MINIMALLY INVASIVE
ABDOMINAL SURGERY SPECIALISTS
A PART OF THE NICHOLSON CLINIC

PLEASE LIST YOUR FULL LEGAL NAME:

LAST: _____ FIRST: _____ MIDDLE: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PLEASE ENTER YOUR CONTACT INFORMATION:

1st Choice: ☐Home ☐Mobile ☐Work (____) _____-_____

2nd Choice: ☐Home ☐Mobile ☐Work (____) _____-_____

E-MAIL: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____ PHONE #_____

Emergency contact may receive information about my medical condition? (Please ☑ one) ☐ Yes ☐ No

SSN: _____ DOB: _____/_____/_____ AGE: _____ GENDER: ☐ F ☐ M

MARITAL STATUS (Optional): ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Other _____

Which best describes your ethnicity? Hispanic/Latino Origin Non-Hispanic/Non-Latino Origin

Which best describes your race? Asian Black American Indian/Alaska Native Native American/Pacific Islander White Other

EMPLOYER: _____ OCCUPATION: _____

PRIMARY CARE PHYSICIAN: _____ Phone: _____

REFERRING DOCTOR: _____ Phone: _____

Address: _____

My physician(s) may receive information from Abdominal Surgery Specialists regarding my surgery? (Please ☑ one) ☐ Yes ☐ No

PLEASE INCLUDE A FRONT & BACK COPY OF YOUR INSURANCE CARD

INSURANCE INFORMATION: (Please be very detailed – incomplete data may delay processing.)

INSURANCE CO.: _____ PLAN TYPE: HMO PPO POS

ADDRESS: _____ ID#: _____

GROUP #: _____ PHONE #: _____

NAME OF INSURED: _____ INSURED'S DOB: _____

RELATIONSHIP TO PT: _____ SS# (IF OTHER THAN PT): _____

EMPLOYER NAME: _____

SECONDARY INSURANCE CO.: _____ PLAN TYPE: HMO PPO POS

ADDRESS: _____ ID#: _____

GROUP #: _____ PHONE #: _____

GROUP #: _____ PHONE #: _____

NAME OF INSURED: _____ DOB: _____

RELATIONSHIP TO PT: _____ SS# (IF OTHER THAN PT): _____

EMPLOYER NAME: _____

_____ _____

PATIENT OR RESPONSIBLE PARTY **DATE**

HEALTH AND MEDICAL HISTORY

(Fill out as completely as possible.)

HEIGHT:_____ CURRENT WEIGHT: _____

HAVE YOU EVER HAD *(Please check each that apply)*

☐ Gallbladder Surgery	Year_____	Type_____
☐ Spleen Surgery	Year_____	Type_____
☐ Esophagus Surgery	Year_____	Type_____
☐ Stomach Surgery	Year_____	Type_____
☐ Hernia Repair Surgery	Year_____	
☐ Caesarian Section	Year_____	
☐ Abdominal Hysterectomy	Year_____	
☐ Prior Weight Loss Surgery	Year_____	

HEALTH AND WELLNESS INFORMATION: (For any "yes" answers list a diagnosing or treating physician.)

DESCRIPTION		YES	NO	YEAR	DIAGNOSING PHYSICIAN
Abdominal Pain		☐	☐		
Shortness of Breath		☐	☐		
Snoring		☐	☐		
Sleep Apnea Syndrome		☐	☐		
CPAP		☐	☐		
BiPAP		☐	☐		
Asthma		☐	☐		
Indigestion/Heartburn		☐	☐		
Gastroesophageal Reflux		☐	☐		
Degenerative Joint	☐ Lower Back	☐	☐		
Disease/Pain	☐ Hips	☐	☐		
	☐ Knees	☐	☐		
	☐ Ankles	☐	☐		
Edema/Swelling	☐ Legs	☐	☐		
	☐ Ankles	☐	☐		
Congestive Heart Failure		☐	☐		
Stroke		☐	☐		
Heart Disease		☐	☐		
Heart Attack		☐	☐		
Hypertension (High Blood Pressure)					
	☐ Self	☐	☐		
	☐ Family History	☐	☐		
Diabetes	☐ Self	☐	☐		
	☐ Family History	☐	☐		
High Cholesterol/Hyperlipidemia		☐	☐		
Hernia		☐	☐		
Depression		☐	☐		
Bipolar Disorder		☐	☐		
Panic Disorder		☐	☐		
Anorexia		☐	☐		
Bulimia		☐	☐		
Schizophrenia		☐	☐		
Chronic Fatigue		☐	☐		
Chest Pain		☐	☐		
Urinary Incontinence (Leaking when you cough or sneeze)		☐	☐		
Cirrhosis		☐	☐		
Hepatitis		☐	☐		
COPD/Emphysema		☐	☐		
Pulmonary Embolism		☐	☐		
Colitis		☐	☐		
Chron's Disease/Ulcerative Colitis		☐	☐		
Hepatitis B or Hepatitis C		☐	☐		

DO YOU HAVE A HEART CONDITION: ☐ YES ☐ NO If yes, please describe:_____

_____

DO YOU HAVE ANY OTHER UNDERLYING MEDICAL CONDITIONS? ☐ YES ☐ NO, If yes, please describe:_____

_____

IS YOUR FATHER LIVING? ☐ YES ☐ NO CAUSE OF DEATH:_____

IS YOUR MOTHER LIVING? ☐ YES ☐ NO CAUSE OF DEATH: _____

_____

RECENT TESTING:				
	PHYSICAL	☐ YES	☐ NO	DATE: _____
	CHEST X-RAY	☐ YES	☐ NO	DATE: _____
	UPPER GI	☐ YES	☐ NO	DATE: _____
	ECHOCARDIOGRAM	☐ YES	☐ NO	DATE: _____
	EKG	☐ YES	☐ NO	DATE: _____

INDICATE ANY NEGATIVE RESULTS: _____

_____

GENERAL AND LIFESTYLE INFORMATION:

DO YOU SMOKE?	☐ YES	☐ NO	DO YOU USE ALCOHOL?	☐ YES	☐ NO
HAVE YOU SMOKED?	☐ YES	☐ NO	HOW OFTEN?	☐ DAILY	☐ WEEKLY
YEAR QUIT	_____			☐ OCCASIONALLY	☐ RARELY
HAVE YOU EVER HAD A PROBLEM WITH SUBSTANCE ABUSE?				☐ YES	☐ NO

PLEASE TAKE A MOMENT AND TELL US HOW YOU HEARD ABOUT OUR PROGRAM:

_____ INTERNET/ABDOMINAL SURGERY SPECIALISTS WEBSITE

_____ INTERNET/NICHOLSON CLINIC WEBSITE

_____ TV/RADIO/MAGAZINE ADVERTISEMENT

_____ CURRENT PATIENT, IF SO WHO?_____

_____ PCP/REFERRING DOCTOR

_____ INSURANCE COMPANY

_____ FRIEND / FAMILY MEMBER

☐ **I REALIZE I AM RESPONSIBLE FOR CHARGES INCURRED FOR MY CARE SHOULD MY INSURER FAIL TO REIMBURSE IN AN ACCEPTABLE AND TIMELY MANNER.**

_____ _____ _____

PATIENT SIGNATURE **DATE OF BIRTH** **DATE**

We often make referrals to medical providers that may be out of network with your insurance plan because we believe them to be quality providers. As a standard of this office, we may refer to Baylor Regional Medical Center at Plano, Baylor Surgicare Garland, Crescent Medical Center, Medical City Frisco, Diez Services Anesthesia, ROON PLLC Anesthesia, Clinical Pathology Labs (CPL), and M3 Sleep Services of Texas, . The surgeons associated with this practice may or may not have a personal investment in these or other healthcare facilities. You are invited to discuss this with us or our office staff if you desire.

Nick Nicholson, M.D. **Thomas Roshek, M.D.** **Brian Long, MD**

CURRENT PATIENT MEDICATIONS DATE:_____

NAME: _____ **DATE OF BIRTH:**_____ **MEDICATION ALLERGIES:**_____

PHARMACY NAME: _____ **PHARMACY PHONE:** _____

Do you take antacids? (please check all that apply) **Date Started:** _____

☐ Maalox ☐ Mylanta ☐ Tums ☐ Rolaids ☐ Pepto-Bismol ☐ Pepcid (famotidine) ☐ Zantac (ranitidine) ☐ Tagamet (cimetidine) ☐ Prilosec (omeprazole)
☐ Aciphex (rabeprazole) RX ☐ Nexium (esomeprazole) RX ☐ Prevacid (lansoprazole) RX ☐ Protonix (pantoprazole)RX OTHER: _____

Vitamin/Mineral Supplements: (please check all that apply): ☐ Never ☐ Occasionally ☐ Daily
☐ Multi Vitamin ☐ Vitamin D ☐ Vitamin B-12 (weekly) Other: _____

Do you have anemia? ☐ YES ☐NO **IRON** supplementation ☐YES ☐NO
Date Started: _____ **How often?** _____

Do you take OTC pain relievers? (please check all that apply): ☐ YES ☐ NO **Date Started**: _____
☐ Acetaminophen (Tylenol) ☐ Ibuprofen (Motrin, Advil) ☐ Naproxen (Aleve, Naprosyn) ☐ Aspirin OTHER: _____

Tobacco: ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently Quit (Month/Year): **Alcohol:** ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently

CPAP/BIPAP: ☐ Never ☐ Occasionally ☐ Every Night

MEDICATION NAME/STRENGTH	ROUTE	DOSE	PURPOSE	DATE STARTED	DATE STOPPED
EXAMPLE: SAMPLE 200mg	*By mouth*	*1xday*	*Blood Pressure*	*May 2009*	
OTHER OTC MEDICATIONS:					

REVIEWED BY MEDICAL STAFF DATE/INITIALS	

DATE UPDATED: _____ **PATIENT INITIALS:** _____ **DATE UPDATED:** _____ **PATIENT INITIALS:** _____
DATE UPDATED: _____ **PATIENT INITIALS:** _____ **DATE UPDATED:** _____ **PATIENT INITIALS:** _____

Email Informed Consent Form

Conditions for the Use of Email

It is the policy of Abdominal Surgery Specialists and Nicholson Clinic to make all email messages sent or received that concern the protected health information ("PHI"), a part of that patient's medical and financial records. Abdominal Surgery Specialists and Nicholson Clinic strive to protect and maintain patient PHI. However, there are numerous risks associated with email communication, which may include but not limited to misaddressed or undelivered emails, risk associated with use of employer owned email address, and/or delay in response time. Abdominal Surgery Specialists and Nicholson Clinic cannot fully guarantee the security and confidentiality of email communications. Thus, patients must consent to the use of email for confidential medical information after having been informed of the above risks. Consent to the use of email includes agreement with the following conditions:

- All emails to or from the patient concerning diagnosis and/or treatment will be made a part of the patient's records. As a part of medical record, other individuals, such as other physicians, nurses, other entities, such as other health care providers and insurers, may have access to email messages contained in medical records.
- Abdominal Surgery Specialists and Nicholson Clinic may forward email messages within the facility as necessary for diagnosis, treatment, and reimbursement. However, emails to entities unassociated with the patient's care, will not be forwarded, unless proper patient consent is received,
- Abdominal Surgery Specialists and Nicholson Clinic and its employees will make every effort to read and respond promptly to patient emails. **Because** Abdominal Surgery Specialists and Nicholson Clinic **cannot assure patients that recipients will read email messages promptly, patients must not use email in a medical or other emergency.**
- If a patient's email requires or invites a response, and the recipient does not respond within a reasonable time, the patient is responsible for following up to determine whether the intended recipient has received the email and when the recipient will respond.
- Because some medical information is so sensitive that unauthorized disclosure can be very damaging, **patients should not use email for communications concerning diagnosis or treatment of the following: AIDS/HIV infection; other sexually transmissible or communicable diseases; mental health or developmental disability; or alcohol and drug abuse.**
- Because employees do not have a right of privacy in their employer's email system, patients should not use their employer's email system to transmit or receive confidential medical information.
- Abdominal Surgery Specialists and Nicholson Clinic will take reasonable steps to protect the confidentiality of patient email, but is not liable for improper disclosure of confidential information not caused by Abdominal Surgery Specialists and Nicholson Clinic's gross negligence or wanton misconduct.
- If the patient consents to the use of email, the patient is responsible for informing Abdominal Surgery Specialists and Nicholson Clinic of any types of information that the patient does not want to be sent by email other than those set out above.
- Patient is responsible for protecting patient's password or other means of access to email sent or received from Abdominal Surgery Specialists and Nicholson Clinic to protect confidentiality. Abdominal Surgery Specialists and Nicholson Clinic is not liable for breaches of confidentiality caused by patient.

Any further use of email by the patient that discusses diagnosis or treatment by the patient constitutes informed consent to the foregoing. You may withdraw consent to the future use of email at any time by email or written communication to Abdominal Surgery Specialists and Nicholson Clinic, attention:

Stephanie G: HIPAA Compliance Officer
5500 Democracy Dr. #150
Plano, Tx 75024
Stephanie@Nicholsonclinic.com

I have read the above risk factors and conditions for the use of email, and I hereby consent to the use of email for communications to and from Abdominal Surgery Specialists and Nicholson Clinic regarding my medical treatment.

_____	_____	_____
Signature of Patient	Email Address	Date
_____	_____	
Printed Name of Patient	Date of Birth	

Segments of this consent were obtained from HIPAA Documents Resource Center CD, 6th ed.

Created 02/24/2016

BAYLOR SCOTT & WHITE HEALTH
PERMISSION FOR VERBAL COMMUNICATION

Patient Name _____ Date of Birth _____ Phone Number(s) _____

Full Address (City, State, and Zip Code) _____

I permit Baylor Scott & White Health to discuss my personal medical health information, in person and/or by telephone, with the following persons involved in my medical care for the following purposes:

- **To orally schedule or confirm my appointments;**
- **To discuss my care including the results of diagnostic tests, diagnosis, prognosis, and treatment plans that may include mental health records, psychotherapy notes, AIDS/HIV test results, substance abuse treatment records, blood bank records, and/or genetic information; or**
- **To discuss billing and payment for medical services.**

I understand that this document applies to all departments, healthcare providers and/or employees with Baylor Scott & White Health. I understand that this authorization is voluntary and that once this information is disclosed to the person(s) designated that it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

	Name	Relationship	Phone Number
1.			
2.			
3.			

I further understand that I may revoke this authorization at any time by sending a written statement of revocation to Baylor Scott & White Health – Office of Corporate Compliance, 2401 S. 31st Street, MS-AR-300, Temple, Texas 76508.

This document of Permission for Verbal Communication will expire upon revocation, or at the date or event specified here _____ .

This document does not permit the release of written information to these individuals. My refusal to sign this authorization will not negatively affect my health care at Baylor Scott & White Health.

_____ _____
Signature of Patient or Legal Representative (electronic signatures not acceptable) Date

_____ _____
Print Name of Patient or Legal Representative Relationship to Patient

_____
Representative's Authority to Act for Patient
(attach supporting documentation)

NOTICE OF PRIVACY PRACTICES

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.

Understanding Your Health Record/ Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you.

This Notice of Privacy Practices ("Notice") describes the privacy practices of Baylor Scott & White Health ("BSWH") and its Affiliated Covered Entity ("BSWH ACE") members. An Affiliated Covered Entity ("ACE") is a group of Covered Entities, Health Care Providers and Health Plan under common ownership or control that designates itself as a single entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The members of the BSWH ACE will share Protected Health Information ("PHI") with each other for the treatment, payment and health care operations of the BSWH ACE and as permitted by HIPAA and this Notice. As an ACE, BSWH may add or remove Covered Entities as part of the BSWH ACE. For a complete current list of the members of the BSWH ACE, please visit our website at www.BSWHealth.com/PrivacyMatters.The list will also be made available upon request either at our facilities or by contacting us toll-free at 1-866-218-6920.

This Notice will tell you about the ways in which we may use and disclose medical information about you and how you can get access to this information. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your records

- You can ask to see or get an electronic or paper copy of your medical records and other health information we have about you by:
  - Contacting the Health Information Management Department at the hospital or the outpatient clinic directly where you received care; or
  - Calling the Customer Advocacy line for Scott and White Health Plan ("SWHP") at 254-298-3000 or toll-free at 1-800-321-7947, FirstCare at 1-800-884-4901 or RightCare at 1-855-897-4448 or writing to 1206 West Campus Drive, Temple, TX 76502, ATTN: Customer Advocacy, if you are a member of the health plan.
- We will provide a copy or a summary of your health information in accordance with applicable state and federal requirements. We may charge a reasonable, cost-based fee.
- You may revoke an authorization to use or disclose your health information except to the extent that action has already been taken in reliance on your authorization. To revoke your authorization:
  - Send written notice to the Office of HIPAA Compliance, 2401 S. 31st Street, MS-AR-300,Temple, TX 76508.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
- To request an Amendment:
  - Send written notice to the Office of HIPAA Compliance, 2401 S. 31st Street, MS-AR-300, Temple, TX 76508.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- We will not ask you the reason for your request.
- You may request a confidential communication by:
  - Contacting us in writing at the Office of HIPAA Compliance, 2401 S. 31st Street, MS-AR-300, Temple, TX 76508.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- You may request this restriction by:
  - Contacting us in writing at the Office of HIPAA Compliance,2401 S. 31st Street, MS-AR-300, Temple, TX 76508.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared your information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why.
- We will include all the disclosures except for those about treatment, payment, health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- To request a list of those with whom we've shared information:
  - Contact us in writing at the Office of HIPAA Compliance,2401 S. 31st Street, MR-AR-300, Temple, TX 76508.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- You may also view a copy of this Notice on our websites.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your privacy rights have been violated

- You can complain if you feel we have violated your privacy rights by:
  - Contacting us toll-free at 1-866-218-6920, by visiting www.BSWHealth.com/PrivacyMatters or in writing at the Office of HIPAA Compliance,2401 S. 31st St., MS-AR-300, Temple, TX 76508.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W.,

Washington, D.C. 20201, calling toll-free at 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

- For questions or other complaints, you may also contact:
  - The outpatient clinic directly or the Patient Relations Department at the hospital where you received care toll-free at 1-866-218-6919.
- For questions or other complaints relating to Health Plan Coverage:
  - contact the Customer Advocacy line for SWHP at 254-298-3000 or toll-free at 1-800-321-7947, FirstCare at 1-800-884-4901 or RightCare at 1-855-897-4448 .
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In the following cases, you have both the right and choice to tell us to:

- Share information with your family, close friends or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Fundraising

- We may contact you for fundraising efforts, but you can tell us not to contact you again by letting us know you wish to opt-out of any further fundraising communications.
- Information on how to opt-out will be included in any fundraising communications you may receive.

OUR USES & DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

- We may use your health information to give you information about treatment alternatives or health related benefits/services that may be of interest to you.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

- We can use and share your health information as necessary to operate and manage our business activities related to providing and managing your health care insurance.

Example: We might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.

Communications regarding treatment alternatives and appointment reminders

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Bill for our services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for our services.

For payment

- We can use and share your health information for payment of premiums due to us, to determine your coverage, and for payment of health care services you receive.

Example: We might tell a doctor if you are eligible for coverage and what percentage of the bill might be covered.

For underwriting purposes

- We may use or share your health information for underwriting purposes; however, we will not use or share your genetic information for such purposes.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as the ways mentioned below. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Student immunizations to schools

- We may disclose proof of your child's immunizations to their school based on your verbal or written permission.

Do research

- We can use or share your information for health research.

Food and Drug Administration (FDA)

- We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services, if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner or funeral director when an individual dies.

Address worker's compensation, law enforcement and other government requests

We can use or share health information about you:

- For worker's compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law

- For special government functions such as military, national security and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Electronic Health Information Exchange (HIE)

- We maintain electronic health information about you from other health care providers or entities that are not part of our healthcare system who have treated you or who are treating you and this information is also stored in the HIE.
- Our healthcare system and these other providers can use the HIE to see your electronic health information for the purposes described in this Notice, to coordinate your care and as allowed by law.
- We monitor who can view your information, but the individuals and entities who use the HIE may disclose your information to other providers.
- You may opt-out of the HIE by providing a written request to the Office of HIPAA Compliance, 2401 S. 31st Street, MS-AR-300, Temple, TX 76508. If you opt-out, your information will still be stored in the HIE, but your information will not be viewable through the HIE.
- You may opt back in to the HIE at any time.
- You do not have to participate in the HIE to receive care.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this Notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our websites.

Effective Date: September 2020

Patient Signature or Legally Authorized Representative