ADDITIONAL DEMOGRAPHIC INFORMATION

Email: _____ Pharmacy name and Cross streets: _____

Marital Status: _____ SSN: _____ Race: _____ Ethnicity: _____

Emergency Contact Name: _____ Relationship: _____ Phone #: _____

ADVANCE DIRECTIVES

Phoenician Medical Center will keep a copy of my advance directive/living will/power of attorney paperwork on file if I wish to offer a copy for my chart. Phoenician will also offer paperwork to me if I am interested in advance directives. I acknowledge that I have been informed and understand Phoenician Medical Center's policy on advance directives.

HIPAA CONSENT PATIENT AUTHORIZATION FOR USE & DISCLOSURE OF PHI WITH CONDITIONS

Patient Name: _____ DOB: _____

I hereby authorize the use or disclosure of my personal health information as described below. I understand the information I authorize a person or entity to receive may be re-disclosed and is no longer protected by federal regulations.

1. Persons within the physician's practice authorized to use or make disclosure of the information: **ALL EMPLOYEES OF PHOENICIAN MEDICAL CENTER GROUP OF COMPANIES**
2. Persons or organizations authorized to receive the information:
   Spouse Yes No If yes, list person (s) name: _____
   Parent Yes No If yes, list person (s) name: _____
   Other individual, i.e., boyfriend/girlfriend, brother, sister, etc. Yes No
   If yes, please list name (s) and relation: _____
3. Specific description of information that may be used or disclosed: e.g.: **Contact information Tests results, referrals, prescriptions, paperwork, pertinent medical record**
4. The information will be used/disclosed for the following purposes:
   A. To inform me of my medical condition (s) by phone, mail, email or in person.
   B. To give information/referrals/medical records/prescription, paperwork, and or test results to you or the person (s) named on this form, by phone, mail email or in person.
   C. For treatment, payment and health care operations.
5. This authorization expires on: _____. I understand that I may revoke this authorization at any time by notifying the physician's office providing the information in writing. However, the revocation will not be valid, if:
   A. The physician has taken action in reliance of this authorization, or
   B. If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Signature of Patient or Representative: _____ Date: _____

Printed Name of Patient or Patient's Representatives: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

❑ I acknowledge that I have been offered a copy of Phoenician Medical Center dba Phoenician Neurology and Pain Notice of Privacy Practices. I also know I can go to https://www.pnpi.care/ website to read or print the notice online.

❑ I acknowledge that I declined a copy of Phoenician Medical Center dba Phoenician Neurology and Pain Notice of privacy Practices offered to me today.

Signature of Patient or Representative: _____ Date: _____

Printed Name of Patient or Patient's Representatives: _____

Phoenician Medical Center
"Quality Healthcare Begins with Us"

PHOENICIAN NEUROLOGY

New Patient Form

Name:_____Age:_____Sex:_____Date of Birth: _____

Reason for visit today? (List in order of importance to you)

1. _____For how long? _____
2. _____For how long? _____
3. _____For how long? _____
4. _____For how long? _____
5. _____For how long? _____

Referred by:_____Phone #_____Fax #_____

FOR INTERNAL USE ONLY (Do not write below this line)

Height:_____Weight:_____BP:_____/_____Pulse:_____RR:_____

Doctor's Notes

Diagnostic Studies

PHOENICIAN NEUROLOGY

List All Current Medications Taken At This Time (Including non-prescription and over-the counter meds.)

Medication	Dose (mg)	Times/day	For what condition
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
List additional medications on the back of this form.			

Past Medical History: Check all major illnesses, injuries, and/or psychiatric problems you have had.

- ☐ Alzheimer's Disease
- ☐ Dizziness/Vertigo
- ☐ Head Injury
- ☐ Headache
- ☐ Migraine
- ☐ Neuropathy
- ☐ Numbness
- ☐ Seizures/Epilepsy
- ☐ Sleep Difficulties
- ☐ Stroke/TIA
- ☐ Tingling
- ☐ Angina
- ☐ Atrial Fibrillation
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Pacemaker/Stent
- ☐ Asthma
- ☐ COPD
- ☐ Lung Disease
- ☐ Shortness of Breath
- ☐ Bleeding/Clotting
- ☐ Blood Clot in Leg
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Acid reflux
- ☐ Liver Disease
- ☐ Peptic Ulcer Disease
- ☐ Weight Loss/Gain
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Depression
- ☐ Drug Use
- ☐ Allergy/Hay fever
- ☐ Sinus Disease
- ☐ Arthritis
- ☐ Back Pain
- ☐ Kidney Disease
- ☐ Kidney Stone
- ☐ AIDS/HIV
- ☐ Cancer of: _____
- ☐ Other: _____

List All Medication Allergies

Medication Allergy	Reaction	Medication Allergy	Reaction
1		2	
3		4	
5		6	

List All Prior Hospitalizations and/or Surgeries

Name of hospital	Year	Reason for hospitalization/Surgery
1		
2		
3		
4		
5		
6		

Family History

	Alive/deceased (age)	Illness
Mother		
Father		
Brother/Sister		
Brother/Sister		
Brother/Sister		
Other		

List any neurological diseases in your family: _____

PHOENICIAN NEUROLOGY

Personal/Social History

Education: ☐ Less than high school graduate ☐ High school graduate ☐ Some College ☐ College graduate

Are you currently working? ☐Yes ☐No Occupation:_____

Marital Status: ☐Single ☐Married ☐Separated/divorced ☐Widowed Number of Children:_____Ages: _____

Have you ever smoked? ☐Yes ☐No if yes, do you currently smoke? ☐Yes ☐No If yes, for how long? _____
If you smoked, how many per day did you smoke? _____if you quit, when did you stop? _____

Have you ever drank alcohol? ☐Yes ☐No if yes, do you currently drink alcohol? ☐Yes ☐No If yes, for how long? _____
If you drank alcohol, how much did you drink?____ If you quit, when did you stop?_____

Have you ever used recreational drugs? ☐Yes ☐No if yes, do you currently use recreational drugs? ☐Yes ☐No
If you used recreational drugs what kind did you use? _____
Have you ever used needles? ☐Yes ☐No If you quit, when did you stop? _____

Indicate the daily amount of each you drink: Coffee:_____Tea_____Soda_____

Do you exercise? ☐Yes ☐No How Often?_____
What type? _____

Are you sexually active? ☐Yes ☐No ☐currently not
Current sex partner: ☐Male ☐Female
Have you ever had a sexually transmitted disease? ☐Yes ☐No
If you are a woman, are you pregnant? ☐Yes ☐No
Last menstrual period? _____ Menopausal? ☐ Yes ☐No At what age? _____

Review of Current Symptoms: Check all of the symptoms you are currently experiencing.

Constitutional
- o Chills
- o Don't Feel Well
- o Excessive Daytime Sleepiness
- o Fainting
- o Fatigue
- o Fever
- o Loss of Consciousness

Gastrointestinal
- o Abdominal Cramps
- o Abdominal Pain
- o Constipation
- o Diarrhea
- o Difficulty Swallowing
- o Heartburn
- o Nausea
- o Rectal Bleeding
- o Vomiting

Hematology
- o Easy Bruising
- o Easy Bleeding
- o Swollen Glands

Respiratory
- o Cough
- o Coughing up Blood
- o Excessive Snoring
- o Nasal Congestion
- o Wheezing

Cardiovascular
- o Chest Pain
- o Cold Extremities
- o Light-Headedness
- o Shortness of Breath
- o Swelling in Legs/Feet

Musculoskeletal
- o Back Pain
- o Foot/Ankle Pain
- o Hip Pain
- o Knee Pain
- o Muscle pain
- o Muscle Weakness
- o Night Cramps
- o Other Joint Pain
- o Shoulder Pain

Genitourinary
- o Blood in Urine
- o Discharge from Genitals
- o Incontinence of stool
- o Incontinence of urine
- o Other urination problems
- o Pain with Urination
- o Voice Changes

Endocrine
- o Bleeding
- o Excessive Thirst
- o Loss of Appetite
- o Sexual difficulty/low desire
- o Swollen Glands
- o Unintentional Weight Loss

integumentary (Skin)
- o Abnormal Hair Loss
- o Brittle nails
- o Pins/Needles Sensation
- o Blisters
- o Itching of the Skin
- o Rash

Eyes/ENT
- o Blurred Vision
- o Double Vision
- o Ear Pain
- o Eye Pain
- o Hearing Loss
- o Ringing of Ears
- o Smell Problems
- o Sore Throat
- o Sores in Mouth
- o Taste Problems
- o Visual Disturbance
- o Visual Loss

Psych
- o Anxiety
- o Confusion
- o Depression
- o Hallucinations
- o Insomnia
- o Memory Loss
- o Personality Change
- o Suicidal Thoughts

Neurology
- o Balance Problems
- o Dizziness
- o Facial Numbness
- o Facial Pain
- o Head Injury
- o Headaches
- o incoordination
- o Involuntary Movement
- o Numbness
- o Prior Euroconsult
- o Seizures
- o Speech Disturbance
- o Tingling
- o Transient Paralysis
- o Tremors
- o Vertigo
- o Weakness

Allergy/Immunology
- o HIV
- o STD
- o Recurrent Infection
- o Vitamin Deficiency

Prior Radiographic/Diagnostic Tests (Check all that apply)

Test	Where	When	Test	Where	When
☐ carotid Doppler/Ultrasound			☐ EEG (brain scan)		
☐ Myelogram			☐ EMG/NCV		
☐ Blood Tests			☐ Sleep Study		
☐ MRI of:			☐ VNG		
☐ CT Scan of:			☐ Lumbar Puncture		
☐ X-Ray of:			☐ Angiogram		

Patient's Signature_____Date _____

Phoenician Medical Center
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PHOENICIAN NEUROLOGY

1343 N ALMA SCHOOL ROAD, SUITE 125, CHANDLER, AZ 85224
606 N COUNTRY CLUB DRIVE, SUITE 5, MESA, AZ 85201
2226 W NORTHERN AVE SUITE C212, PHOENIX AZ 85021
PH: 480-776-2982 FAX: 480-917-7309

NO SHOW/LATE CANCELLATION POLICY

Please initial the below and then sign and date at the bottom

_____Phoenix Neurological and Sleep Institute has instituted a "No Show" policy for late cancellations or missed appointments. Although we attempt to call and remind patients of their appointments as a courtesy, it is thepatient's responsibility to keep track of the date and time of their scheduled appointments. Our office requires a 24-hour notice to cancel an appointment. Patients who do not show upfor a scheduled appointment will be charged a $25.00 fee, at the discretion of our office. We appreciate your cooperation and understanding in this matter.I acknowledge receipt of this notice.

PRESCRIPTION REFILL POLICY

_____If a prescription refill is necessary, then you will need to contact our office directly. DO NOT Call the pharmacy. Failure to do so will result in delays. Also note that it can take up to 48 business hours for the request to be processed. No action will be taken on requests submitted on Fridays, Saturday s, or Sundays so please plan appropriately. Further, the doctor may requirea follow up appointment before refilling the prescription.

_____
Patient's Name (Printed)

_____
Patient's Signature

_____
Date

PHOENICIAN NEUROLOGY

Fall Prevention Balance and Dizziness Survey

Patient Name: _____ Age: _____ Date: _____

To help determine if you may be headed for a fall or balance disorder, take the Balance Self-Test below.If you answer yes to one or more of the questions, you could be at risk. The best way to determine if you have a problem is to share with the doctor any fears or concerns you have regarding falling, dizziness, or vertigo, so that he or she may help determine the cause of your symptoms.

	Please read each question and check the box that most describesyour answer.	**Yes, or Often**	**Some-times**	**No or Never**
1	Do you ever lose your balance or feel dizzy or unsteady?	☐	☐	☐
2	Have you continued to experience dizziness after an injury or accident?	☐	☐	☐
3	Do you feel unsteady when you are walking or climbing stairs?	☐	☐	☐
4	Do you feel dizzy while sitting down or rising from a seated or lyingposition?	☐	☐	☐
5	Does walking down the aisle of a supermarket or stopping next tomoving traffic make you dizzy?	☐	☐	☐
6	Does moving your head quickly make you dizzy or cause you to feel nauseous?	☐	☐	☐
7	Are you dizzy or unsteady when you first get up in the morning?	☐	☐	☐
8	Do you ever fall or feel like you are about to fall for no apparentreason?	☐	☐	☐
9	Do you use a walker, cane, or any other form of assistance for your mobility?	☐	☐	☐
10	Have you had a recent loss of, or decrease in, your vision or hearing?	☐	☐	☐
11	Do you fear falling?	☐	☐	☐
12	Have you experienced dizziness, vertigo, or serious imbalance in thepast six months?	☐	☐	☐
13	Has your balance problem caused problems in your social life?	☐	☐	☐
14	Have you fallen more than once in the past year without an obviouscause?	☐	☐	☐
15	Does dizziness or imbalance interfere with your job or your household responsibilities?	☐	☐	☐

Please provide this to your physician during your visit.

Rights of the Patient: *Effective 5.1.2016 / Reviewed 1.2025*

You have the right to be treated with dignity, respect and consideration and you will not be subjected to:

* ABUSE * NEGLECT * EXPLOITATION * COERCION * MANIPULATION * SEXUAL Abuse or Assault
* RESTRAINT OR SECLUTION (except as allowed in R9-10-1012(B).
* RETAILIATION for submitting a complaint to our office, The AZDHS or any other entity.
* Misappropriation of personal or private property by a staff member, volunteer or student

You or your representative:

- Except in an emergency, either consents to or refuses treatment
- May refuse or withdraw consent for treatment before treatment is initiated
- Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of proposed psychotropic medication or surgical procedure
- Is informed of our policy on Healthcare directives
- Is informed on the patient complaint process. (See “License Posting Notice”)
- To consent to a photograph before being photographed.
- Except as otherwise permitted by law, provides written consent to the release of information in the patient’s medical record or financial records.

You have the right:

- Not to be discriminated against based on Race, National origin, Religion, Gender, Sexual orientation, Age, Disability, Marital Status or Diagnosis
- To receive treatment that supports & respects your individuality, choices, strengths and abilities
- To receive privacy in treatment and care for personal needs
- To review upon written request, your own medical record according to A.R.S 12-2293, 12-2294 & 12-2294.01
- To receive a referral to another healthcare institution if our office is not authorized or not able to provide care needed by you the patient.
- To participate or have your representative participate in the development of or decisions concerning treatment
- To participate or refuse to participate in research or experimental treatment
- To receive assistance from a family member, your representative or other individual in understanding, protecting or exercising your rights.

Responsibilities of the Patient:

- To provide accurate and complete information concerning your present complaints, past illnesses, hospitalizations, medications and other matters relating to your health.
- To report perceived risks in your care and unexpected changes in you condition to your provider
- To ask questions if you do not understand what you have been told about your care or what you are expected to do
- To follow the treatment plan established by your provider, including the instructions of support staff as they carry out the providers orders
- To keep appointments and for notifying the office when you are unable to do so.
- For your actions should you refuse treatment or not follow your providers orders.
- To assure that the financial obligations of your medical care are fulfilled as promptly as possible.
- For being considerate of the rights of other patients and office staff & respectful of your personal property and that of other persons in the office.
- To have a surrogate decision maker identified if you are unable to make decisions about care, treatment or services.
- To involve the family in care, treatment and services with permission from you or your surrogate decision maker.

_____

Signature Date

Phoenician Medical Center
"Quality Healthcare Begins with Us"

PHOENICIAN NEUROLOGY

FINANCIAL POLICIES AND ARRANGEMENTS

We recognize the need for understanding the areas of payment arrangements and insurance filings. This sheet has been put together to address some of these areas for you.

INSURANCE, FILING/BENEFITS/PAYMENT

There are numerous insurance plans with which we have contracted to receive payment directly from the insurance company. With these plans, the patient is generally required to meet a deductible or make a co-payment. If you are covered by one of these plans, please show us your card. Be prepared to make your co-payment or pay for your office visit if your deductible has not been met at the time of service. We accept cash, checks, Visa, and MasterCard. With plans that we are not contracted with, you will be asked to pay at the time service is rendered. If we are billing your insurance for you, it is extremely important that you furnish us with accurate and updated information so your claim can be filed. It is your responsibility as a consumer to know what benefits are covered by your insurance plan. Most insurance carriers have numerous plans that cover different types of services. Contraception, immunizations, and other services may not be covered on your particular plan. Services provided that are not a coveredbenefit are your responsibility and payment is due at the time services are rendered. If you have questions as to what services are covered, contact member services (the number is listed on your insurance card). We will set aside the portion of the balance estimated to be paid by your insurance carrier for 45 days. If your carrier does not remit payment within 45 days, you will be responsible for the full balance. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim, you will continue to receive statements until the account is paid in full.

PAYMENT ARRANGEMENTS

Payment is expected at the time of service. If you do not have your co-pay at the time of service, your visit may be rescheduled. Also, we recognize the need to set up payment plans for patients who require extensive treatment. Our business office will be happy to help you with these arrangements.

DELINQUENT ACCOUNTS

Bills that are delinquent for more than ninety (90) days may be transferred to an outside collection agency unless prior arrangements have been made. If you have questions or think an error has been made, please discuss them with us priorto the 90 days in order to help us resolve this.

RETURNED CHECKS

There is a $25.00 service fee for checks returned for insufficient funds. We belong to the Maricopa County Attorney's Check Enforcement Bureau. We request a copy of your driver's license or ID card as identification.

CANCELLATION OF APPOINTMENTS/ NO-SHOW APPOINTMENTS

We ask that you give us 24 hours' notice to cancel an appointment. If you do not cancel an appointment, you can becharged $25.00 as this will be considered a no-show. Three no-show appointments are grounds for dismissal from theoffice.

ADVANCED BENEFICIARY AGREEMENT

Medicare and other insurance plans will only pay for services that they determine to be reasonable and necessary undersection 1862 (a) (1) of Medicare Law. If payment is denied for services or tests, (i.e., routine exam/lab work,

vaccinations, contraception, procedures, and non-related diagnoses for the services provided), then the patient is personally and fully responsible for payment.

CONSENT FOR TREATMENT

I consent to evaluation and treatment of the condition for which I, or my child or dependent, have come to Phoenician Neurology (PN) and authorize the physicians and other health care providers affiliated with Phoenician Neurology & Phoenician Medical Center group of companies to provide such evaluation and treatment. I understand that health careproviders in training may be involved in my care and treatment and consent to their involvement. I understand that thepractice of medicine is not an exact science and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by PNI. I authorize PNI to examine, use, store and dispose of all tissue, fluids, or specimens removed from my body. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at PNI.

ADVANCE DIRECTIVES

Phoenician Medical Center will keep a copy of my advance directive/living will/power of attorney paperwork on file if I wish to offer a copy for my chart. Phoenician will also offer paperwork to me if I am interested in advance directives. I acknowledge that I have been informed and understand Phoenician Medical Center's policy on advance directives.

CONSENT FOR SHARED ELECTRONIC MEDICAL RECORDS

I understand PNI shares an electronic medical record system (MDSynergy/Althea) with Phoenician Medical Center Group ofCompanies. I also understand only the minimum necessary will be viewed by staff members and only for continuation of patient care.

Please feel free to discuss any concerns you may have with our office staff. Our staff is dedicated to making your visits with us as pleasant as possible. **It is your responsibility to know what is covered by your insurance plan as well as being financially responsible for any services denied or not covered by insurance.**

I have read and agree to the above policies of Phoenician Neurology. I understand the contents and by signing belowaccept the aforementioned financial responsibilities.

Patient/Guardian's Signature: _____ Date: _____

Prescription Medical Refill Policy

PNI never wants you to be without your prescribed medications. Our refill policy is to protect your health and to reduce complications and errors on medications. It also will allow our medical staff to respond and focus on your clinical questions and needs quickly and efficiently. Our prescription medication refill policy states: Medication refills will be given at your regularly scheduled appointment by your provider. If you are low on medications, we will schedule you an appointment and make sure you have enough medications to last until we can get you in for an office visit, normally 1–2-week supply. We will not call-in antibiotics or controlled medications under any circumstance, **nor do we authorizeany refills by fax or pharmacy calls.**

Please bring a list of your current medications to your appointment as well as how many refills you have available. This way we can ensure you have enough medications to last until your next scheduled appointment. Thankyou for your understanding and cooperation. By signing below, I understand and agree to this policy.

Patient Signature: _____ Date: _____

NOTICE OF HEALTH INFORMATION 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 see the receptionist to request a copy.

Understanding Your Health Record/Information

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- tool in educating health professionals
- source of data for medical research
- source of information for public health officials charged with improving the health of the nation
- source of data for facility planning and marketing
- tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- notify you of a breach of "unsecured" protected health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

We will not use or disclose your health information without your written authorization, except as described in this notice.

To Report a Problem

If you have questions and would like additional information, you may contact the Privacy Officer at this office.

If you believe your privacy rights have been violated, you can file a complaint with this office or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

Treatment: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide subsequent healthcare providers with copies of various reports that should assist them in treating you.

Payment: A bill may be sent to you or a third-party payer. This information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

Health Operations:

1. **Risk Management** - Members of the medical staff or the risk or quality improvement staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
2. **Business Associates** - There are some services provided in our organization through contacts with business associates. Examples include radiology, laboratory, copy services, transcription services, billing services, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
3. **Notification –** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.
4. **Communication With Family** - Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
5. **Research** - We may disclose 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 health information.
6. **Funeral Directors –** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
7. **Organ Procurement Organizations** – Consistent with applicable law, we may disclose 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.
8. **Marketing –** 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.
9. **Food and Drug Administration (FDA) –** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, recalls, repairs or replacement.
10. **Workers' Compensation –** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.
11. **Public Health –** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
12. **Law Enforcement –** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

This notice is effective as of 1/1/2010 and will remain in effect until revised.