James C. Ho MD Medical Corporation 何醫師

First **name**/ 名_____Last name? / 姓_____

Birth date / 出生日期_____

Street address 街道地址_____

City, state / 市，州_____Zip code / 邮政编码_____

☐ Male / 男 ☐ Female / 女 ☐Gender queer/Non-Binary / 其他/性别酷儿 ☐ Married 已婚 ☐ Single / 单 ☐ Divorced / 离婚了 ☐ Widowed / 寡 ☐ Civil Union/Common Law/Domestic Partner / 同居

Social Security Number / 社会安全卡号码_____

Driver's License Number /驾驶执照号码_____

Primary **Language** / 主要语言_____

Need an **interpreter**? / 你是否需要翻译员 Si / 是 No / 不

Insurance Company /Billing Information
保险公司 / 付款方式

Names of Responsible Party / 责任方名称_____

What is the relationship of patient to responsible party? / 病人与负责人之间关系？_____

What is the birth date of responsible party? /责任方的生日？_____

Insurance / Seguro / 保险_____

Insurance company street **address** / 保险公司街道地址_____

Insurance company City, State / 保险公司: 市 _____

Policy Holder Relationship to Patient / 保单持有人与患者的关系_____

Insured **Social Security** Number / 保险持有人的社會安全卡號碼_____

Policy/Group **Number** / 保险号码_____ _____

Member ID number /會員身分證號碼_____

HIC (**Medicare Number**) / 医疗保险号码_____

Medical Problems 列出您的醫療問題

_____

_____

_____

_____

_____

_____

Past **surgeries** 列出過去的手術

_____

_____

Please list current **medications**, including milligrams, frequency (once daily, twice daily, three times day, bed time, as needed.) 請列出目前的藥物治療，包括毫克數、頻率（每天一次、每天兩次、每天三次、就寢時間，根據需要。）

_____

_____

_____

_____

_____

_____

Please list your medication **allergies** below. Please note your reactions such as rash, throat swelling, breathing difficulty 请在下面列出您的药物过敏情况。请注意您的反应，例如皮疹，喉咙肿胀，呼吸困难

_____

_____

Name of your preferred **pharmacy**, include address or cross streets and City. 您首選藥房的名稱，包括地址或十字路口和城市_____

Family History: Mainly blood-related first degree relatives (Parents, brothers and sisters) / 主要是一级亲戚（父母，兄弟姐妹）

Cancer in the family? 家人有癌症嗎?

For cancers noted above, indicate the type of cancer, which relative, the age of cancer diagnosis. 对于上面提到的癌症，请指明癌症的类型，哪个相对，癌症诊断的年龄._____

Heart disease in the family?/家族中有心臟病嗎?

This is for coronary artery disease such as heart attacks and those requiring stents, heart by-pass 这适用于冠心病，例如心脏病发作和那些需要支架，心脏搭桥的疾病_____

What is your **occupation**? (If your are retired, your prior occupation) / 你的职业是什么？（如果你退休了，你以前的职业）

_____

Do you now or have you in the past used **illegal drugs**? When and what type? 您現在或過去是否使用過非法藥物？什麼時候、什麼類型？

_____

Do you **smoke** or vape tobacco now or in the past?/ 你抽煙或使用 电子煙嗎? 你过去有抽烟吗 Yes/Si/有 No/ 沒有

How many years total did you smoke? How many packs of cigarettes did you average per day? If you quit, when did you quit? 您总共抽了几年烟？您每天平均要抽几包香烟? 如果您戒烟，您什么时候戒烟的?_____

Are you considering **quitting**? 是否想要戒煙？Yes/Si/有 No/ 沒有

What **methods** of quitting have you tried? 嘗試過那些戒煙的方式？_____

When was your last colonoscopy? 您上次结肠镜检查是什么时候？_____

When was your last stool colon cancer screening? 既往糞便大腸癌篩檢_____

When was your last mammogram? 您上次进行乳房 X 光检查是什么时候? _____

When was your last pap smear? 您 上 次子宫颈抹片检查是什么时候？ _____

When was your last tetanus shot?/ 你上次破伤风疫苗注射是什么时候? _____

When was your last flu shot? 你上次注射流感疫苗是什么时候? _____

When was your last pneumonia vaccine (Pneumovax, Prevnar, PCV)?

您上次接種肺炎疫苗是什麼時候? _____

Dates of your shingles vaccine?您上次接種帶狀皰疹疫苗是什麼時候? _____

Name 名_____Date of Birth 出生日期_____

Today's Date 今天的日期_____

病人健康狀況問卷 － 9
(PHQ-9)

在過去兩個星期，你有多經常受以下問題困擾？ *（請用「✔」勾選你的答案）*	**完全沒有**	**幾天**	**一半以上的天數**	**近乎每天**
1. 做任何事都覺得沉悶或者根本不想做任何事	0	1	2	3
2. 情緒低落、抑鬱或絕望	0	1	2	3
3. 難於入睡；半夜會醒或相反地睡覺時間過多	0	1	2	3
4. 覺得疲倦或活力不足	0	1	2	3
5. 胃口極差或進食過量	0	1	2	3
6. 不喜歡自己──覺得自己做得不好、對自己失望或有負家人期望	0	1	2	3
7. 難於集中精神做事，例如看報紙或看電視	0	1	2	3
8. 其他人反映你行動或說話遲緩；或者相反地，你比平常活動更多──坐立不安、停不下來	0	1	2	3
9. 想到自己最好去死或者自殘	0	1	2	3

Total_____

James C. Ho MD Medical Corporation 何醫師

Name 名_____Date of Birth 出生日期_____

Today's Date 今天的日期_____

年齡: _____ 性別: 男 □ 女 □

1. 你多經常飲用含有酒精的飲料?
   - 從不(請跳到問題9-10)
   - 每月一次或更少
   - 每月2-4次
   - 每星期2-3次
   - 每星期4次或更多

2. 在你飲酒時，一般每天飲用多少个數量的飲品?
   - 1或2
   - 3或4
   - 5或6
   - 7, 8或9
   - 10或更多

3.你在飲酒時多經常會每次飲用六個或更多數量的飲品?
   - 從不
   - 少於每月一次
   - 每月一次
   - 每星期一次
   - 每日或幾乎每日一次

4. 在過去一年當中，你多經常出現一旦開始飲酒就不能停止的情況?
   - 從不
   - 少於每月一次
   - 每月一次
   - 每星期一次
   - 每日一次或者幾乎每日一次

5.在過去一年當中，你多經常出現過正常情況下能做的事情但是因爲飲酒而不能做?
   - 從不
   - 少於每月一次
   - 每月一次
   - 每星期一次
   - 每日一次或者幾乎每日一次

6. 在過去一年當中，你多經常出現過在經歷過大量飲酒之後的早晨你首先需要喝一杯才能正常生活?
   - 從不
   - 少於每月一次
   - 每月一次
   - 每星期一次
   - 每日一次或者幾乎每日一次

7.在過去一年當中，你多經常出現在飲酒之後感到內疚或者後悔?
   - 從不
   - 少於每月一次
   - 每月一次
   - 每星期一次
   - 每日一次或者幾乎每日一次

8. 在過去一年當中，你多經常因爲飲酒而不能想起前一天晚上發生了什麼事情?
   - 從不
   - 少於每月一次
   - 每月一次
   - 每星期一次
   - 每日一次或者幾乎每日一次

9. 你是否有過因爲飲酒而使你自己或者其他人受傷?
   - 沒有
   - 有，但不是過去的一年
   - 有，在過去的一年

10. 是否有親戚或者朋友或者醫生或者其他健康工作人員對你的飲酒感到擔心或者建議你減少飲酒?
   - 沒有
   - 有，但不是過去的一年
   - 有，在過去的一年

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W:	0-3	4-12	13-19	20+

Total_____

1330 San Bernardino Rd Suite G, Upland CA 91786 Phone: 909-755-0622 Fax909-931-3627

Name 名_____Date of Birth 出生日期_____

Today's Date 今天的日期_____

儿童期不良经历修订版问卷调查

加州主管医务总监办公室临床咨询委员会

aces aware
SCREEN. TREAT. HEAL.

我们的人际关系和经历，包括儿童期，都会对个人健康和福祉产生影响。许多人都拥有不幸的童年。请告诉我们您是否有过以下任何经历，因为这些经历可能正在影响您今天的健康或可能影响您未来的健康。此类信息能帮助您和您的提供者展开更好的协作，全力确保您的健康和福祉。

说明：下表列出了 10 类儿童期不良经历 (Adverse Childhood Experiences, ACE)。在下表中，请勾选您在 18 岁生日前所经历过的 ACE 类别。然后，请计算您所经历过的 ACE 类别数量，并将*总数*填写至底部。

您是否曾没有足够食物而挨饿、被迫穿着肮脏衣物或者无人保护或照顾您？	☐
您是否因父母离异、父母一方被抛弃、父母一方死亡或其他原因而失去父亲或母亲？	☐
您是否曾与罹患抑郁症、精神病或自杀未遂的任何人生活在一起？	☐
您是否曾与存在酗酒或嗑药（包括处方药）等问题的任何人生活在一起？	☐
您的父母或您家中的成人是否曾彼此击打、殴打、抽打或威胁互相伤害？	☐
您是否曾与被监禁或坐过牢的任何人生活在一起？	☐
您的父母或您家中的成人是否曾对您实施咒骂、侮辱或羞辱？	☐
您的父母或您家中的成人是否曾对您实施过击打、殴打、踢打或任何形式的身体伤害？	☐
您是否曾认为家中没有人爱您，或没有人认为您对他们来说是特别的？	☐
您是否经历过非自愿的性接触（例如抚摸或口交/肛交/阴道性交/插入）？	☐
ACE 分数是您勾选的总数	

您认为这些经历对您的健康产生了多大的影响？ ◯ **影响很小** ◯ **一定影响** ◯ **影响很大**

童年经历只是人生故事的很小部分。
在未来的人生里，我们可以采用各种方法，真正治愈内心的创伤。

如有隐私或保密相关疑问，请告诉我们。

Name 名_____Date of Birth 出生日期_____

Today's Date 今天的日期_____

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

社會需求篩選工具

住房

1. 您是否擔心或擔憂在接下來的兩個月中可能沒有自己擁有、租住 或作爲家庭一部分居住的穩定住房？[1]
   - ☐ 是
   - ☐ 否

2. 想想您居住的環境。您是否有以下任一個問題？(可複選)[2]
   - ☐ 害蟲侵染
   - ☐ 黴菌
   - ☐ 油漆或水管含鉛
   - ☐ 暖氣不足
   - ☐ 爐子無法運作
   - ☐ 沒有煙霧探測器或不起作用
   - ☐ 漏水
   - ☐ 以上皆非

食物

3. 在過去 12 個月裏，您是否擔心食物在您有錢購買更多之前消耗完畢？[3]
   - ☐ 經常擔心
   - ☐ 有時擔心
   - ☐ 從不擔心

4. 在過去 12 個月裏，您購買的食物不夠用，而且您沒有錢買更多。[3]
   - ☐ 經常擔心
   - ☐ 有時擔心
   - ☐ 從不擔心

交通

5. 您是否因爲 距離或交通原因推遲或忽略去看醫生？[1]
   - ☐ 是
   - ☐ 否

公用事業

6. 在過去 12 個月裏，電、瓦斯、油或水公司是否威脅將您家中的電、瓦斯、油或水關掉？[4]
   - ☐ 是
   - ☐ 否
   - ☐ 已經關閉

兒童看護

7. 兒童看護的問題是否讓您難以工作或求學？[5]
   - ☐ 是
   - ☐ 否

就業

8. 您是否有工作？[6]
   - ☐ 是
   - ☐ 否

教育

9. 您是否有高中學歷？[6]
   - ☐ 是
   - ☐ 否

財務

10. 您有多常發生這種情況？我沒有足夠的錢支付我的帳單：[7]
    - ☐ 從未發生 (1)
    - ☐ 很少發生 (2)
    - ☐ 有時發生 (3)
    - ☐ 經常發生 (4)
    - ☐ 總是發生 (5)

個人安全

11. 任何人，包括家人，多常傷害您的身體？[8]
    - ☐ 從未發生 (1)
    - ☐ 很少發生 (2)
    - ☐ 有時發生 (3)
    - ☐ 經常發生 (4)
    - ☐ 總是發生 (5)

12. 任何人，包括家人，多常侮辱或責罵您？[8]
    - ☐ 從 未發生 (1)
    - ☐ 很少發生 (2)
    - ☐ 有時發生 (3)
    - ☐ 經常發生 (4)
    - ☐ 總是發生 (5)

The EveryONE Project®
Advancing health equity in every community

Name 名_____Date of Birth 出生日期_____

Today's Date 今天的日期_____

13. 任何人，包括家人，多常威脅要傷害您？[8]
- ☐ 從未發生 (1)
- ☐ 很少發生 (2)
- ☐ 有時發生 (3)
- ☐ 經常發生 (4)
- ☐ 總是發生 (5)

14. 任何人（包括家人）尖叫或詛咒您的頻次 ？[8]
- ☐ 從未發生 (1)
- ☐ 很少發生 (2)
- ☐ 有時發生 (3)
- ☐ 經常發生 (4)
- ☐ 總是發生 (5)

協助

15. .您是否要協助以滿足任何這些需求？
- ☐ 是
- ☐ 否

評分說明：
關於住房、食物、交通、公用事業、兒童看護、
就業、教育和財務問題：加下劃線的
答案表示該類別的社會需求的正面回答。

關於個人安全問題：當這些問題的答案的數值加總時，值大
於 10 表示個人安全的社會需求的正面回答。

問題 11 – 14 的總分：_____
關於個人安全，大於 10 的正分畫面。

參考

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3. Hager ER, Quigg AM, Black MM, et al. Development and validity of a 2-item screen to identify families at risk for food insecurity. *Pediatrics.* 2010;126(1):e26-e32.
4. Cook JT, Frank DA, Casey PH, et al. A brief indicator of household energy security: associations with food security, child health, and child development in US infants and toddlers. *Pediatrics.* 2008;122(4):e867-e875.
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7. Aldana SG, Liljenquist W. Validity and reliability of a financial strain survey. *J Financ Couns Plan.* 1998;9(2):11-19.
8. Sherin KM, Sinacore JM, Li XQ, Zitter RE, Shakil A. HITS: a short domestic violence screening tool for use in a family practice setting. *Fam Med.* 1998;30(7):508-512.

AMERICAN ACADEMY OF FAMILY PHYSICIANS FOUNDATION Supported in part by a grant from the AAFP Foundation

The EveryONE Project® Advancing health equity in every community

James C. Ho MD Medical Corporation 何醫師

Contact Information 聯絡資訊

	OK to contact regard appt? 可以联系预约事吗		OK to leave a message? 可以留言吗？	
(_____) _____ Home Phone Number / 家庭电话号码	Yes / 是	No / 不	Yes / 是	No / 不
(_____) _____ Work Phone Number 工作电话号码	Yes / 是	No / 不	Yes / 是	No / 不
(_____) _____ Cell Phone 手机号码	Yes / 是	No / 不	Yes / 是	No / 不
_____ Email 电子邮件地址	Yes / 是	No / 不	Yes / 是	No / 不

Emergency Contact Name and relationship / 紧急联系人姓名和关系. Write “decline” below if you do not want to provide this 紧急联络电话号码。如果您不想提供此信息，请在下方写下拒绝 “decline”

_____

James C. Ho MD Medical Corporation 何醫師

Due to stringent rules adopted by the Federal Government (HIPAA-Health Insurance Portability and Accountability Act) with regard to patient confidentiality, the responsibility of delivery of medical testing results and medical records will be the responsibility of the patient. Many facilities will no longer provide a copy of your medical testing or records via fax or mail without an authorization signed by you on the date it is being requested. This is for your protection but our office is unable to obtain your testing results with a phone call. It is your responsibility to assure that the results of any testing from other facilities are faxed to our office in time for your next appointment. I authorize James Ho MD Medical Corporation to obtain medical records, testing, x-rays or any pertinent information to assist in evaluation and treatment of my medical condition. This authorization shall remain in effect for 1 (one) year unless revoked by me in writing.

由於聯邦政府採用的嚴格規則（HIPAA-健康保險流通和責任法案）考慮到病患的隱私，提供醫療檢測結果和醫療記錄的責任將由患者的責任。許多機構將不再透過傳真或郵件提供您的醫療測試或記錄的副本 未經您在請求之日簽署的授權。這是為了保護您，但我們的辦公室無法 透過電話獲取您的測試結果。您有責任確保其他機構的任何測試結果 設施會及時傳真到我們的辦公室，以便您下次預約。本授權的有效期限為一（一）年，除非 由我以書面撤銷

打印您的姓名以表明您的同意 Initial or sign 首字母或簽_____

Insurance - Authorization & Benefit Assignment / 保险-授权和利益分配

*

I hereby authorize James C Ho MD Medical Corporation to furnish Personal Health Information concerning my illness and treatment to insurance carriers or other entity necessary to pay the claim, and I hereby assign to James C Ho MD Medical Corporation all payment for medical services rendered to my dependents or myself. I understand I am responsible for patient deductibles and any amount not covered by the insurance. Laboratory, radiology and other ancillary services provided in connection with physician's office will be billed separately. Co-pays must be made at the time of service and a fee of $25.00 will be added to any returned check balances. I understand and agree to give at least 24 hours notice if I am unable to keep an appointment. Failure to do so will result in a "No-Show"charge of $25.00 added to my account balance. Print Your Names to Indicate Agreement to benefit assignment

本人特此授权 James C Ho MD 医疗公司向我的个人健康信息提供给保险公司或其他支付索赔所必需的实体，并将本人分配给 James C Ho MD 医疗公司向我提供的所有医疗服务付款家属或我本人。我了解我对患者自付额以及保险未涵盖的任何金额负责。与医师办公室相关的实验室，放射学和其他辅助服务将另行收费。服务时必须同时付款，并在退还的支票余额中加收 25 美元的手续费。我理解并同意在无法预约的情况下至少提前 24 小时发出通知。否则，我的帐户余额中会出现$ 25.00 的"不显示"费用。打印您的姓名以表明协议以受益分配

Initial or sign 首字母或簽名_____

Consent to Treatment / Consentimiento para el tratamiento / 同意治疗

The undersigned consents to the treatment including emergency treatment or services which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures rendered to the patient under the general and specific instructions of the patient's physician. Print Your Names to Indicate Agreement to treat

签署人同意接受包括紧急治疗或服务在内的治疗，这些治疗或服务可能包括但不限于实验室程序，X 射线检查，医学或外科治疗或根据患者医师的一般和特定说明向患者提供的程序。打印您的姓名以表明同意治疗

Initial or sign 首字母或簽名_____

Diagnostic and/or therapeutic treatment of minor / Tratamiento diagnóstico y / o terapéutico de menores / 未成年人的诊断和/或治疗

Diagnostic and/or therapeutic treatment including emergency treatment or services which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures rendered under the general and specific instructions of the physician. I am a legal guardian or parent with the legal authority to give consent to treatment. Print Your Names to Indicate Agreement

诊断和/或治疗包括紧急治疗或服务，包括但不限于实验室程序，X 射线检查，医学或外科治疗或根据医生的一般和特定说明进行的程序。我是法定监护人或具有法定权力同意治疗的父母。打印您的姓名以表明协议

Initial or sign 首字母或簽名_____

What is the minor's birth date 未成年人的出生日期_____

Does the minor child live with you? 未成年子女與您住在一起嗎？Yes / 是 No / 没有

Your phone number if different from child: 您的電話號碼（如果與孩子不同）_____

If divorced, name of person with legal custody of minor child. 若離婚，擁有未成年子女合法監護權的人的姓名

_____

Patient's Rights

You may refuse to give consent and may object to any part of this form. If so, please ask to speak with us about that. If you chose to give consent in this document, you may revoke your consent in the future, in writing. This right, and other rights that you have in regard to your Personal Health Information use and disclosure are detailed in our Privacy Notice. If you did not receive a copy of this Privacy Notice, please ask for one and read it carefully. We value you as a patient and strive to achieve the highest standards in our service to you.

您可以拒绝同意，也可以反对本表格的任何部分。如果是这样，请要求与我们交谈。如果您选择在本文档中表示同意，则将来可以书面形式撤销同意。您在个人健康信息的使用和披露方面享有的这项权利以及其他权利在我们的隐私声明中有详细说明。如果您没有收到本隐私声明的副本，请索取一份并仔细阅读。我们重视您的耐心，并努力在我们为您提供的服务中达到最高标准。

Initial or sign 首字母或簽名_____

ACKNOWLEDGEMENT OF NOTICE REGARDING PRIVACY OF INFORMATION

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to provide you, the patient, a Notice of our Privacy Practices. The notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

符合 1996 年的《健康保险携带与责任法案》（HIPAA），我们需要向您（患者）提供我们的隐私惯例通知。该通知描述了如何使用和披露有关您的健康信息，以及 您如何获得此信息。请仔细检查。

Initial or sign 首字母或簽名_____

I hereby acknowledge that I was given a copy of James C Ho MD Medical Corporation's Notice of Privacy Practices to read. I was also given the opportunity to have a copy to take with me if I desired. In addition, a Notice of Privacy Practices is posted in the patient waiting area. I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

我特此確認，我已取得 James C Ho MD Medical Corporation 的《隱私權慣例通知》副本供閱讀。如果我願意的話，我還有機會隨身攜帶一本。此外，病患等候區也張貼了隱私權慣例通知。我了解我可能會以書面形式請求您限制我的私人資訊的使用和披露方式以進行治療、付款或醫療保健操作。我也了解您無需同意我所要求的限制，但如果您同意
同意，則您有義務遵守此類限制。

Initial or sign 首字母或簽名_____

James C. Ho MD Medical Corporation 何醫師

生效日期 2013 年 9 月 1 日

隱私權慣例通知

本通知說明如何使用和揭露您的醫療資訊以及您如何取得這些資訊

資訊.請仔細閱讀。我們了解隱私的重要性，並致力於維護您的醫療資訊的機密性。我們記錄我們提供的醫療護理，並可能從其他人那裡收到此類記錄。我們使用這些記錄來提供或使其他醫療保健提供者能夠提供優質的醫療護理，以獲取您的健康計劃允許的向您提供的服務的付款，並使我們能夠履行我們的專業和法律義務，以正確運營此醫療實踐。法律要求我們維護受保護的健康資訊的隱私，並向個人提供有關我們與受保護的健康資訊相關的法律義務和隱私慣例的通知。本通知描述了我們如何使用和揭露您的醫療資訊。它還描述了您對您的醫療資訊的權利和我們的法律義務。如果您對本通知有任何疑問，請聯絡上面列出的我們的隱私權長。

A. 該醫療機構如何使用或揭露您的健康資訊

此醫療實踐收集有關您的健康資訊並將其儲存在圖表和計算機中。這是您的病歷。病歷是該醫療機構的財產，但病歷中的資訊屬於您。法律允許我們出於以下目的使用或披露您的健康資訊：

1.治療。我們使用您的醫療資訊來為您提供醫療護理。我們向我們的員工和其他參與提供您所需護理的人員揭露醫療資訊。例如，我們可能會與其他醫生或其他醫療保健提供者分享您的醫療信息，他們將提供我們不提供的服務。或者，我們可能會與需要這些資訊的藥劑師或進行測試的實驗室分享這些訊息，以便為您開立處方。我們也可能向您的家人或其他在您生病或受傷時可以為您提供幫助的人披露醫療資訊。

2.付款。我們使用和揭露有關您的醫療資訊以獲得我們提供的服務的付款。例如，我們會在您的健康計劃向我們付款之前向您提供其所需的資訊。我們也可能向其他醫療保健提供者披露信息，以幫助他們獲得向您提供的服務的付款。

3. 醫療保健運作。我們可能會使用和揭露有關您的醫療資訊來進行醫療實務。例如，我們可能會使用和揭露這些資訊來審查和提高我們提供的護理品質，或我們專業人員的能力和資格。或者，我們可能會使用和披露此信息，以使您的健康計劃授權服務或服務和審計，包括欺詐和濫用檢測以及合規計劃以及業務規劃和管理。我們也可能與為我們提供行政服務的「業務夥伴」（例如我們的計費服務機構）共享您的醫療資訊。我們與每個業務夥伴都簽訂了書面合同，其中包含要求他們保護您的醫療資訊的機密性和安全性的條款。儘管聯邦法律不保護向其他醫療保健提供者、健康計劃、醫療保健資訊交換所或其其中之一以外的人披露的健康資訊

4. [可選：預約提醒。我們可能會使用和揭露醫療資訊來聯絡您並提醒您預約。如果您不在家，我們可能會將此資訊留在您的答錄機上或留給接聽電話的人的訊息中。

5. 簽到表。當您到達我們的辦公室時登錄，我們可能會使用和揭露您的醫療資訊。當我們準備好見您時，我們也可能會叫出您的名字。

6. 與家人的通知和溝通。我們可能會披露您的健康信息，以通知或協助通知家庭成員、您的個人代表或負責照顧您的其他人員您的位置、您的一般狀況，或者，除非您另有指示，否則，在您死亡的情況下。如果發生災難，我們可能會向救援組織披露訊息，以便他們協調這些通知工作。我們也可能向參與您的照護或協助支付您的照護費用的人員揭露資訊。如果您能夠同意或反對，我們將在進行這些披露之前為您提供反對的機會，但如果我們認為有必要應對緊急情況，即使您反對，我們也可能會在災難中披露此資訊。如果您無法或無法同意或反對，我們的健康專業人員將利用他們的最佳判斷與您的家人和其他人溝通。

7. 行銷。如果我們沒有因進行這些通信而收到任何付款，我們可能會聯絡您，鼓勵您購買或使用與您的治療、個案管理或護理協調相關的產品或服務，或指導或推薦其他治療、療法、醫療保健提供者或您可能感興趣的照護環境。我們可能會類似地描述這種做法提供的產品或服務，並告訴您我們參與了哪些健康計劃。費用提醒您服藥並補充藥物或以其他方式傳達目前為您開出的藥物或生物製劑，但前提是您符合以下條件：(1) 患有慢性且嚴重衰弱或危及生命的疾病，並且該傳達是為了教育您或就治療方案向您提供建議，並以其他方式堅持遵守規定的治療療程，或 (2) 您是當前健康計劃的參與者，並且溝通僅限於提供更具成本效益的藥物。如果我們在您患有慢性且嚴重衰弱或危及生命的疾病時進行這些溝通，我們將提供至少 14 點類型的以下通知： (1) 報酬的事實和來源； (2) 您有權透過撥打通訊者的免費電話號碼選擇退出未來的有償通訊。未經您事先書面授權，我們不會出於行銷目的使用或披露您的醫療訊息，也不會接受其他行銷傳播的任何付款。該授權將揭露我們是否會因您授權的任何行銷活動而獲得任何經濟補償，並且在您撤銷該授權的範圍內，我們將停止任何未來的行銷活動。

8. 出售健康資訊。未經您事先書面授權，我們不會出售您的健康資訊。該授權將披露，如果您授權我們出售您的健康信息，我們將獲得您的健康信息的補償，並且在您撤銷該授權的範圍內，我們將停止未來出售您的信息。

9. 法律要求。根據法律要求，我們會使用和揭露您的健康資訊，但我們會將我們的使用或揭露限制在法律的相關要求範圍內。當法律要求我們舉報虐待、忽視或家庭暴力，或對司法或行政訴訟或執法官員作出回應時，我們將進一步遵守以下有關這些活動的要求。

10. 公共衛生。我們可能（有時法律要求）為以下目的向公共衛生當局披露您的健康資訊：預防或控制疾病、傷害或殘疾；舉報虐待或忽視兒童、老人或受扶養成人；報告家庭暴力；向食品藥物管理局報告產品問題和藥物反應；報告疾病或感染暴露。當我們報告涉嫌虐待老年人或受扶養成人或家庭暴力時，我們將立即通知您或您的個人代表，除非根據我們的最佳專業判斷，我們認為該通知會將您置於有嚴重傷害的風險，或需要通知我們認為對虐待或傷害負責的個人代表。

11. 健康監督活動。我們可能（有時法律要求）在審計、調查、檢查、許可和其他程序過程中向健康監督機構披露您的健康信息，但須遵守聯邦和加利福尼亞州法律規定的限制。

12. 司法和行政訴訟。我們可能（有時法律要求）在任何行政或司法程序過程中，在法院或行政命令明確授權的範圍內披露您的健康資訊。如果我們已盡合理努力通知您該請求並且您沒有反對，或者如果您的反對已由法院或行政命令解決，我們也可能會根據傳票、證據開示請求或其他合法程序披露您的資訊。

13. 執法。我們可能（有時法律要求）向執法官員披露您的健康信息，以用於識別或定位嫌疑人、逃犯、重要證人或失踪人員、遵守法院命令、搜查令、大陪審團傳票和其他執法目的。

14. 驗屍官。我們可能而且經常根據法律要求，向驗屍官披露您與死亡調查有關的健康資訊。

15. 器官或組織捐贈。我們可能會向參與採購、儲存或移植器官和組織的組織揭露您的健康資訊。

16. 公共安全。我們可能（有時法律要求）向適當的人員披露您的健康信息，以防止或減輕對特定人員或公眾的健康或安全的嚴重和迫在眉睫的威脅。

17. 免疫證明。如果法律要求學校在錄取學生之前獲得此類信息，如果您代表自己或您的家屬同意披露，我們將向學校披露免疫接種證明。

18. 專門的政府職能。我們可能出於軍事或國家安全目的或向合法拘留您的懲教機構或執法人員披露您的健康資訊。

19. 工人賠償。我們可能會根據需要披露您的健康信息，以遵守工人賠償法。例如，在工傷賠償涵蓋您的照護的範圍內，我們將定期向您的雇主報告您的狀況。法律也要求我們向雇主或工人賠償保險公司報告職業傷害或職業病案件。

20. 所有權變更。如果該醫療機構被出售或與其他組織合併，您的健康資訊/記錄將成為新所有者的財產，但您仍保留要求將您的健康資訊副本轉讓給其他醫生或醫療機構的權利。
21. 違規通知。如果不安全的受保護健康資訊遭到破壞，我們將依照法律要求通知您。如果您向我們提供了當前的電子郵件地址，我們可能會使用電子郵件來傳達與違規行為相關的資訊。在某些情況下，我們的業務夥伴可能會提供通知。我們還可以
酌情透過其他方式提供通知。 [注意：僅當您確定電子郵件通知不包含 PHI 並且不會洩露不當資訊時才使用電子郵件通知。例如，如果您的電子郵件地址是“digestivediseaseassociates.com”，則使用此地址發送的電子郵件如果被攔截，可以識別患者及其病情。三項活動中的任何一項打算從事這些活動。
22.心理治療筆記。未經您事先書面授權，我們不會使用或揭露您的心理治療筆記，以下情況除外：(1) 您的治療，
(2) 用於培訓我們的員工、學生和其他受訓人員，(3) 在您起訴我們或提起其他法律訴訟時為自己辯護，(4) 如果法律要求我們向您或 HHS 部長披露信息，或出於某些其他原因，(5) 為了回應有關您的心理治療師的健康監督活動，(6) 避免對健康或安全造成嚴重威脅，或(7) 在您死後向驗屍官或法醫提供幫助。如果您撤銷使用或揭露您的心理治療筆記的授權，我們將停止使用或揭露這些筆記。
23. 研究。根據適用法律，我們可能會向進行研究的研究人員披露您的健康信息，而無需您的書面授權，且經機構審查委員會或隱私委員會批准。
24. 籌款。我們可能會使用或揭露您的人口統計資料、您接受治療的日期、服務部門、您的治療醫生、結果資訊和健康保險狀態，以便就我們的募款活動與您聯繫。如果您不想收到這些資料，請通知列出的隱私權官本隱私權慣例通知的頂部，我們將停止任何進一步的籌款通訊。同樣，如果您決定再次開始接收這些請求，您應該通知隱私辦公室。
B. 本醫療實務不得使用或揭露您的健康資訊時除本隱私權慣例通知中所述的情況外，本醫療機構將根據其法律義務，在未經您書面授權的情況下不會使用或披露可識別您身分的健康資訊。如果您確實授權該醫療機構出於其他目的使用或披露您的健康信息，您可以撤銷您的授權隨時書面授權。
C. 您的健康資訊權利
1. 請求特殊隱私保護的權利。您有權透過書面請求來要求限制您的健康資訊的某些使用和披露，具體說明您想要限制哪些信息，以及您希望對我們使用或披露該信息施加哪些限制。如果您告訴我們不要向您的商業健康計劃披露有關您全額自付費用的醫療保健項目或服務的信息，我們將遵守您的要求，除非我們
出於治療或法律原因必須披露該資訊。我們保留接受或拒絕任何其他請求的權利，並將我們的決定通知您。
2. 要求保密通信的權利。您有權要求以特定方式或在特定地點接收您的健康資訊。例如，您可能要求我們將資訊傳送到特定電子郵件帳戶或您的工作地址。我們將遵守所有以書面形式提交的合理請求，其中指定您希望如何或在何處接收這些通信。
3. 檢查和複製的權利。除有限的例外情況外，您有權檢查和複製您的健康資訊。要存取您的醫療信息，您必須提交一份書面請求，詳細說明您想要存取哪些資訊、您是否想要檢查或取得其副本，以及如果您想要副本，請說明您首選的形式和格式。如果可以輕鬆製作，我們將按照您要求的形式和格式提供副本，或者我們將為您提供您認為可以接受的替代格式，或者如果我們不能同意並且我們以電子格式保存記錄，您可以選擇可讀的電子或硬拷貝格式。我們還將向您的其他人發送一份副本
以書面指定。我們將收取合理的費用，其中包括我們的人工、用品、郵資費用，以及在聯邦和加州法律允許的情況下（如果事先要求並同意）準備解釋或摘要的費用。在有限的情況下，我們可能會拒絕您的要求。如果我們拒絕您存取您孩子的記錄或您所代表的無行為能力成年人的記錄的請求，因為我們認為允許訪問很可能會對患者造成重大傷害，您將有權對我們的決定提出上訴。如果我們拒絕您查看心理治療記錄的請求，您將有權將其轉移給另一位心理健康專業人員。
4. 修改或補充的權利。您有權要求我們修改您認為不正確或不完整的健康資訊。您必須以書面提出修改請求，並說明您認為資訊不準確或不完整的原因。我們不需要更改您的健康訊息，並且會向您提供有關此醫療機構的拒絕以及您如何不同意該拒絕的資訊。如果我們沒有該資訊、如果我們沒有創建該資訊（除非創建該資訊的個人或實體無法再進行修改）、如果您不被允許檢查或複製，我們可能會拒絕您的請求有爭議的訊息，或者該資訊是否準確且完整。如果我們否認你的
要求時，您可以提交一份書面聲明，表明您不同意該決定，而我們可以準備一份書面反駁。您也有權要求我們在您的記錄中添加最多 250 字的聲明，涉及您認為記錄中不完整或不正確的任何內容。與任何修改或補充請求相關的所有資訊將與爭議資訊的任何後續披露一起維護和披露。
5. 揭露資訊的核算權。您有權獲得該醫療機構披露的您的健康資訊的說明，但該醫療機構不必說明向您提供的或根據您的書面授權或第 1 段中所述的披露（本隱私權聲明 A 部分的 2（付款）、3（醫療保健操作）、6（通知和與家人溝通）和 18（專門的政府職能）出於研究或公共衛生目的而排除直接患者標識符的實踐或披露，或與法律允許或授權的使用或披露有關的實踐或披露，或在該醫療實踐範圍內向衛生監督機構或執法官員披露的實踐或揭露已收到該機構或官員的通知，表示提供此會計資訊很可能會阻礙其活動。
6. 您有權了解我們與您的健康資訊相關的法律義務和隱私慣例，包括有權獲得本隱私權慣例通知的紙本副本，即使您先前已要求透過電子郵件收到該通知。如果您想取得這些權利的更詳細解釋，或者您想行使其中一項或多項權利，請聯絡本隱私權慣例通知頂部列出的我們的隱私權官。
D. 本隱私權慣例通知的變更
我們保留將來隨時修改我們的隱私權慣例和本隱私權慣例通知條款的權利。在做出此類修訂之前，法律要求我們遵守本通知。修訂後，修訂後的隱私保護通知將適用於我們維護的所有受保護的健康訊息，無論其何時創建或接收。我們將在接待區張貼目前通知的副本，每次預約時都會提供一份。投訴
有關本隱私權慣例通知或該醫療機構如何處理您的健康資訊的投訴應直接發送至本隱私權慣例通知頂部列出的我們的隱私權官。
如果您對該辦公室處理投訴的方式不滿意，您可以向以下地址提交正式投訴：
第九區，美國衛生與公共服務部民權辦公室，90 7th Street, Suite 4-100, San Francisco, CA 94103
(415) 437-8310； (415) 437-8311 (TDD), (415) 437-8329 傳真 OCRMMail@hhs.gov
投訴表可在 www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf 上找到。您不會因提出投訴而受到任何形式的處罰。

James C. Ho MD Medical Corporation 何醫師

NOTICE OF PRIVACY PRACTICES

Effective Date September 1, 2013

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 and to provide individuals with notice of our legal duties and privacy practices with respect to 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.

A. 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 and on a computer. 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:

1. 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 which 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.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. 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 services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. 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, 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, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. [Participants in organized health care arrangements only should add: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]

4. [Optional: 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.]

5. 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.

6. 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 have 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.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use 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 we participate in.We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover 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, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. 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 financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. 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.

9. 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.

10. 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.

11. 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 federal and California law.

12. 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.

13. 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.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. 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.
17. Proof of Immunization. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.
18. 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.
19. Worker's Compensation. We may disclose your health information as necessary to comply with worker's 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.
20. 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.
21. 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 email address, we may use email 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. [Note: Only use email notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your email address is "digestivediseaseassociates.com" an email sent with this address could, if intercepted, identify the patient and their condition.] [Add the following three activities, or any of the three, only if the organization engages or intends to engage in these activities.]
22. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) 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 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.
23. 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.
24. Fundraising. We may use or disclose your demographic information, the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status in order to contact you for our fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Office if you decide you want to start receiving these solicitations again.

B. 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.

C. YOUR HEALTH INFORMATION RIGHTS

1. 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.
2. 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 a particular email account or 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.
3. 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 another 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, as allowed by federal and California law. 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. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
4. 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. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
5. 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.
6. 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 of Privacy Practices, even if you have previously requested its receipt by email. 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.

D. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. 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. 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:

Region IX, Office for Civil Rights, U.S. Department of Health & Human Services, 90 7th Street, Suite 4-100, San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD), (415) 437-8329 FAX 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.