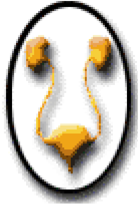

Urology Consultants

www.urologyorlando.com

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Longwood, FL 32750

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(407) 332-0777
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FAX (407) 332.8767

Board Certified Urologists
E. Jake Jacobo, MD, FA
Steven K. Brooks, MD

A Patient Demographics

"PLEASE PRINT IN BLACK INK ONLY"

Today's Date ______________________ Date of Last Physical Exam ______________________
Last Name ______________________ First Name ______________ MI ________
Address ______________________ City, State, Zip ______________________
Home Phone ______________________ Work Phone ______________________
Emergency Contact Name & Phone # ______________________
SSN ______________ DOB ____________ Age __________ Marital Status ______
Employer ______________________ Address ______________________
How were you referred to our office? please list first & last name ______________________
Who is your family doctor? please list first & last name ______________________

B Guarantor Demographics

Last Name ______________________ First Name ______________ MI ________
Address ______________________ City, State, Zip ______________________
Home Phone ______________________ Work Phone ______________________
SSN ______________ DOB ____________ Age __________ Marital Status ______

C Patient Financial Demographics

How will you be paying for your services today? ☐Insurance ☐Self Pay ☐Worker's Comp ☐Other

Primary
Insurance Carrier ______________________ Benefits Phone# ______________________
ID#: ______________________ Group # ______________________
Insurance Type ☐HMO ☐PPO ☐Indemnity ☐Worker's Comp

Secondary
Insurance Carrier ______________________ Benefits Phone# ______________________
ID#: ______________________ Group # ______________________
Insurance Type ☐HMO ☐PPO ☐Indemnity ☐Worker's Comp

If your claim is not being filed under your own policy please complete section B

Patient's Signature ______________________ Today's Date ______________

FOR OFFICE USE ONLY

Copay $ ________ Deductible $ __________ Participating Providers? ☐Yes ☐No
Effective Coverage Date ______________________ Referral/Authorization **Required**? ☐Yes ☐No
Referring Physician & Phone # ______________________
PCP & Phone # ______________________
Contracted Hospitals ______________________
Contracted Labs ______________________
Contracted Diagnostic Facilities ______________________
Initials ______ ______ ______ ______ ______ ______
______ ______ ______ ______ ______ ______
______ ______ ______ ______ ______ ______

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE ______/______/______ **DATE OF LAST PHYSICAL EXAM** ______/______/______

LAST NAME ____________________________________ **FIRST NAME** ______________________ **MIDDLE** ______________

SOCIAL SECURITY NO. ________________________________ **DATE OF BIRTH** ______/______/______

CHIEF COMPLAINT What is the main reason for your visit today? (Describe your problem in detail.)

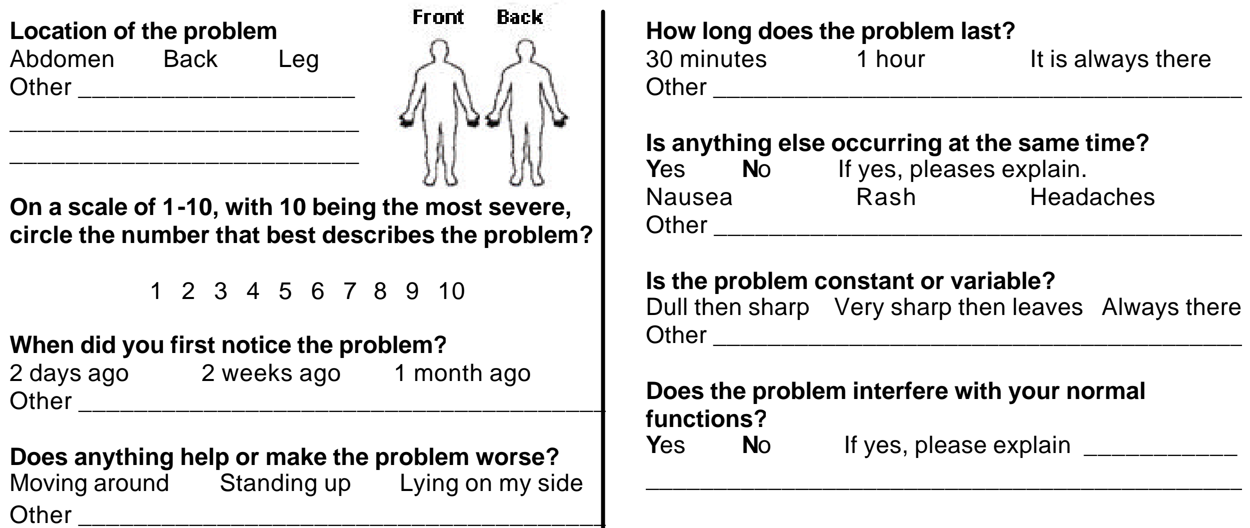
____

____

____

History of Present Illness

Please answer the following questions



Location of the problem

Abdomen Back Leg

Other ____________________

____

____

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other ____

Does anything help or make the problem worse?

Moving around Standing up Lying on my side

Other ____

How long does the problem last?

30 minutes 1 hour It is always there

Other ____

Is anything else occurring at the same time?

Yes **N**o If yes, pleases explain.

Nausea Rash Headaches

Other ____

Is the problem constant or variable?

Dull then sharp Very sharp then leaves Always there

Other ____

Does the problem interfere with your normal functions?

Yes **N**o If yes, please explain ___________

____

Physician use only: (Comments/Notes)	# Answers	Level of Service
	1 – 3	1 or 2
	4+	3 - 5

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.)

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery Date

____

____

____

Do you smoke? **Y** **N**

If yes, how much? ___________________________

Do you drink? **Y** **N**

If yes, how much? ___________________________

Are you on any medications? **Y** **N** (If yes, list all.)

_________________________ _________________________

_________________________ _________________________

Are you on a special diet? **Y** **N** (If yes, please explain.)

____

Do you have allergies? **Y** **N** (If yes, please explain.)

____

____

Physician use only: (Comments/Notes)	#Answer	Level of Service
	0	1 or 2
	1 – 2	3
	3	4 or 5

Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o.

Please explain any Yes answers in the space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other ___________________________		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other ___________________________		

Allergic/Immunologic

Hay fever	Y	N
Drug allergies	Y	N
Other ___________________________		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other ___________________________		

Endocrine

Excessive heat	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other ___________________________		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other ___________________________		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other ___________________________		

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other _______________________________________		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other _______________________________________		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other _______________________________________		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other _______________________________________		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of Breath	Y	N
Other _______________________________________		

Hematological/Lymphatic

Swollen glands	Y	N
Blood clotting problems	Y	N
Other _______________________________________		

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other _______________________________________		

Physician use only: (Comments/Notes)

#Answer	Level of Service
0 – 1	1 or 2
2 – 9	3
10 +	4 or 5

Physician: ____ Date: _____/_____/_____

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MASTER MEDICATION SHEET

Today's Date ______________________ Attending Physician ______________________

Last Name ______________________ First Name ______________________ MI ______

Social Security # ______________________ DOB ______________________ Age ______

Please list all medications you are currently taking:

Medication	Daily Dose	Start Date	Reason

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PATIENT NAME______________________________**ACCOUNT**__________

PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION SO YOUR PRESCRIPTION (IF ANY) MAY BE EXPEDITIOUSLY SENT TO THE PHARMACY OF YOUR CHOICE ELECTRONICALLY. Our system communicates with thousands of pharmacies nationwide, we would like to make sure that if a prescription is assigned to you it **REACHES** the pharmacy of your choice.

YOUR LOCAL PHARMACY

(name)____

ADDRESS:____

and cross street__________________________

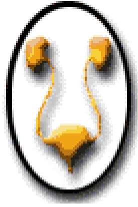
CITY__________________________

PHARMACY TELEPHONE NUMBER______________________________

FOR LONG TERM PRESCRIPTION(S) (90 DAYS OR MORE)
also known as "prescription by mail pharmacy" please provide with

PHARMACY NAME____

FAX OR PHONE NUMBER___________________________________



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Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment. All patients must complete all required paperwork before seeing the doctor.

PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, OR CREDIT CARDS. Payments are required to be paid at time of service. Pre-payment options are available and are encouraged in order to avoid any additional charges. Patients will be responsible for any fees incurred from collection agencies and/or legal services hired by Urology Consultants to secure payment for services.

INSURANCE
With prior arrangements we will file to your insurance company. However, we do require the patient's percentage of the bill to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give a copy of your insurance card. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full with 45 days, you will be responsible for the bill within 10 days of receipt of your statement. Please be aware that some, and perhaps all, of the services provided may be NON-COVERED SERVICES and not considered reasonable by your insurance policy. Regarding Insurance Plans in which we are a participating provider; all co-pays are due at the time of treatment. In the event that your insurance coverage changes to a plan where we are not participating providers it is the responsibility of the patient to pay for services rendered at the time of the appointment.

USUAL & CUSTOMARY RATES
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MANAGED CARE & REFERRALS
Patients are responsible for ensuring that they are seeing a physician that is listed in their Provider Directory. Failure to do so would result in the patient being responsible for charges incurred. It is not the responsibility of Urology Consultants to ensure we are providers. Our main concern is the health of our patients. Patients that are members of an HMO are required to secure a referral from their Primary Care Physician (PCP) before scheduling an appointment with a specialist. To accommodate our patients in informing the PCP, medical records will be sent after each visit as well as a faxed request two days prior to follow up visits. If the referral is not secured by our office the day prior to follow up visits, the patient will be notified and will be given the following options: 1. Reschedule Appointment 2. Keep appointment & pay for services 3. Secure his referral from the PCP.
To expedite the referral process, patients are encouraged to inform their PCP's office of any follow up visits, procedures and/or surgery.

BENEFITS ASSIGNMENT/RELEASE OF INFORMATION/MEDIGAP
I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to Urology Consultants. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

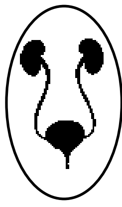
A photocopy of my insurance card is to be considered as valid as the original. I, hereby authorize Urology Consultants to release all information necessary, including medical records and **HIV related medical record documentation**, if any, to any third party payer to whom the patient has directed the bill be sent to secure payment. My signature constitutes a lifetime authorization. I authorize the doctors to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

☐ I prefer that Urology Consultants contact me before any HIV related medical record documentation be given to any party including my insurance company. In which case I will be responsible for any charges incurred from your office within 10 days after contacting me. I do understand that information regarding HIV results, therapy, counseling, etc., obtained by Urology Consultants will be released to the Health Department as required by law. I request that payment of authorized **MEDIGAP** benefits be made either to me or on my behalf to Urology Consultants for any services furnished me by that physician. I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits or the benefits payable for related services. My signature constitutes a lifetime authorization.

Name of Patient (printed)____

Signature of Patient ____ Today's Date ______________________________

Signature of Guardian ____ Today's Date ______________________________
(if applicable)



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Receipt of Privacy and Financial Policies

By signing below I acknowledge that I have received, read, and been given the opportunity to ask questions regarding these polices. By signing I agree to the terms and conditions contained in these policies. A written notice is required to terminate the agreement of these policies. I am aware that the termination of these policies may result in the dismissal from Urology Consultants.

Print Name of Patient: ____**DOB**_______________

**** **Patient Signature:** ____**Date:** ______________

Release of Confidential Information

It is the policy of Urology Consultants not to release any protected information regarding your medical and or personal information to anyone except those indicated in our Privacy Policy required by Law. Entities receiving information for the continuity of care may include your Primary Care Physician, Pharmacies, Insurance Companies, and other health care providers referred. Your written permission is needed in order for the following individuals to obtain information regardless of who is financially responsible for your account: **Spouses, children or other family members.**

Please list below the names of individuals that you authorize us to disclose your medical information with. A password will be required to obtain this information. The individuals you list will require the password. Please make sure they are aware of your password.

☐ I **DO NOT** wish you to discuss my medical information with anyone except those outlined in the Privacy Policy and myself.

☐ You may discuss my medical information with the following individuals:

Password: ______________________________(Please give to individuals below)

_________________________________ __________________________________

_________________________________ __________________________________

☐ I authorized Urology Consultants to leave detailed messages on my home/cell phone number answering machine as needed for the following purposes: appointments, insurance/billing inquires, test results. I understand that someone other than myself may hear this information and I will not hold Urology Consultants responsible for information left via telephone message systems.

Print Name of Patient: ____**DOB**________________

******Patient Signature:** ____**Date:** ______________

HIPAA NOTICE OF PRIVACY PRACTICES

UROLOGY CONSULTANTS

Effective Date: April 14, 2003

THIS 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.

If you have any questions about this notice, please contact Susan Sackett, Privacy Officer at (407) 332-0777.

WHO WILL FOLLOW THIS NOTICE:

• Urology Consultants

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:
We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:
• make sure that health information that identifies you is kept private;
• give you this notice of our legal duties and privacy practices with respect to health information about you; and
• follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.
The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and

try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other health care provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, to have prescriptions filled, or for other treatment purposes. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian at the hospital if you have diabetes so that we can arrange for appropriate meals. We may also disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

For Payment. We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your office visit so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

Research. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process; but we may disclose health information about you to people preparing to conduct a research project. For example, we may help potential researchers look for patients with specific health needs, so long as the health information they review does not leave our facility. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

As Required By Law. We will disclose health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans. If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Worker's Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose health information about you for public health activities. These activities generally include the following:
- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify person or organization required to receive information on FDA-regulated products;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release health information if asked to do so by a law enforcement official:
- in reporting certain injuries, as required by law, gunshot wounds, burns, injuries to perpetrators of crime;

• in response to a court order, subpoena, warrant, summons or similar process;
• to identify or locate a suspect, fugitive, material witness, or missing person:

- Name and address
- Date of birth or place of birth;
- Social security number;
- Blood type or rh factor;
- Type of injury;
- Date and time of treatment and/or death, if applicable; and
- A description of distinguishing physical characteristics.

• about the victim of a crime, if the victim agrees to disclosure or under certain limited circumstances, we are unable to obtain the person's agreement;
• about a death we believe may be the result of criminal conduct;
• about criminal conduct at our facility; and
• in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Coroners, Health Examiners and Funeral Directors. We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to Susan Sackett, Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies and services associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that health information we have about you is incorrect or incomplete; you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request

- must be made in writing, submitted to Susan Sackett, Privacy Officer, and must be contained on one page of paper legibly handwritten or typed in at least 10 point font size. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

· was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
· is not part of the health information kept by or for our practice;
· is not part of the information which you would be permitted to inspect and copy; or
· is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures. You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. To request this list of disclosures, you must submit your request in writing to Susan Sackett, Privacy Officer. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date will not exceed a total of 60 days from the date you made the request.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we restrict a specified nurse from use of your information, or that we not disclose information to your spouse about a surgery you had. ***We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing to Susan Sackett, Privacy Officer. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, use of any information by a specified nurse, or disclosure of specified surgery to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location.

For example, you can ask that we only contact you at work or by mail to a post office box. To request confidential communications, you must make your request in writing to Susan Sackett, Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to obtain a paper copy of this notice at any time. However, at the time of first service rendered after April 14, 2003, it is required that you receive a paper copy. To obtain a copy, please request it from Susan Sackett, Privacy Officer. You may also obtain a copy of this notice either from our website, www.urologyorlando.com, or by requesting a copy of this notice be sent through electronic mail. If we know that the electronic message has failed to be delivered, a paper copy of the notice will be provided. Even if you have received a notice electronically, you still retain the right to receive a paper copy upon request. **If the first service delivery is delivered electronically, other than by telephone, we provide electronic notice in the same medium, automatically and contemporaneously in response to a first request for service.**

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 health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services; we will offer you a copy of the current notice in effect.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Susan Sackett, Privacy Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION. Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE. We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name, date. This acknowledgement will be filed with your records.

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