UL Physicians

PATIENT INFORMATION FORM

Patient Information Name _____ Also Known As _____

SSN _____ Date of Birth _____ Sex ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Preferred Language _____

Special Needs ☐ Adult Sitter/Guardian ☐ Ambulates with Assistive Dev ☐ Hearing Impaired ☐ Sight Impaired ☐ Multiple Birth ☐ Speech Impaired ☐ Wheelchair ☐ Interpreter ☐ Transportation Needs

Patient Race: Race – a human population considered distinct based on physical characteristics.	Ethnicity: Ethnicity a term which represents social groups with a shared history, sense of identity, geography and cultural roots which may occur despite racial difference.
☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander	☐ Hispanic or Latino ☐ Not Hispanic or Latino Religion _____

Home Address _____

City, St _____ County _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work/Other Phone _____

Employment Status _____ Email _____

Employer Name _____ Employer Phone Number _____

Employer Address _____

Employer City, St _____ Zip Code _____

Primary Physician _____ Primary Physician Phone _____

Referring Physician _____ Referring Physician Phone _____

Preferred Pharmacy _____ Pharmacy Phone _____

Pharmacy Address, City, St, Zip _____

Parent/Guardian(s) or Spouse Information Name _____

Relationship to Patient _____ SSN _____ Date of Birth _____

Address (If Different) _____ Zip Code _____

Employer _____ Employer Phone Number _____

Employer Address _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

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Patient Name: _____ Patient DOB_____2.

Emergency Contact (someone other than a parent and who does not live with the patient or a parent)

Name _____ Relationship _____ Phone _____

Parent/Guardian #2 Name_____

Relationship to Patient _____ SSN _____ Date of Birth _____

Address (If Different) _____ Zip Code_____

Employer _____ Employer Phone Number _____

Employer Address _____ Zip Code_____

Home Phone _____ Cell Phone _____ Email _____

Medical Insurance Info.	Primary Insurance	Secondary Insurance
Subscriber ID		
Group or Plan Number		
Plan/Program Code		
Insurance Co. Name		
Insurance Co. Phone Number		
Patient Relation to Subscriber		
Subscriber Name		
Subscriber Street Address		
Subscriber City and State		
Subscriber Zip Code		
Subscriber Date of Birth		
Subscriber Sex		
Subscriber Social Security #		
Subscriber Employer		
Co-pay Amount		

Injury Related Information ☐Work Related ☐Auto ☐Motorcycle ☐Other Date & Time of Injury _____

State Where Injury Occurred _____Contact Name _____ Phone _____

Claim # _____ Insurance Co. _____

Insurance Co. Address, City, St, Zip _____

_____ _____

Patient/Parent/Legal Guardian/Legal Authorized Representative Signature Date

If Parent/Legal Guardian/Legal Authorized Representative, Print Name _____

Name _____ Date of Birth: _____

WELCOME to UofL Physicians Family & Geriatric Medicine

FAMILY HISTORY

Father: Present Health/Cause of Death	Mother: Present Health/Cause of Death	Spouse: Present Health/Cause of Death

Total # Brothers	# Alive	Health	# Deceased	Cause(s) of Death
Total # Sisters	# Alive	Health	# Deceased	Cause(s) of Death
Total # Children	# Alive	Ages & Health	# Deceased	Ages & Cause(s) of Death

Circle Illnesses which have occurred in your parents, aunts, uncles, grandparents and/or children:

Diabetes Stroke Heart Disease Tuberculosis Bleeding Tendency Kidney Disease Emphysema

High Blood Pressure Mental Illness Cancer: _____ (Please list type)

MEDICAL HISTORY

Check Symptoms you currently have or have had recently within the past 6 months:

General		Gastrointestinal		Eye / Ear / Nose / Throat		Men ONLY	
☐	Chills	☐	Poor Appetite	☐	Double Vision	☐	Erection Difficulties
☐	Fever	☐	Stomach Pain	☐	Blurred Vision	☐	Lump in Testicle
☐	Night Sweats	☐	Bloating	☐	Vision Flashes / Halos	☐	Penis Discharge
☐	Fatigue	☐	Vomiting	☐	Dry Eyes	☐	Sore on Penis
☐	Forgetfulness	☐	Vomiting Blood	☐	Itchy Eyes	☐	Other _____
☐	Sleep Issues	☐	Nausea	☐	Earache / Ear Discharge	☐	
☐	Weight Loss	☐	Indigestion / Heartburn	☐	Loss of Hearing	**Women ONLY**	
☐	Weight Gain	☐	Bowel Changes	☐	Ringing in Ears	☐	Abnormal Pap Smear
☐	Excess Thirst	☐	Constipation	☐	Sinus Problems	☐	Bleeding between Periods
Muscular / Bone / Joints		☐	Diarrhea	☐	Nosebleeds	☐	Extreme Menstrual Pain
☐	Leg Cramps	☐	Excess Gas	☐	Hayfever / Allergies	☐	Painful Intercourse
☐	Back Pain	☐	Hemorrhoids	☐	Hoarseness	☐	Vaginal Discharge
☐	Muscle Pain	☐	Blood in Stool	☐	Sore Throat	☐	Nipple Discharge
☐	Joint Pain	**Cardiovascular**		☐	Difficulty Swallowing	☐	Breast Lump
☐	Joint Swelling			☐	Bleeding Gums	☐	Hot Flashes
☐	Other:	☐	Chest Pain	**Skin & Nails**		☐	Date of Last Menstrual Period
		☐	High / Low Blood Pressure				
Urinary		☐	Irregular / Rapid Heart Rate	☐	Easy Bruising	☐	Date of Last Pap Smear
☐	Blood in Urine	☐	Poor Circulation	☐	Easy Bleeding	☐	Date of Last Mammogram
☐	Frequent Urination	☐	Swelling of Lower Legs	☐	Rash	☐	Are you Pregnant? Yes No
☐	Lack of Bladder Control	☐	Varicose Veins	☐	Hives	☐	Number of pregnancies
☐	Painful Urination	☐	Calf Pain with Walking	☐	Abnormal Scarring / Keloids	☐	
Pulmonary		**Neuro**		☐	Sores that Won't Heal	**Mental Health**	
☐	Cough	☐	Headache	☐	Change in Moles	☐	Depression
☐	Coughing up Blood	☐	Dizziness	☐	Acne	☐	Anxiety
☐	Shortness of Breath	☐	Fainting	☐	In-Grown Toe Nails	☐	Thoughts of hurting yourself
☐	Shortness of Breath w/Exertion	☐	Seizures	☐	Fungal Infections	☐	Thoughts of Suicide
☐	Snoring	☐	Numbness	☐		☐	Alcohol Abuse
☐	Wheezing	☐	Tingling	☐		☐	Substance Abuse

Name _____ *(continued)* Date of Birth: _____

PLEASE LIST ALL medications, supplements / vitamins and over-the-counter-medications you are currently taking:

_____

_____

_____

_____

_____

_____

PLEASE LIST ALL allergies to medications, food and/or latex:

_____

_____

_____

Please check conditions you have had in the past:

☐	**AIDS**	☐	**Lupus**	☐	**HIV Positive**	☐	**Polio**
☐	**Appendicitis**	☐	**Diabetes ____Type 1 ____Type 2**	☐	**Kidney Disease**	☐	**Prostate Problem**
☐	**Arthritis**	☐	**Emphysema / COPD**	☐	**Liver Disease**	☐	**Rheumatic Fever**
☐	**Asthma**	☐	**Epilepsy / Seizures**	☐	**Chicken Pox or Shingles**	☐	**Scarlet Fever**
☐	**Bleeding Disorders**	☐	**Glaucoma or Cataracts**	☐	**Migraine Headaches**	☐	**Stroke**
☐	**Breast Lump**	☐	**Heart Disease**	☐	**Multiple Sclerosis**	☐	**Thyroid Problems**
☐	**Cancer**	☐	**Hepatitis A / B / C (circle one)**	☐	**Skin Cancer**	☐	**Tuberculosis**
☐	**Raynaud's Disease**	☐	**Herpes**	☐	**Pacemaker**	☐	**Ulcers**
☐	**Alcohol or Drug Abuse**	☐	**Bipolar**	☐	**Pneumonia**	☐	**Reflux**
☐	**High Blood Pressure**	☐	**Depression / Anxiety**	☐	**High Cholesterol**	☐	**Sexually Transmitted Diseases**

_____

HOSPITALIZATIONS / SURGERIES / FRACTURES

Year	Diagnosis / Issue

Health Habits

Dates for last: Tetanus Shot _____ Pneumonia Vax _____Shingles Vax _____Flu Vax _____

Tobacco Use: ☐ Yes ☐ No How much? _____ per day/ week / month *****Desire to Quit?***** ☐ Yes ☐ No ☐ Maybe	**Alcohol Use: ☐ Yes ☐ No** How many drinks? _____ per day/ week / month	**Caffeine Use: ☐ Yes ☐ No** How many drinks? _____ per day/ week / month	**Exercise: ☐ Yes ☐ No** How many times? _____ per day/ week / month

Signatures

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member responsible for any errors or omissions that I may have made in the completion of this form.

Signature:_____ Date: _____

Reviewed by: _____ Date: _____

UofL Physicians

GENERAL CONSENT FORM

PATIENT NAME: _____ Date of Birth: _____

Payment. I authorize University of Louisville Physicians, Inc. (UofL Physicians) to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that UofL Physicians will direct payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. Initials: _____

Consent for Treatment. I consent for UofL Physicians to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, as part of the care to be given a test may be performed for human immunodeficiency virus infection (HIV/AIDS), hepatitis, or other blood-borne infectious or communicable diseases if the doctor, APRN, or Physician Assistant orders the test for diagnostic purposes because of my/the patient's medical history, symptoms, or conditions. Initials: _____

Electronic Prescription. I understand UofL Physicians utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient. Initials: _____

Cell Phone Calls. As a service to our patients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Involvement of Others in Care. I authorize UofL Physicians to provide and discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth	Relationship	Phone

Patient Rights and Responsibilities

I acknowledge receipt of the Patient Rights and Responsibilities_____ Declined_____

Notice of Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices_____ Declined_____

Minor Patient Photograph

I consent for UofL Physicians to photograph the patient for identification purposes only_____ Declined_____

_____ _____

Patient/Parent/Legal Guardian/Legal Authorized Representative Signature **Date**

If Parent/Legal Guardian/Legal Authorized Representative, Print Name _____

Cardinal Station • Newburg • Centers for Primary Care • Sports Medicine • Geriatrics

Office Acknowledgements and Policies

1. I am aware of the policy regarding diagnostic tests. UofL Family and Geriatric Medicine will attempt to inform me of the results within 14 days. If I have not received a call or notification by mail in 14 days, it is my responsibility to contact the office. **I WILL NOT** assume that results are normal if I have not heard from the office.

2. If I need to cancel or reschedule an appointment I will do so **24 hours in advance**.

3. Please arrive **15 minutes** early to your appointment. If I arrive late, I may be asked to reschedule or wait until scheduled patients have been seen.

4. I understand that all co-payments and account balances are due at the time of service.

5. I understand that I will be charged **$25** for any returned checks.

6. I am aware that medications will be filled **only during regular office hours** (Monday-Friday, 8:30am-5:00pm). Please allow 48-72 hours for refills to be processed.

7. I will notify the receptionist if my appointment involves care for a motor vehicle accident or a work- related injury.

8. I agree to turn off or silence my cell phone while in the office.

9. I will bring **all of my medication in its original bottle** to every visit.

10. I understand that **no pain medication will be filled on the first visit**. Medical records **must be received and reviewed** before consideration of prescription refills.

11. I understand that there will be a **$30** charge for any forms completed by the providers. (FMLA, disability, etc.)

By signing below, I acknowledge that I have been informed of these policies.

_____ _____ / / _____

Patient or Guardian Signature | Patient Date of Birth

UofL Physicians

HIPAA AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Section I – Patient Information

Name:	**Date of Birth:**
Street Address:	**Last 4 digits of SSN:**
City:	**State:**
Zip Code:	**Telephone:**

I, or my authorized representative, hereby authorize UofL Physicians employees, and subcontractors to disclose my Personal Health Information (PHI) to the designee identified below.

Section II – Authorized Designee (to whom the information will be sent or received from)

Where records are being sent to:		
Where records are requested from:		
Street Address:		
City:	**State:**	**Zip Code:**
Telephone:		

In accordance with the Health Insurance Portability and Accountability Act (HIPAA):

- I understand this authorization is voluntary. My treatment will not be impacted if I sign this authorization or not.
- I understand this authorization may include disclosure of information related to Alcohol and Drug Abuse, STD, Mental Health Treatment, except psychotherapy notes, and HIV information.
- I understand that if my PHI is disclosed to someone who is not required to comply with the Federal privacy regulations, then my information may be re-disclosed and would no longer be protected.
- I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to University of Louisville Physicians, Inc. (UofL Physicians) at the address listed below. I also understand that my request is not effective for actions already completed.

UL Physicians

- Unless otherwise revoked, I understand that this authorization will expire one hundred and eighty days (180) from the date on this form.

I understand that I have the right to refuse to sign this authorization.

I certify that I have received a signed copy of this authorization.

Section III - Information to be Released:

☐ My Medical Records from date: _____ to date: _____

☐ My entire Medical record

☐ Other: Please explain: _____

_____

_____

Section IV: Authorized Representative

If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as Power of Attorney or Guardianship papers.

AUTHORIZED REPRESENTATIVE

Name:	
Street Address:	
City:	**State:** **Zip Code:**
Telephone:	

By signing this from, I am confirming that it accurately reflects my wishes. I have received a copy of this form for my records.

_____
Printed Name

_____ _____
Signature of Patient/Personal Representative/Guardian Date

University of Louisville Physicians
UofL Health Care Outpatient Center
401 East Chestnut Street
Louisville, KY 40202

JOINT NOTICE OF PRIVACY PRACTICES

University of Louisville Physicians
Organized Health Care Arrangement

Effective Date: April 14, 2003
Revised: December 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.

OUR PLEDGE TO YOU

Your health information is something that University of Louisville Physicians has always worked to keep private. We also are ethically and legally bound to keep it confidential under state and federal laws.

WHAT IS THIS DOCUMENT?

This document, called a Joint Notice of Privacy Practices, tells you how we may use and share your health information. This includes using and sharing it so that we may provide you with health care and be paid for it, and so that we may run our business and follow state and federal legal rules. We are required by law to provide you with this notice and to follow its terms.

WHO FOLLOWS THIS NOTICE?

This Joint Notice describes the privacy practices of the following groups or entities:

1) University of Louisville Physicians practices
2) University of Louisville Practices: Children and Youth Project, Neonatal Follow-up, Weisskopf Child Evaluation Center (WCEC), Pediatrics Kosair Charities clinic, 550 Clinic, and Campus Health Services (all locations).

These groups or entities may change from time to time. You will be provided with a separate notice if they do not follow the privacy practices of this notice.

Other separate health care providers at the University of Louisville Medical Center also may provide you with health services. You might receive a notice of privacy practices from them, too.

WAYS WE MAY USE AND SHARE YOUR HEALTH INFORMATION FOR CERTAIN PURPOSES WITHOUT YOUR PERMISSION

Treatment. We will use and share your medical information for your care.

Example: Doctors, dentists, students, medical residents, or other university workers may read your record to learn if a treatment is working. Your medical information also may be shared with doctors or dentists outside of University of Louisville Physicians to decide the best treatment for you.

Payment. We may use and share your medical information to be paid for the care and services we provided you.

Examples: We may contact your insurance company to check coverage or benefits for a certain procedure, or for referral purposes. Please be aware that we report information to insurance companies based on the insurance information you provide. Insurance companies send bills to the person who is named on the insurance card, which may or may not be you.

Health Care Operations. We need to use and share your health information to run our health care business. We may use or share your information for several reasons related to our health care activities.

Examples: We may share your medical information in our training programs where students, trainees, or other health care practitioners learn to improve their health care skills. Your information may also be used for quality improvement, safety programs, and to see how well our health care personnel are doing.

University of Louisville Physicians
UofL Health Care Outpatient Center
401 East Chestnut Street
Louisville, KY 40202

JOINT NOTICE OF PRIVACY PRACTICES

University of Louisville Physicians
Organized Health Care Arrangement

Effective Date: April 14, 2003
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Business Associates. We may share your medical information with another company or organization, called a "business associate" that we hire to provide a service to us or on our behalf. Business associates must also follow privacy rules.

Example: A company that submits bills on our behalf to your insurance company.

Appointment Reminders. We may contact you to remind you of an appointment or to change one. We may also let you know that it is time for a follow-up appointment or a regular check-up.

Health-Related Benefits, Services and Treatment Alternatives. We may contact you to let you know about health-related benefits or services, or possible treatment alternatives that may be of interest to you.

Fundraising Activities. UofL health care providers rely on the kindness of the community to help us provide quality health care to this region. *Patients who share their experiences and suggest ways to work with us are giving back in a meaningful way.* Their information also helps us improve and expand our services. We may use limited information about you, called demographic information, along with the dates you received care, the department and/or physician who provided your care, outcome information, and your health insurance status for fundraising efforts to support our mission. We also may share this information with our related foundation or business associates so they can contact you for your support. Your generosity helps us continue to be an outstanding provider of health care services in this region. You have a right to opt out of receiving such communications.

Required Disclosures. The Secretary of the Department of Health and Human Services may investigate privacy violations. If your health information is requested as part of an investigation, *we must share your information with the Secretary of the Department of Health and Human Services.* Under the same laws, we must give you access to information in your medical record. The laws also permit us to keep certain information from you.

Required by Law. We must share medical information if federal, state, or local law requires us to.

Public Health and Safety. We may share your medical information for public health reasons. These include:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report information to the FDA about the products it oversees;
- to let you know that you may have been exposed to a disease or may be at risk for getting or spreading a disease or condition; or
- to your employer in certain limited instances.

Abuse and Neglect. The law may require us to report suspected abuse, neglect or domestic violence to state and federal agencies. Your information may be shared with these agencies for this purpose. Generally, you will be told that we are sharing this information with these agencies.

Health Oversight Activities. Certain health agencies are in charge of overseeing health care systems and government programs or to make sure that civil rights laws are being followed. We may share your information with these agencies for these purposes.

Legal Proceedings. If a court or administrative authority orders us to do so, we may release your health information and records. We will only share the information required by the order. If we receive

any other legal request, we may also release your health information and records. However, for such other requests, we will only release the information if we are told that you know about it, and had a chance to object and did not, or if we have received confirmation that the party requesting the information has agreed to protect it under an order approved by a court or administrative authority.

Law Enforcement. We may share health information if a law enforcement official asks for it:

- to respond to a court order, warrant, summons, or other similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person; or
- to obtain information about an actual or suspected victim of a crime.

We may share information with a law enforcement official:

- if we believe a death was the result of a crime;
- to report crimes on our property; or
- in an emergency.

Coroners, Medical Examiners, and Funeral Directors. We may share health information with a coroner or medical examiner to identify a deceased person or find the cause of death. We also may release health information to funeral directors if they need it to do their job.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to the organizations in charge of getting, transporting, or transplanting an organ, eye, or tissue.

Research. We may share your medical record with researchers, without your permission, in very limited situations. In most cases, a researcher must submit his/her request to see your information to a special group called the Institutional Review Board ("IRB"). The IRB will decide if it should allow the researcher to use or share your information. Your medical information also may be used by or shared with researchers to prepare for research, but only under strict conditions. Under similar strict conditions, medical information about deceased people can be used or shared.

To Prevent a Serious Threat to Safety. We may use and share your medical information to prevent a serious threat to your health and safety or the health and safety of others.

Specialized Governmental Functions. We may share your medical information and records with:

Authorized federal officials

- for intelligence, counter-intelligence, and other national security activities authorized by law; or
- to protect the President.

Armed forces command authorities or the Department of Veterans Affairs

- to see if you are fit for military duty or eligible for veterans health services; or
- to see if you are medically fit to receive a security clearance by the Department of State.

Correctional facility or law enforcement official or agency if you are an inmate or under the custody of a law enforcement official or agency, if necessary, to:

- help the correctional facility provide you with health care; or
- protect the health and safety of you and/or others.

Workers Compensation. We may share your health information with agencies or individuals to

follow workers compensation laws or other similar programs.

WAYS WE MAY USE AND SHARE YOUR HEALTH INFORMATION WHEN WE HAVE GIVEN YOU A CHANCE TO OBJECT

You have the right to agree or disagree to the following uses of your medical information. If you are not here or able to agree or disagree, we may still use and share information if we think that it may be best for you.

Individuals Involved in Your Care or Payment for Your Care. We may share medical information about you with your family members, friends, or any other person you tell us who is involved in your medical care or who helps pay for it.

Disaster Relief. We also may share medical information about you to a disaster relief agency so that your family can be told of your condition and location.

In some circumstances, you may have a chance to object to the sharing of information for this purpose.

OTHER USES AND SHARING OF YOUR HEALTH INFORMATION REQUIRE YOUR WRITTEN AUTHORIZATION

Certain uses and sharing of your health information that are not described in this notice will be made only with your written permission, called an Authorization. These include uses and disclosures of psychotherapy notes, uses and disclosures of your health information for marketing purposes, and disclosures that constitute a sale of your health information.

You may revoke your authorization at any time, but it will not be effective for uses or disclosures that have already taken place. To revoke an authorization, you must write to the University of Louisville Physicians Privacy Officer at the address listed below.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have certain rights regarding your health information, described below. These rights apply to the health information we keep. You must submit a written request to use any of these rights. You can send your written request to the University of Louisville Physicians Privacy Officer at the address listed below.

Right to Request Special Communications. You have the right to ask that we write or call you at a different address or phone number and/or by a different way. We will try to follow all reasonable requests.

If you would like us to use a different address, phone number, or different way of reaching you, you must ask for this in writing. We will not ask why you want to do this. Your request must tell us how you wish to be contacted.

Right to Inspect and Copy. You have the right to read or get a copy of your health information, with some exceptions. We may turn down your request under certain circumstances. If we do so, you may ask for a licensed health care professional chosen by us to review why we turned you down. We will follow the reviewer's decision.

Right to Request Changes. If you believe the health information that we created is wrong or incomplete, you may ask us to change it. *You must provide a reason why you want the change*. We cannot take out or destroy any information already in your medical record. Under certain circumstances, we are permitted to deny your request for a change. If we do not agree to the change, we will provide you with a letter explaining the reason for our denial. You can then write us a

letter if you disagree with our reason for denying the changes. You can send this letter to the University of Louisville Physicians Privacy Officer at the address listed below. Your letter will be attached to the information you wanted changed or corrected. We may also send you a letter in response.

Right to an Accounting of Disclosures. We are required to track who we share your health information with under certain circumstances. You have the right to ask for a copy of this list. Your request must give a time period, which may not be longer than 6 years.

If you would like to ask for a list of disclosures, you must ask for it in writing. You must tell us the date(s) you would like to see. The first list will be given to you free. We are permitted to charge a reasonable fee if you request an additional list of disclosures in the same 12 month period. Your right to receive this list is subject to certain limitations and the law permits us to exclude certain types of disclosures from the list we provide.

Right to Request Restrictions. You have the right to ask for a restriction or limitation on the medical information we use or share about you. We are not required to agree to your request, with one exception. We are required to agree when you ask us to refrain from sharing your information with a health plan, if the information pertains to a health care item or service that you have paid for out of pocket in full. For other requests, if we choose to agree, we will follow your request unless the information is needed to provide you with emergency treatment. You must tell us the type of restriction you want and to whom it applies.

Right to Receive Breach Notifications. In many instances, you have the right to know if your unsecured information has been lost, stolen, or otherwise seen by people who do not usually have the right to see it.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. Copies of this notice will be posted and available at each location where medical services are provided and at www.uoflphysicians.com.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for your health information we already have as well as any we get in the future. Any changes in this notice will be posted on our web site at www.uoflphysicians.com. The revised notice also will be available at any of the locations where University of Louisville Physicians offers services.

WHAT IF I HAVE QUESTIONS OR NEED TO REPORT A PROBLEM?

If you have any questions about this notice or about how your health information is used or shared by us please contact the University of Louisville Physicians Privacy Officer by calling 502-588-4520 or 855-588-6001.

If you believe your privacy rights have been violated, you may file a complaint with us.

To file a complaint, please contact the University of Louisville Physicians Privacy Officer at 502-588-4520 or 855-588-6001, or write to the Privacy Officer at PO Box 909, Louisville, KY 40201-0909. Please give as much information as possible so that the complaint can be looked into properly.

You may also file a complaint with the Secretary of the Department of Health and Human Services. ***Your care will not be affected if you file a complaint, nor will any action be taken against you.***