Number:	**Policy Number:**
Group Number:	**Group Number:**

Authorization, Assignment of Benefits, and Referral Medical Release:
I hereby consent to the treatment of _____ at Riverwood Medical Associates including diagnostic and other medical care that is deemed necessary. I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company and to other medical professionals and medical card institutions that I may be referred to for treatment. I understand that this information will be used to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution.
I authorize payment directly to Carolinas Physicians Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature: _____ Date: _____

For Office Use Only:

Date Entered: _____ Initials: _____

HEALTH HISTORY PROFILE

FOR OFFICE USE ONLY	DATE:	FINANCIAL CODE:
CHART # :	HOSPITAL UNIT # :	MD: POD:

PLEASE COMPLETE INFORMATION BELOW: (PRINT ONLY)

NAME (Last, First, MI):			
ADDRESS:		CITY: STATE: ZIP:	
PHONE: (H)	(W)	DATE OF BIRTH:	SEX:
SS # :		GUARANTOR:	
INSURANCE:		POLICY NUMBER:	
OTHER		EMPLOYED BY:	
RACE:	OCCUPATION:		
EDUCATION: (Circle highest grade completed) 1 2 3 4 5 6 7 8 9 10 11 12; College: 1 2 3 4; Post Grad.			
MARITAL STATUS:	SPOUSE:		
# CHILDREN IN HOME:	HEAD OF HOUSEHOLD:		

CHILDREN'S NAMES:	DATE OF BIRTH:	EMERGENCY CONTACT PERSON:
		EMERGENCY PHONE # :
		KNOWN ALLERGIES: (drug or other)
		Children's Name; DOB, Cont.:

HEALTH RISK PROFILE SUMMARY

PROBLEM	SELF	FAMILY	RELATION*	TYPE OR BODY REGION
HBP / Stroke				
Cancer (region)/Leukemia				
Diabetes				
Heart Disease / Reumatic Fever				
Arthritis / Gout				
Anemia / Bleeding				
Asthma				
Alcoholism / Drugs				
Seizure Disorder				
Birth Defects / Mental Retardation				
Mental Ill / Suicide / Depression				
Glaucoma / Eye Problems				
Tuberculosis / Lung Disease				
Colitis / Polyps / Bowel Problems				
Liver Disease / Hepatitis				
Kidney / Bladder				
Venereal Disease				
Phlebitis				
Thyroid Disease				
Other				

*If deceased, give age when deceased.

(Please see reverse side)

HEALTH BEHAVIORS (Please answer questions below "Yes," "No," or "Occasionally")			
Tobacco:	Pks/week:	How long?	Age quit:
Alcohol:	Last use:		Past problems with alcohol?
Drug use:	Type:	Last use:	Past problems with drugs?
Exercise:	Type:		Time/wk.:
Safety Belt Use:			
Special Diet:		Sleeping Habits:	

PAST OPERATIONS / HOSPITALIZATIONS	DATE
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

REPRODUCTIVE HISTORY		
FEMALE ONLY	MALE & FEMALE	
1. # times pregnant:	12.	Fertility problems (yes or no):
2. # premature births:	13.	Contraception (type):
3. # miscarriages:	14.	Safe sex practices (yes or no):
4. # abortions:		
5. # live births:		
6. # living children:		
7. # days cycle:		
8. # days of flow:		
9. Age onset of period:		
10. Age at menopause:		
11. Menstrual problems (yes or no):		

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? _____ yes _____ no

If Yes Please List Below:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DATE OF LAST TETANUS: _____

DATE OF LAST TB TEST: _____

DATE OF LAST FLU VACCINE: _____

HAVE YOU EVER HAD THE PNEUMONIA VACCINE? _____ yes _____ no

If Yes, Date Received: _____

_____

PATIENT SIGNATURE

ntial History - Date: _____ Complete: _____ Incomplete: _____

Riverwood Medical Associates

Parental Consent to Treat for Minor or Incapable Adults

Signing this form gives Riverwood Medical Associates permission to treat the patient indicated for the items specified below. This consent form will be valid for one (1) year, or until our practice is notified otherwise.

As the parent or legal guardian, I _____ (print name), give permission for

_____ (patient's name) to be seen at Riverwood Medical

Associates according to the guidelines below.

□ May visit the physician's office alone.

□ May visit the physician's office with a responsible adult [print name(s)] _____

_____

I give permission for the following:

□ Well child checks or routine physical/sports examinations

□ Immunizations

□ Office visits

□ Sick Visits

□ Other: _____

If additional treatment is needed, I am to be contacted to give verbal consent. I can be reached at: _____

_____

Parent/Legal Guardian Signature: _____ Date: _____

Carolinas Physicians Network

ACKNOWLEDGEMENT FORM

Medical Records # _____

Patient's Name: _____ Date of Birth _____/_____/_____
Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explain how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature:_____ Date: _____
(Patient or Authorized Representative)

Relationship to Patient: _____ Self _____ Spouse _____ Other _____

Reason Patient Unable/Unwilling to Sign: _____

_____

ACKNOWLEDGEMENT FORM
DOCUMENTO DE RECONOCIMIENTO DE CAROLINAS PHYSICANS NETWORK

Numero de Registro Medico _____

Nombre del Paciente _____ Fecha de Nacimiento _____/_____/_____
Dia Mes Ano

La ley nos requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulgar su informacion medica. La ley tambien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted.

Firma: _____ Fecha: _____
(Paciente o Representante Autorizado)

Relacion al Paciente: _____ Mismo _____ Esposo (a) _____ Otro _____

Razon Por la Cual El Paciente No Puede/No Desea Firmar:_____

One patient per authorization form

There may be a charge for record copies.

Carolinas HealthCare System

Authorization for Release of Health Information

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations.

PURPOSE OF RELEASE: ❑ Ongoing Communication ❑ Copy of Record ❑ Legal or Insurance Review ❑ Authorized Representative's Request ❑ Other _____

RELEASE FROM: The facility / practice / individual listed below is authorized to release the requested health information:

Facility/Practice Name: _____ **Telephone #:** _____

Facility/Practice Address: _____ **Fax #:** _____

The facility / practice / individual listed above is authorized to release the requested health information for the following: date(s) of service, range of time or event(s): **From:** (MM / DD / YY) _____ **To:** (MM / DD / YY) _____

CHECK THE SPECIFIC INFORMATION TO BE RELEASED:

❑ **All Records & Details**
❑ Appointment Information
❑ Billing Information
❑ Consultation Report
❑ Discharge Summary
❑ Emergency Room Records
❑ History & Physical
❑ Immunization Records
❑ Lab / Pathology Reports
❑ Medication Records
❑ Office / Clinic Notes
❑ Operative Report
❑ Physician's Orders
❑ Progress Notes
❑ Psychiatric Evaluation
❑ Radiology / Imaging Reports
❑ Test Results
❑ Other (Please Specify) _____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

NAME OF PATIENT WHOSE INFORMATION IS TO BE RELEASED:

Patient Name: _____ (First) _____ (Middle / Maiden) _____ (Last)

Patient Address: _____ (Street Address / PO Box, City, State, Zip)

Social Security #: _____ **Date of Birth:** _____ **Medical Record/Chart #** _____

Please provide phone numbers where you are authorizing CHS to leave patient information as described above:

Home: _____ **Work:** _____ **Cell:** _____

RELEASE TO: This information may be released to and used by the following individuals / organizations. A separate authorization must be completed if the information being released or the purpose differs between the individuals / organizations listed below:

Name	Address	Telephone/Fax #	Relationship

PATIENT'S RIGHTS AND SIGNATURE:

- I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the above named organization in writing. (I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.)
- I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.
- I understand that I may request to obtain a copy of the information to be used or disclosed per CHS' Notice of Privacy Practices / Policy.
- This authorization will expire when the information from the event / purpose noted above is released to the recipient named in this document.

If the patient is a minor or is clinically unable to sign, an authorized representative may sign this authorization.

PRINT NAME (Patient/Authorized Representative): _____

SIGNATURE: _____ **DATE:** _____

If Authorized Representative, please indicate relationship to patient: ❑ Spouse ❑ Parent ❑ Guardian ❑ Executor of Estate ❑ Power of Attorney

MINOR'S SIGNATURE: Please note, if the information is relating to the treatment of pregnancy, drug and / or alcohol abuse, venereal disease, or emotional disturbance for a patient under the age of of 18, the patient must also sign this authorization.

NAME OF MINOR: _____ **SIGNATURE OF MINOR:** _____ **DATE:** _____

FINANCIAL COMPENSATION: If the requestor of patient information is a health care provider, will the health care provider receive any financial compensation in exchange for using or disclosing the health information described above? ❑ Yes ❑ No ❑ N / A

For Carolinas HealthCare System Use Only: CHS Employees Please Complete

❑ Identification verified ❑ Copy of Authorization given to patient Date of release: _____ via ❑ Mail ❑ Fax ❑ Other _____

❑ Accepted - Released information as described above ❑ Partially Accepted - Describe patient information not released: _____

_____

Employee Name & Title _____

Employee Signature: _____ Date: _____

Carolinas HealthCare System

Un Paciente Por Formulario de Autorización | Podría Haber un Costo por Copias de Historiales

Carolinas HealthCare System - Authorization for Release of Health Information Form

Carolinas HealthCare System – Formulario de Autorización para Dar a Conocer Información de Salud

Por medio del presente, autorizo el uso o la revelación de mi información de salud identificable como es descrito abajo. Entiendo que si la organización autorizada a recibir la información no es una compañía de seguro o un proveedor de salud, la información entregada podría ya no ser protegida por las regulaciones federales de privacidad.

PROPÓSITO DE LA ENTREGA: ❑Comunicación en Curso ❑Copia del Historial ❑Revisión Legal o del Seguro ❑Solicitación de un Representante Autorizado ❑ Otro _____

ENTREGA POR PARTE DE: La instalación/consultorio/individuo anotado abajo está autorizado a entregar la información de salud solicitada:

Nombre de la instalación/consultorio: _____ Número Telefónico _____

Dirección de la instalación/consultorio: _____ Número de Fax_____

La instalación/consultorio/individuo anotado arriba está autorizado a entregar la información de salud por lo siguiente: fecha(s) del servicio, margen de tiempo o evento(s): Desde:(mes/día/año) _____ Hasta:(mes/día/año) _____

MARQUE LA INFORMACIÓN ESPECÍFICA A SER ENTREGADA:

❑ Todos los Historiales y Detalles	❑ Resumen del Alta	❑ Reportes de Laboratorio/Patología	❑ Notas de Progreso	❑ Ordenes del Doctor
❑ Información de Citas	❑ Historiales de la Sala de Emergencia	❑ Registro de Medicamentos	❑ Evaluación Previa Psiquiátrica	❑ Otros (Por favor, especifíque) _____
❑ Información de Cobros	❑ Historial y Examen Físico	❑ Notas de Oficina/Clínica	❑ Radiología/Reportes de Imágenes	_____
❑ Reporte de la Consulta	❑ Registro de Vacunas	❑ Reporte Operatorio	❑ Resultados de Pruebas	_____

Entiendo que la información en mi historial médico puede incluir información relacionada a tratamiento de abuso de droga o alcohol, anemia de células falciformes, insuficiencia psicológica o psiquiátrica, enfermedades por transmisión sexual, síndrome de inmunodeficiencia adquirida (SIDA), complejo relacionado al SIDA y/o otros virus de la inmunodeficiencia humana (VIH).

NOMBRE DEL PACIENTE CUYA INFORMACIÓN SERÁ ENTREGADA:

Nombre del Paciente: _____ _____ _____
Primer Segundo/De Soltera Apellido

Dirección del Paciente: _____
(Dirección de Calle/Apdo. Postal, Ciudad, Estado, Código Postal)

Número de Seguro Social: _____Fecha de Nacimiento: _____ Número de Historial/Hoja Médica_____

Por favor, provea los números telefónicos donde usted está autorizando a CHS a dejar la información del paciente descrita arriba:

Casa: _____ Trabajo: _____ Celular: _____

ENTREGAR A: Esta información puede ser entregada a y usada por los siguientes individuos/organizaciones. Una autorización aparte debe ser completada si la información entregada o el propósito difieren entre los individuos/organizaciones anotados abajo:

Nombre	Dirección	Número Telefónico/Fax	Parentesco/Relación
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DERECHOS Y FIRMA DEL PACIENTE:

- Entiendo que tengo el derecho de revocar esta autorización en cualquier momento al notificar por escrito al Departamento de Registros Médicos ("Medical Record Department") de la organización mencionada arriba. (Entiendo que la revocación no se aplicará a la información que ya ha sido entregada en respuesta a esta autorización. Entiendo que una revocación no se aplicará a mi compañía de seguro cuando la ley le otorga el derecho de impugnar un reclamo bajo mi póliza.)
- Entiendo que autorizar la revelación de esta información de salud privada es voluntario y puedo rehusarme a firmar esta autorización.
- Entiendo, según el CHS Anuncio de Cómo Manejamos la Privacidad, que puedo solicitar inspeccionar u obtener una copia de la información a ser usada o revelada.
- Esta autorización se vencerá cuando la información del evento/propósito anotado arriba es entregada al destinatario nombrado en este documento.

Si el paciente es menor de edad o es incapaz clínicamente de firmar, un representante autorizado puede firmar esta autorización.

NOMBRE EN LETRA DE IMPRENTA (Paciente/Representante Autorizado): _____

FIRMA: _____ FECHA: _____

Si la firma es de un Representante Autorizado, por favor, indique su parentesco/relación: ❑ Esposo/a ❑ Padre/Madre ❑ Guardián ❑ Testamentario ❑ Apoderado

FIRMA DEL MENOR DE EDAD: Por favor, tome nota, si la información es relacionada al tratamiento de un embarazo, abuso de droga y/o alcohol, enfermedad venérea, o trastorno emocional para un paciente menor de 18 años de edad, el paciente debe también firmar esta autorización.

NOMBRE DEL MENOR: _____FIRMA DEL MENOR: _____ FECHA: _____

COMPENSACIÓN FINANCIERA: Si el solicitante de la información es un proveedor de cuidado de salud, ¿recibirá él alguna compensación financiera a cambio del uso o revelación de la información descrita arriba? ❑ Sí ❑ No ❑ No se aplica

For Carolinas HealthCare System Use Only: CHS Employees Please Complete

❑ Identification verified ❑ Copy of Authorization given to patient / Date of release:_____via ❑Mail ❑Fax ❑Other_____

❑ Accepted - Released information as described above ❑ Partially Accepted - Describe patient information not released: _____

CHS Employee Name & Title: _____CHS Employee Signature: _____Date _____

Treatment for Drug and Alcohol Use If you receive treatment for drug or alcohol use in a federally funded rehabilitation center, federal laws prevent us from releasing that information, except in certain situations. For example, if there is an emergency or if you threaten to hurt someone, we can disclose the information appropriately.

Unemancipated Minors In North Carolina, if you are under the age of 18, are not married and have not been legally emancipated, you can consent to treatment for pregnancy, drug and/or alcohol abuse, venereal disease or emotional disturbances without an adult. This information will remain confidential, unless your doctor determines your parents or guardian need to know this information because there is a serious threat to your life or health, or your parents or guardian have specifically asked about your treatment. Note that minors are still required to get parental or court consent for an abortion.

Inspections and Surveys One or more of our facilities and services are subject to inspection by state and federal agency and accreditation representatives who may review patient health information, which we are required to provide. For example, the state may ask to review records as part of their review of our hospital license or review of a complaint (you may have certain rights to object to these disclosures). A licensing board may review records when evaluating a provider's qualifications.

OTHER USES OF HEALTH INFORMATION

Uses and disclosures of your health information not covered by this Notice or by applicable laws not necessarily listed here will be made only with your written permission.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

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

1. Access A Copy Of Your Health Records

You can ask to see and get a copy of your health record and other health information. You may not be able to get all of your information in a few special cases. For example, if your doctor decides something in your file might endanger you or someone else, your request for access may be denied.

- In most cases, copies of your health record will be given to you within 30 days, but this time frame can be extended for another 30 days.
- You may have to pay for the cost of copying and mailing if you request copies and mailing.

To request a copy of your health record, you must submit your request in writing to the Medical Records Custodian at the facility or practice where you were treated. You can find the form to request your records on the Carolinas HealthCare System website – **www.carolinashealthcare.org.**

2. Revoke An Authorization

If you have provided us permission to use or disclose your health information, you may revoke that permission at any time by giving written notice to the Chief Privacy Officer, P.O. Box 32861, Charlotte, NC 28232. If you revoke your permission, we will no longer use or disclose your 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 before you notify us of your revocation.

3. Request Changes To Your Health Information

You can ask to change or add information to your health record that you think is wrong or incomplete. A request to change your health information is also known as a "request for amendment." The provider has the right to decide whether to grant the request for amendment. For example, if you and your provider agree that your file has the wrong result for a test, the provider will change it. However, if the provider believes the test result is correct, your disagreement will be noted in your file.

- A request for amendment must be made in writing to the Medical Records Custodian at the facility or practice where you were treated. You must describe the amendment and provide a reason for why it should be made.
- We will usually respond to your request for amendment within 60 days, but it may take an extra 30 days in some cases and if it does, we will provide you with the reason.

4. Obtain A List Of When And Why Your Health Information Was Shared

You have the right to request an "accounting of disclosures." This is a list of the disclosures of your health information (though it does not include disclosures made for treatment, payment, or for health care operations, or as authorized by you). This list is known as an "accounting of disclosures." To get this list, you must make your request in writing to the Chief Privacy Officer, P.O. Box 32861, Charlotte, NC 28232. You must include the time frame for the request.

- You can get an accounting of disclosures for free every 12 months. There may be a charge for more than one report within a 12 month time frame.
- In most cases, we will get you the accounting of disclosures within 60 days, but it may take an extra 30 days in some cases and if it does, we will provide you with the reason.

5. Request Restrictions On Sharing Of Your Information

You have the right to request a restriction or limitation on the 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 health information we disclose about you to someone who is involved in your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had to your siblings. Note that if you ask us not to disclose health information to your health plan for items or services for which you paid in full and out of pocket, we will not disclose the information to the plan. To request a restriction, you must make your request in writing to the Chief Privacy Officer, P.O. Box 32861, Charlotte, NC 28232. 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). ***We are not required to agree to your request*.** If we do agree, your restrictions may not be followed in some situations, such as emergencies or when required by law.

6. Request That We Change How We Contact You

You can make reasonable requests to be contacted at different places or in different ways. For example, you can have the nurse call you on your cell phone instead of your home number, or ask that your lab results be sent to your office, instead of to your home. If sending information to you at home might put you in danger, your health provider must talk, call, or write to you where you ask and in the way you ask, if the request is reasonable. To request confidential communications, you must make your request in writing to the Chief Privacy Officer, P.O. Box 32861, Charlotte, NC 28232. You are not required to tell us the reason for your request. We will accommodate all reasonable requests, but your request must specify how or where you wish to be contacted. We may ask how you will handle payments as well.

7. Right to a Paper Copy of This Notice You have the right to a paper copy of this Notice upon request. You may also obtain a copy of this Notice at any time from our website, **www.carolinashealthcare.org**, or from the CHS facility where you obtained treatment.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised Notice effective for health information we already have about you, as well as any health information we create or receive in the future. The Notice will contain the effective date on the first page. We will post a copy of the current Notice of Privacy Practices at each CHS treatment facility and on our website, **www.carolinashealthcare.org,**

COMPLAINTS

If you believe your information was used or shared in a way that is not allowed under the privacy law or if you believe your rights were denied you can file a complaint with CHS and with the Secretary of the Department of Health and Human Services.

MORE INFORMATION AND NOTICE

If you have any questions about this Notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact the Chief Privacy Officer at (704) 512-5900. ***You will not be penalized for filing a complaint*.**

NOTICE OF PRIVACY PRACTICES

Carolinas HealthCare System

For a list of the Carolinas HealthCare System facilities covered by this Notice of Privacy Practices, please see our website, www.carolinashealthcare.org, or call the Customer Care Line at (704) 355-8363

Effective April 14, 2003
Modified December 15, 2012

A copy of this Notice is also available in Spanish.
Una copia de este anuncio esta disponible tambien en Espanol.

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

OUR PLEDGE REGARDING HEALTH INFORMATION

We understand that information about you and your health is personal. We are committed to protecting your health information. We will create a record of the care and services you receive at Carolinas HealthCare System (CHS), its subsidiaries and other related entities. We use and disclose this record to provide you with quality care and to comply with certain legal requirements. This record will be available to all health care professionals who need access as described in this Notice, many of whom will be involved in your treatment at any CHS health care facility or practice. This Notice will apply to all of the records of your care generated by CHS.

This Notice will tell you about the ways we may use and disclose your health information. It also describes your rights and certain obligations we have regarding the use and disclosure of health information.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Provide you notice of our legal duties and privacy practices with respect to your health information.
- Follow the terms of the Notice that is currently in effect.

WHO WILL FOLLOW THIS NOTICE?

- Any health care professional authorized to enter information into your CHS medical record, including doctors on the medical staff, while at a CHS health care facility or practice.
- All departments and units of CHS, and practices owned by CHS and its subsidiaries.
- All employees, staff, volunteers and other CHS personnel.

In addition, these CHS facilities may share health information with each other for treatment, payment or health care operations purposes as described in this Notice.

HOW IS YOUR INFORMATION USED?

For Treatment We may use and disclose your health information to provide, coordinate, or manage your health care and related services, both among our own providers, and with others involved in your care. For example, a doctor treating you for a broken leg may need to know if you have diabetes because it affects the healing process. S/he may tell the dietitian, so you can have appropriate meals. S/he may tell a case manager so you can get proper resources at discharge. Different CHS departments also may share your health information in order to coordinate the different things you need, such as prescriptions, lab work and x-rays.

For Payment Generally, we may use and give your health information to others to bill and collect payment for the treatment and services we provide to you. Before you receive scheduled services, we may contact your health plan to ask for approval of payment before we provide the services, or we might contact Medicare or Medicaid to inquire as to whether you qualify for coverage. We may also share portions of your health information with billing departments, insurance companies, health plans and their agents which do or could provide you coverage; and consumer reporting agencies. For example, if you broke your leg, we may need to give your health plan information about your condition, the supplies used (such as plaster for your cast or crutches), and the services you received (such as X-rays or surgery).

For Health Care Operations We may use and disclose health information to conduct our business activities and health care operations, which assist us in improving the quality and cost of the care we provide to you and other patients. For example, we may look at patient records from the ICU to review our treatment and services and to evaluate the performance of our staff. We may also use patient health information to decide what new services we should offer, what services are not needed, and whether certain new treatments are effective. We may disclose information for education, licensing, legal and other purposes.

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

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

Health-Related Benefits and Services We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you, or to tell you about new facilities that we are opening.

Business Associates We sometimes hire other people to help us perform our services. We may disclose your health information to them so that they can perform the job we have asked them to do. We require them to protect your health information and keep it confidential. For example, we may hire a transcription service to transcribe parts of your medical record, or a billing and collections agency to bill you or your insurance company for the services rendered or collect payment.

USES OF HEALTH INFORMATION FROM WHICH YOU CAN OPT OUT

You can object to some uses and disclosures of your information.

Fundraising Activities We may use your health information to contact you in an effort to raise money for CHS and its operations. We may disclose health information to a CHS-related foundation which may contact you regarding raising money for a treatment or service related cause. We would only release demographic information, such as your name, address and phone number and the dates you received treatment or services. If you do not want CHS to contact you for fundraising efforts, you must notify the Chief Privacy Officer in writing at PO Box 32861, Charlotte, N.C. 28232.

Hospital Directory Unless you object, we may include your name, location in the hospital, and your general condition (e.g., good, fair, serious, etc.) in the CHS hospital directory while you are a patient at the hospital. The directory information may be released to people who ask for you by name. Unless you object, we can also share this information, as well as your religious affiliation, to clergy affiliated with your faith, regardless of whether they ask for you by name**.** To object to being included in the directory, notify the staff member registering you or providing your care.

Mental Health If you received treatment at a mental health facility, your information can be shared with other providers outside of the mental health facility for purposes of treatment, payment, and health care operations. For example, if you are having surgery at a hospital, your surgeon can review your mental health treatment information to make sure the plan of care is right for you. You have the right to opt out of the mental health facility information being available by submitting a written request to the staff member registering you or providing your care. Please allow five (5) business days for the opt out to take effect. Note that there are other situations in which we can disclose your mental health information, even if you opt out, such as in an emergency. You can opt back in by giving similar notice.

Individuals Involved in Your Care or Payment for Your Care We may share with a family member, personal representative, friend or other person you identify, your health information that is directly related to their involvement in your care or payment for your care. For example, if you are on a spouse's insurance plan, your spouse may have access to a bill explaining your treatment. We may share your health information when it is necessary to notify them of your location, general condition or death. In an emergency, or if you are incapacitated, we will use our professional judgment to decide if it is in your best interest to disclose your health information to a person involved in your care. If you bring family members or others to your appointments and do not tell us that you object to them hearing your medical information, then we are allowed to interpret that as your consent for them to do so.

HEALTH INFORMATION EXCHANGES

We may provide your health care information to a health information exchange (HIE) in which we participate. A HIE is a medical record database where other health care providers caring for you can access your medical information from wherever they are, assuming they are members of the HIE. These providers may include your doctors, nursing facilities, home health agencies or other providers who care for you outside of our hospitals or our practices. For example, you may be travelling and have an accident in another area of the state. If the doctor treating you is a member of the HIE in which we participate, s/he can access the information about you that other providers have contributed. Accessing this additional information can help your doctor provide you with well-informed care quickly because s/he will have learned a lot about your medical history or allergies or prescriptions from the HIE. If you do not want your medical information to be contributed to the HIE and shared with these member health care providers, you can opt out by visiting **www.CareConnectCarolinas.com** and submitting the opt out form. It will take 5 business days for the opt out to go into effect. Note that if you opt out, your providers may not have the most recent information about you which may affect your care. You can always opt in at a later date by visiting **www.CareConnectCarolinas.com**.

SPECIAL SITUATIONS

In some situations, we may use or share your health information without your permission or allowing you an opportunity to object. Examples of these situations include:

When the disclosure is required by law
For Organ, Eye or Tissue Donation Purposes
For Public Health Activities (such as to prevent or control disease, injury, or disability; to report births or deaths; to report child or disabled adult abuse or neglect; to report reactions to medicine or problems with medical products, etc.)
For Health Oversight Activities
For a Legal Proceeding
To Law Enforcement
To Avoid a Serious Threat to Health or Safety
To Coroners, Medical Examiners and Funeral Directors
For Disaster Relief
For Research
For Specialized Government Functions
For Workers' Compensation

STATE AND FEDERAL LAWS

Sometimes, state or federal laws require us to protect or disclose your health information in keeping with or in addition to the ways stated in this Notice. For example, state law protects your health information under the doctor-patient privilege. There are also situations when we are required or permitted to disclose your information under the law, such as our obligation to report gun shot wounds. The following are just a few examples of some common situations where state or federal laws require us to protect or disclose your information: