



Thank you for choosing The Lighter Weigh for your weight management needs. We sincerely look forward to meeting you and working together to help you achieve your goals.

Location:

Our office address is 1 Hospital Drive SW, Suite 300 Huntsville AL 3580. We are located in the Crestwood Medical Center Medical Pavilion 2 and our building also has the Maternity Center, the Cancer Center and valet parking.

Directions:

Crestwood Medical Center is off Airport Road. Take Memorial Parkway South and exit on Airport Road. Turn left onto Airport Road. Go through 3 traffic lights and then turn left onto Hospital Drive. At the stop sign, cross over Whitesport Drive and continue to the main parking area. Our building is to the right. You have the option to valet park.

Here are a few things to know and have prepared for your first visit:

- 1) **New Patient Forms.** Please fill out the complete paperwork and forms in advance of your visit. It contains your medical history, weight history, consent forms, and a copy our "Privacy Policy" for your records. **We understand and appreciate that the forms and questionnaires are very detailed and will take about 20 minutes to complete. Please take the time to fill them out completely and accurately as this really helps us learn more about you so that we can better assist you during your visit.**

If you can, **please fax your new patient forms to our office 3-7 days prior to your visit** as this will allow us time to transfer your information into our electronic medical record and allow us to review your chart prior to your visit. You may fax your paperwork to **(256) 429-9109**.

- 2) **Medication List.** Please make sure to bring all of your medication bottles or a pharmacy printout of your medications so that we may accurately record them in our chart.
- 3) **Labs.** If you have had blood work drawn in the last 3 months, please bring a copy to your 1st visit, or arrange for a copy to be faxed to our office. If not, **we can order any necessary labs. You may obtain these on the day of the visit, if you are fasting.** Labs may be drawn at a lab facility at your convenience.
- 4) **Payment.** Please note that full payment is required at the time of service. We accept cash, and all major bank cards. We do not accept checks.
- 5) **Check In.** Please report **directly** to the receptionist in order to check in for your visit. Any payment made via office kiosks will require reversal.
- 6) **Please arrive 30 min prior to your scheduled appointment** so we can register you and start your visit on time.
- 7) **Fax New Patient Forms.** Again, if possible, please fax your completed New Patient Forms to **(256) 429-9109** in advance of your scheduled appointment.

Thank you and we look forward to meeting you



**TAKE HOME
FOR YOUR
PERSONAL
RECORDS**

**1 Hospital Drive SW, Suite 300
Huntsville, AL 35801
Phone: 256-429-9152 Fax: 256-429-9109
Practice Policies and Consent**

We are dedicated to providing the best possible care for you, and we want you to completely understand our practice policies.

1. **Payment is due at the time of service. We accept Cash, and all major credit cards. If you are not able to pay at the time of your visit, we will ask that you reschedule your appointment until you are able to do so.**
2. There is a fee for forms to be completed by your provider. Forms may take up to 10 days to complete.
3. We may require a fee for medical records requests. Payment is due prior to the release of any records. Please note that it may take up to 10 business days to process medical record requests.
4. Any patient that is **15 minutes late** for their appointment may be asked to reschedule.

Prescription Refill Policy

All prescriptions will be filled at the time of a visit. Any lost or misplaced prescriptions will require a visit in order to be replaced.

No Show Policy

Your appointment is reserved specifically for you. In order to serve all of our patients, we respectfully ask you to notify our office at least 24 hours prior to your visit if you cannot keep the appointment. If you do not provide at least 24 hours' notice, it will be considered a No-Show. **If you No-Show, we will ask that you pay in advance for your next visit at the time of scheduling. This fee is non-refundable.** If you continue to No-Show to your appointments, you may jeopardize your ability to schedule further appointments in our office.

Electronic Prescription History Data Access

By signing below I give permission for The Lighter Weigh, LLC to access my pharmacy benefits data electronically. This consent will enable The Lighter Weigh, LLC to:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

CONSENT:

I have read and understand the practice's policies. I understand that these policies may be amended by the practice from time to time without notice. My **electronic signature** signifies that I have received the practice's privacy statement, and I hereby agree to be bound by the practice's financial policies. I consent to the performance of examinations, diagnostic procedures and treatments which my physician deems necessary. I also give permission to access my prescription history electronically, take a digital photograph for identification and to be contacted via phone, including text messaging. This consent shall remain in effect until I choose to revoke it in writing.

Signature of Patient (or responsible party, if patient is a minor).

New Patient Demographic Info

Patient Information		Please Print all Information Clearly with a Black Pen	
Title	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		
First, Middle, and Last Name			
Preferred / nickname if different from above			
Address Line 1			
City, State, Zip Code			
Phone Number(s) please star (*) your preferred phone number	Home	()	
		()	
	Cell		
Work	()		
Okay to leave a message on home phone? Okay to leave a message on cell phone?	no yes	What is the best time of day to contact you?	
E-mail address	no yes		
Birthday (mm/dd/yyyy)			Age:
Primary Care Provider's Name and Number			
Names of your other Physicians			
How did you hear about us? (Circle One)	Friend	Website	Physician DEW Center Other
Pharmacy Information			
Pharmacy Name			
Pharmacy Phone Number			
Pharmacy Street Address (or street name)			
Pharmacy City / State / Zip			
Emergency Contact Information			
First and Last Name and Relationship			
Phone Number(s)			

Stroke / TIA	no	yes	
PCOS (polycystic ovary syndrome)	no	yes	
Low Thyroid (Hypothyroidism)	no	yes	
Migraine Headaches	no	yes	List any previous SURGERIES below:
Sleep Apnea	no	yes	check here for "no previous surgeries"
If so do you use a CPAP machine?	no	yes	
Depression	no	yes	
Anxiety	no	yes	
Asthma / Emphysema / COPD	no	yes	
Eating Disorder (anorexia / bulimia)	no	yes	
Glaucoma	no	yes	

Family History (list family members below with each of the following conditions)

<p>Indicate who in your family have any of the following medical conditions:</p> <p>(e.g. mother, father, brother, sister, children, cousins, uncles, aunts, grandparents)</p>	Cancer (list types):
	Diabetes:
	Heart Disease:
	High Blood Pressure:
	High Cholesterol:
	Hypothyroidism/Low Thyroid:
	Sudden Death (age < 40):
	Other Family Conditions:

Review of Systems (please circle if you have any of the following)

General	Fatigue	Change in weight	Always Cold	Always Hot
Heart	Chest Pain	Palpitations	Leg Swelling	
Lungs	Shortness of Breath	Coughing	Wheezing	
Abdomen	Nausea / Vomiting	Constipation	Diarrhea	
Menstrual	Irregular Cycles	No Menstrual Cycles	Post-Menopausal	
Mental Health	Depression	Anxiety	Trouble Sleeping	
Skin	Hair Loss	Acne/Extra	Facial Hair	
Neurological	Headaches	Numbness/Tingling		

Social History	
Smoking History	<input type="checkbox"/> I've never smoked
	<input type="checkbox"/> I previously smoked but quit
	<input type="checkbox"/> I currently smoke the following # of packs per day:
Alcohol Use	<input type="checkbox"/> I do not drink any alcohol
	<input type="checkbox"/> I previously drank but quit History of alcoholism? no yes
	<input type="checkbox"/> I currently drink alcohol. How many drinks per week?
Drugs / Illicit Substances	Have you ever given yourself street drugs with a needle? no yes
	Do you have a history of any drug addiction? no yes
	Are you currently using any street/illicit drugs? no yes
Sexual / Reproductive History	Are you sexually active? no yes
	If yes, are you currently trying to become pregnant? no yes
	If not trying to conceive, what contraceptive method?
	Is there a possibility that you are pregnant right now? no yes
	Do you have a history of infertility? no yes
	When was your last menstrual cycle?
	How many menstrual cycles do you have per year?
Your Occupation	
Employer Name	
Marital Status (Circle one)	Single Married Engaged Partnered Divorced Widowed
Spouse's Name	
Spouse's Occupation	
Who lives in the Household with you?	
Your Children's Ages & Names:	

Weight History

Life Milestones/Events & Weight				
In the space provided, share any life events that relate to your weight loss or weight gain. Add any specifics you would like. <i>Possible life events may include: Special occasions/events (e.g., wedding, baby, class reunion, vacation), Home or work changes (eg job change, divorce, personal loss, move), Health or medical changes (e.g. nutritionist, injury, surgery, medication)</i>				
When did this occur? (age)	Event	How much weight did you lose/gain?	Weight Loss	
			What did you do to lose weight?	Would you do it again? (Y/N)
__ years old		Starting weight _____ lbs		
__ years old		Lost ___ lbs /Gained ___ lbs		
__ years old		Lost ___ lbs /Gained ___ lbs		
__ years old		Lost ___ lbs /Gained ___ lbs		
__ years old		Lost ___ lbs /Gained ___ lbs		
__ years old		Lost ___ lbs /Gained ___ lbs		
__ years old		Lost ___ lbs /Gained ___ lbs		

Weight-Loss/Management Efforts

How would you describe your efforts to lose or maintain weight? Please select all that apply.

Efforts	Tried it in the past	Doing it now
Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>
Healthy Eating	<input type="checkbox"/>	<input type="checkbox"/>
Over-the-Counter Products	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Medication	<input type="checkbox"/>	<input type="checkbox"/>
Commercial Weight-Loss Programs (e.g. Weight Watchers)	<input type="checkbox"/>	<input type="checkbox"/>
Bariatric Surgery	<input type="checkbox"/>	<input type="checkbox"/>

How long have you been trying to lose weight?

Less than 2 years <input type="checkbox"/>	2-4 years <input type="checkbox"/>	5-9 years <input type="checkbox"/>	As long as I can remember <input type="checkbox"/>
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Diet and Nutrition Questionnaire (List common foods you eat at the following times of the day)					
Meal	Main Dishes	Side dishes	Desserts	Drinks	Eating Out / Restaurants
Breakfast					# breakfasts out/week & where?
Morning Snacks					
Lunch					# lunches out/week & where?
Afternoon Snacks					
Dinner					# dinners out/week & where?
Evening Snacks					
How many <u>breakfasts</u> do you skip per week?		Why?			
How many <u>lunches</u> do you skip per week?		Why?			
How many <u>dinners</u> do you skip per week?		Why?			
How many meals per week do you eat out or take out (Including breakfast, lunch, and dinner)?					
Which restaurants do you usually eat out or take out at?					
Do you frequently eat overnight?		<input type="checkbox"/> No <input type="checkbox"/> Yes, I eat overnight			
Do you consider yourself a stress eater?		<input type="checkbox"/> No <input type="checkbox"/> Yes, I eat when I'm stressed			
Do you feel hungry all the time?		<input type="checkbox"/> No <input type="checkbox"/> Yes, I'm always hungry			

<p>Activity and Exercise Please select your current activity level (select only <u>one</u> of the options)</p>	<p><input type="checkbox"/> Heavy Activity - regular exercise at least 3x per week</p> <p><input type="checkbox"/> Vigorous Activity - extensive exercise > 60 min at least 4x/week</p> <p><input type="checkbox"/> Inactive - no regular physical activity with a sit down sedentary job</p> <p><input type="checkbox"/> Moderate Activity - i.e. occasionally walk, jog, run, bike, golf, tennis</p>
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Outside of work and working in the home, please describe what physical activity you do and how often:

Do you do any form of resistance training and if so describe and how often (i.e. lift weights, resistance bands)?

What limits or prevents you from participating in more physical activity or exercise (e.g. joint problems, arthritis, time)?

Do you have membership at any gyms or exercise facilities? Which one(s)?

Behavior Styles, Stress, and Sleep Hygiene

<p>Behavior Style (select only <u>one</u> of the options)</p>	<p><input type="checkbox"/> You are calm and easygoing</p> <p><input type="checkbox"/> You are sometimes calm but frequently impatient</p> <p><input type="checkbox"/> You are seldom calm and have overwhelming drive for ambition</p> <p><input type="checkbox"/> You are hard driving and can never relax</p>
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Please circle your **STRESS** level:

0	1	2	3	4	5	6	7	8	9	10
0=no stress					5=moderate stress			10=extreme stress		

Please describe major sources of stress in your life and how they affect you:

<p>Sleep Hygiene and Sleep Patterns (select <u>all</u> that apply)</p>	<p>* What time do you usually go to sleep?</p> <p>* What time do you usually wake up?</p> <p>* Do you wake up through the night? <input type="checkbox"/> no <input type="checkbox"/> yes</p> <p>* Do you wake up and <u>eat</u> overnight? <input type="checkbox"/> no <input type="checkbox"/> yes</p> <p><input type="checkbox"/> I usually sleep 8 or more hours per night</p> <p><input type="checkbox"/> I usually sleep 6 - 8 hours per night</p> <p><input type="checkbox"/> I usually sleep 4 - 6 hours per night</p> <p><input type="checkbox"/> I usually sleep < 4 hours per night</p> <p><input type="checkbox"/> I snore heavily at night</p> <p><input type="checkbox"/> I wake up in the morning still tired</p> <p>Have you ever had a sleep study? <input type="checkbox"/> no <input type="checkbox"/> yes</p> <p>I have sleep apnea; if yes do you use CPAP? <input type="checkbox"/> no <input type="checkbox"/> yes</p> <p><input type="checkbox"/> I work at night and sleep during the day</p>
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PHQ-9 Depression

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "✓" to indicate your answer"

	Not all	at Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.....	0	1	2	3
2. Feeling down, depressed, or hopeless.....	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.....	0	1	2	3
4. Feeling tired or having little energy.....	0	1	2	3
5. Poor appetite or overeating.....	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.....	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.....	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.....	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.....	0	1	2	3

Column totals ___ + ___ + ___ + ___
 = *Total Score* ___

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission



Photography/Video Consent and Release Form

Without expectation of compensation or other remuneration, now or in the future, I _____ hereby give my consent to **The Lighter Weigh, LLC**, its affiliates and agents, to use my image and likeness and/or any interview statements from me in its publications, advertising or other media activities (including the Internet). This consent includes, but is not limited to:

- a. Permission to interview, film, photograph, tape, or otherwise make a video reproduction of me and/or record my voice;
- b. Permission to use my name; and
- c. Permission to use quotes from the interview(s) (or excerpts of such quotes), the film, photograph(s), tape(s) or reproduction(s) of me, and/or recording of my voice, in part or in whole, in its publications, in newspapers, magazines and other print media, on television, radio and electronic media (including the Internet), in theatrical media and/or in mailings for educational and awareness purposes.

This consent is given in perpetuity, and each instance does not require prior approval by me. This consent may be withdrawn at any time by completion of the Photography/Video Consent and Release Revocation Form.

Name: _____

Signature: _____

Date: _____

Witness Signature: _____



**Charmaine Blake Woode, MD
Dwain E. Woode, MD**

One Hospital Drive SW, Suite 300 Huntsville, AL 35801 Phone: 256-429-9152 Fax: 256-429-9109

PERSONAL AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ **Social Security Number:** _____

I request and authorize The Lighter Weigh, LLC to verbally release my healthcare information to the person(s) indicated below:

Name: _____ Relationship: _____ Address: _____

Name: _____ Relationship: _____ Address: _____

Name: _____ Relationship: _____ Address: _____

AUTHORIZATION TO RELEASE WRITTEN MEDICAL RECORDS TO PHYSICIAN/INDIVIDUAL

Physician/Individual Name: _____

Medical Practice/Company Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ **Fax:** _____

Reason for Request: _____

Please Release:

___ All Records

___ Specific Information or Dates: _____

___ Letter Containing the Following Information: _____

___ **From** The Lighter Weigh, LLC to the practice /individual listed above.

___ **To** The Lighter Weigh, LLC from the practice /individual listed above.

Patient's Signature: _____ **Date:** _____

Guardian's Signature: _____ Relationship: _____ Date: _____
(Patient under the age of 18)

Witness: _____ **Date:** _____

I understand that this authorization is voluntary and it expires 12 months after the date signed. I may choose to revoke this consent at any time in writing.



**TAKE HOME
FOR YOUR
PERSONAL
RECORDS**

1 Hospital Drive, Suite 300
Huntsville, AL 35801
Dwain E. Woode, MD Charmaine B. Woode, MD
Privacy Officer: Cassandra Ways, MBA
256-429-9152

NOTICE OF PRIVACY PRACTICES

Effective Date: January 1, 2019

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

I. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart on a computer in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

- A. Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.
- B. Payment.** We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
- C. Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

1. **Appointment Reminders.** We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
2. **Sign In Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
3. **Notification and Communication With Family.** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
4. **Marketing.** Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
5. **Sale of Health Information.** We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
6. **Required by Law.** As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
7. **Public Health.** We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
8. **Health Oversight Activities.** We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
9. **Judicial and Administrative Proceedings.** We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

- 10. Law Enforcement.** We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
- 11. Coroners.** We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
- 12. Organ or Tissue Donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
- 13. Public Safety.** We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
- 14. Specialized Government Functions.** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
- 15. Workers' Compensation.** We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
- 16. Change of Ownership.** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
- 17. Breach Notification.** In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use your patient portal to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.
- 18. Psychotherapy Notes.** We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
- 19. Research.** We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

II. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. Your Health Information Rights

- A. Right to Request Special Privacy Protections.** You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
- B. Right to Request Confidential Communications.** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

- C. Right to Inspect and Copy.** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.
- D. Right to Amend or Supplement.** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
- E. Right to an Accounting of Disclosures.** You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
- F. Right to a Paper or Electronic Copy of this Notice.** You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this notice. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

IV. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

V. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Sam Nunn Atlanta Federal Center (SNAFC)
61 Forsyth Street, SW
Atlanta, GA 30303-8909
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.