



www.memphishealthcenter.org

Dear Patient,

Thank you for becoming a new patient or recertifying your registration with Memphis Health Center (MHC)! We are very excited to have the opportunity to serve you and your family with the most comprehensive and high-quality array of primary medical and social support services available throughout the Mid-South!

MHC provides the following primary care and ancillary services:

Pediatric/Adolescent	Radiology
Adult Medicine	Mammogram
Obstetrics/Gynecology	Pharmacy
Behavioral Health	Laboratory
Dental	Podiatry
Ophthalmology	Telehealth

As a patient receiving care at MHC, you also have access to enabling/social services and value-added programs.

Enabling/Social Services	Value-Added Programs
Case Management	Sliding Fee Discount
Translation/Interpretation	
Transportation	Healthcare For Homeless
Eligibility/Enrollment Assistance	Ryan White Part A & MIA
Health Education	340B Discount Prescription Drugs
Medication Assistance	A Step Ahead
Housing Assistance	TN Breast/Cervical Cancer Screening

Please note the items below that are required to complete your registration:

Adult (18 years & older)

- ✓ Two (2) Valid Forms of Identification (One MUST be a Photo ID)
- ✓ Insurance Card
- ✓ Income Verification (If Applicable)

Minors (0 to 17 years)

- ✓ Two (2) Valid Forms of Identification (Parent)
- ✓ Insurance Card
- ✓ Income Verification (Parent If Applicable)
- ✓ Birth Certificate
- ✓ Social Security Card

To schedule your next appointment or for more information about our services and programs, please call (901) 261-2000 during regular business hours or request an appointment online at www.memphishealthcenter.org. If you need medical care after hours of operation, please call (901) 261-2000.

Hours of Operation:

Monday & Thursday: 7:30 AM to 5:30 PM

Friday: 7:30 AM to 11:30 AM

Saturday: 8:00 AM to 12:00 PM (1st & 3rd)



PATIENT REGISTRATION FORM

PATIENT INFORMATION					
Last Name		First Name		Middle Name	Preferred Name
Date of Birth / /	Social Security Number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
Mailing Address (Street or P.O. Box)		Apt.	City	State	Zip Code
Home Phone Number ()		Cell Phone Number ()		Email Address	
Emergency Contact Name		Relationship to Patient		Emergency Contact Phone Number ()	
Do you have an Advance Directive/Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you desire to create an Advance Directive/Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is your primary language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			
RESPONSIBLE PARTY (Complete if different from above)					
Last Name		First Name		Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Child <input type="checkbox"/> Other _____	
Date of Birth / /	Social Security Number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
Mailing Address (Street or P.O. Box)		Apt.	City	State	Zip Code
Home Phone Number ()	Mobile Phone Number ()	Work Phone Number ()	Email Address		
Primary Insurance Company		Policy/Member ID #		Policy Group #	Copayment
Secondary Insurance Company		Policy/Member ID #		Policy Group #	Copayment
DEMOGRAPHIC INFORMATION					
Our federal grant requires us to collect and report on the information below in an effort to provide culturally competent healthcare services. The information is reported on the population, not by specific individuals.					
Annual household income _____ <i>This is used to assess your need for, and ability to qualify for, financial assistance programs.</i>		Are you homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No (please check the box that best describes your household) <input type="checkbox"/> Shelter <input type="checkbox"/> Transitional <input type="checkbox"/> Street <input type="checkbox"/> Doubling up (with family/friends)		Veteran Status (Have you ever served in the U.S. Military?) <input type="checkbox"/> Yes <input type="checkbox"/> No	
How many dependents are in your home, including you? (yourself, spouse/partner, and minor children under 18 years) _____				Are you a migrant or seasonal worker? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, which one _____)	
Are you in need of financial assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Race (Please check ALL that best describes your race) <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> White <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Korean <input type="checkbox"/> Chose not to disclose		Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American, Chicano <input type="checkbox"/> Cuban <input type="checkbox"/> Chose not to disclose		Gender Identify <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Other <input type="checkbox"/> Chose not to disclose	
				Sexual Orientation <input type="checkbox"/> Heterosexual <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Other <input type="checkbox"/> Don't Know <input type="checkbox"/> Chose not to disclose	
				How did you hear about MHC? Relative/Friend; Community Event; Radio/TV; Other _____	

*Please provide your current address, phone number, and insurance card(s) at each appointment.



CONSENT FOR EVALUATION AND TREATMENT

Memphis Health Center (MHC) is committed to providing comprehensive primary care, dental, and behavioral health services. Because collaborative, patient-centered care plays an integral role in the care you receive, our multi-disciplinary team of providers works together to ensure your needs are being addressed and to offer you high-quality whole person healthcare.

Some services at MHC may involve the use of telemedicine equipment and interaction with providers who are not physically onsite. These sessions are transmitted via secure, dedicated high-speed lines and are not videotaped, routed through the internet, or saved in any way.

I understand, that if I am 13 years of age or older, I may consent for family planning or obstetrical services; if I am 16 years of age or older, I may consent for certain types of health services, including mental health services; and if I am 18 years of age or older, I may consent for all other health services; otherwise, my parent or legal guardian will need to consent to services.

I hereby authorize the providers of MHC to provide reasonable and necessary medical, dental, and behavioral health services in connection with evaluation and treatment of the named patient.

Thus, I hereby ask, agree, and consent to evaluation and treatment for myself and/or child(ren) as set forth above, including any tests or procedures that MHC professional staff decide are necessary or appropriate. If signing as parent or legal guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

By signing this form, (parent or legal guardian, if required) I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I understand that I agree to be truthful in providing information.

Form with fields for Patient Name, Patient DOB, Signature, Date, and Printed Name if Parent/Guardian Signing.

NOTICE OF PRIVACY PRACTICES

Memphis Health Center (MHC) strongly believes in safeguarding the privacy of our patients' protected health information (PHI). PHI is information which:

- Identifies you (or can reasonably be used to identify you); and
Relates to your physical or mental health condition, the provision of health care to you or the payment for that care.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. This Notice of Privacy Practices describes how we may collect, use and disclose your PHI, and your rights concerning your PHI.

You will be provided with a copy of the Notice of Privacy Practices during the registration process. The Notice is also posted on our website at www.memphishealthcenter.org.

My signature below serves to confirm I have received the Notice of Privacy Practices and information on how to obtain a copy of the MHC's Notice of Privacy Practices.

Signature lines for Patient Name (Print), Signature of Patient, and Date.



SLIDING FEE DISCOUNT PROGRAM APPLICATION

It is the policy of Memphis Health Center (MHC) to provide services regardless of the patient’s ability to pay. As a Federally Qualified Health Center, MHC offers a Sliding Fee Discount Program designed to allow patients to pay for healthcare services based on family size and household income. Sliding Fee Discounts are determined by using:

Recent Income Tax Return	Recent W-2 Form	Current Pay Stubs
Unemployment Award Notice	Social Security Notice	Self-declaration Letter

To apply for the Sliding Fee Discount Program, please complete the following information and return to the front desk with proof of household income and photo identification. To remain eligible for the discount, this form must be completed every 12 months or if your family/financial situation changes.

PATIENT INFORMATION

Last Name		First Name		DOB	
Mailing Address (Street or P.O. Box)		Apt.	City	State	Zip Code
Home Phone Number ()		Cell Phone Number ()		Email Address	

Please list all household members, including those under the age of 18 and income.

Household Members	Number	Gross Income (Before Taxes)
Total Household Members/Gross Income		

I understand that if I am applying for financial assistance and do not have any source of income or do not have proof of income with me today, MHC will discount my services for today based on estimated income. **However, I will be totally responsible for any subsequent visits at MHC if I do not bring proof of income within 30 business days.**

I, _____ (print name), certify that the above information is true and correct to the best of my knowledge. I agree to notify MHC if there are any changes in my household size or income. If the above information proves to be incorrect, I understand that the discount provided to me will be terminated.

Patient (Legal Guardian) Signature

Date

FOR OFFICE USE ONLY			
Verified By	Effective Date	Expiration Date	Sliding Fee Scale (circle one)
			A B C D E F



SELF-DECLARATION OF INCOME FORM

Complete the information below only if you have no other way to document your income. Failure to complete this form may result in denial of your application from the Sliding Fee Discount Schedule Program.

Check all that applies:

- I am currently unemployed.
I get paid in cash.
I do not get pay checks.
I do not get pay stubs.
I cannot get a letter from my employer establishing my income. Explain why:

My gross household income is \$ (circle one: per week / month / year) and there are family members living in my household.

Current Employer
Employer Address
Employer Phone Number

I certify that I have no other way to document my income and that all the above information is true and correct. I understand that this information is to be used to determine eligibility for the Sliding Fee Discount ("SFD") Program. I understand that Memphis Health Center may verify information on this form. I also understand that if I intentionally misrepresent my income, I may be denied from the SFD Program.

Patient Name (Print)

Date of Birth

Signature (Patient/Parent/Guardian)

Date

Witness Name and Signature

Date



ADVANCE DIRECTIVE

What is an Advance Directive?

An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions (ex. In a coma). If you are admitted to the hospital, the staff will probably talk to you about advance directives.

A good advance directive describes that kind of treatment you want depending on how sick you are. For example, the directives would describe what kind of care you want if you have an illness that you are unlikely to recover from, or if you are permanently unconscious. Advance directives usually tell your doctor that you don't want certain kinds of treatment. However, they also can say that you want a certain treatment no matter how sick you are.

Should I have an advance directive?

By creating an advance directive, you are making your preferences about medical care known before you're faced with a serious injury or sickness. This will spare your loved ones the stress of making decisions about your care while you are sick. Any person 18 years or older can prepare an advance directive.

People who are seriously or terminally ill are likelier to have an advance directive. For example, someone with terminal cancer might write that he/she doesn't want to be put on a respirator if he/she stops breathing. This action can reduce his/her suffering, increase his/her peace of mind and increase his/her control over his/her death.

However, even if you are in good health, you might want to consider an advance directive. An accident or serious illness can happen suddenly, and if you already have a signed advance directive, your wishes are more likely to be followed.

You can write an advance directive in several ways:

- Use a form provided by your doctor
- Write your wishes down by yourself
- Call your health department or state department on aging to get a form
- Call a Lawyer
- Legal documents online

Advance directives and living wills do not have to be a complicated legal document. They can be a short simple statement about what you want done or not done if you cannot speak for yourself. Remember, anything you write yourself or with computer software package should follow your state laws. You may also want to have what was written reviewed by your doctor or lawyer to make sure your directives are understood exactly as you intended. When you are satisfied with your directives, the orders should be notarized if possible, and copies should be given to your family and your doctor.

Can I change my advance directive?

You may change or cancel your advance directive at any time, as long as you are considered of sound mind to do so. Being of sound mind means that you are still able to think rationally and communicate your wishes in a clear manner. Again, your changes must be made, signed and notarized according to the laws in your state. Make sure that your doctor and family members who knew about your directive are also aware that you changed them. If you do not have time to put your changes in writing, you can make them known while you are in the hospital. Tell your doctor and any family or friend present exactly what you want to happen. Usually, wishes that are made in person will be followed in place of the ones made earlier in writing. Be sure your instructions are clearly understood by everyone you have told.

PATIENT RIGHTS AND RESPONSIBILITIES

Memphis Health Center, Inc. (MHC) believes that every patient deserves to be treated with dignity and respect and ensures that patients' rights and responsibilities are observed and supported.

PATIENT RIGHTS

At MHC, every patient has the right to:

- Affordable, impartial access to treatment without discrimination
- Reasonable continuity of care
- Culturally and linguistically appropriate services
- Interpretation services at no cost to you
- Know the professional experience and name of your healthcare provider
- Receive information about any proposed treatment plan in order to give informed consent or to refuse a course of treatment
- Participate in decisions involving your healthcare
- Appropriate assessment and management of pain
- Receive information about advance health care directive and formulate an Advance Directive
- Personal and informational privacy
- Confidentiality of records and disclosures
- Access to your medical records
- Explanation of your fees
- An environment free of disruptive behavior (yelling, profanity, threatening)
- Complain without fear of reprisals

PATIENT RESPONSIBILITIES

All patients receiving health care services at MHC have the responsibility to:

- Provide complete and accurate contact information
- Be open and honest with your healthcare provider
- Provide accurate and complete information about your health status
- Ask questions fully
- Let your healthcare provider know that you understand the treatment plan
- Accept responsibility for your action if you do not follow agreed upon treatment plan
- Arrive on time for scheduled appointment
- Keep scheduled appointment and when unable to do so, notify the center at least 24 hours before scheduled appointment
- Schedule an appointment before running out of medications
- Respect others' privacy and property
- Disclose financial information and pay for services responsibly
- Advise any changes in insurance plan and billing/payment information



NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY**

For More Information, Please Contact:

HIM Manager/Privacy Officer
Memphis Health Center, Inc.
360 E E.H. Crump Boulevard
Memphis, TN 38126
(901) 261-2006 | jhoskins@mphshc.org

Who We Are:

This Notice describes the privacy practices of Memphis Health Center (MHC) and the privacy practices of:

- all our doctors, nurses, and other health care professionals are authorized to enter information about you into your medical chart.
- all our departments, including our medical records and billing departments.
- all the primary care service sites:
 - Memphis Health Center, 360 E E.H. Crump Blvd., Memphis, TN 38126
 - Rossville Health Center, 4940 Highway 57, Rossville, TN 38066
 - Whitehaven Health Center, 4593 Elvis Presley Boulevard #101, Memphis, TN 38116
- all our employees, staff, volunteers, and other personnel who work for us or on our behalf.

Our Pledge:

We understand that health information about you and the health care you receive is personal. We are committed to protecting your personal health information. When you receive treatment and other health care services from us, we create a record of the services that you received. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all our records of your care, whether made by our health care professionals or others working in this office and tells you about the ways in which we may use and disclose your personal health information. This notice also describes your rights with respect to the health information that we keep about you and the obligations that we have when we use and disclose your health information.

We are required by law to:

- make sure that health information that identifies you is kept private in accordance with relevant law.
- give you this notice of our legal duties and privacy practices with respect to your personal health information.
- follow the terms of the notice that is currently in effect for all your personal health information.

How We May Use and Disclose Your Health Information. We may use and disclose your personal health information for these purposes:

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 the doctors, nurses, technicians, medical students, and others who are involved in your care. They may work at MHC, 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 treatment, consultation, x-rays, lab tests, prescriptions, or other health care service. They may also include doctors and other health care professionals who work at MHC, or elsewhere, whom we consult about your care. For example, we may consult with a specialist who lends his/her services to MHC about your care or disclose to an emergency room doctor who is treating you for a broken leg that you have diabetes, because diabetes may affect your body's healing process.

For Payment. We may use and disclose health information about you to bill and collect payment from you, your insurance company, including TennCare and Medicare, or other third parties that may be available to reimburse us for some or all your health care. We may also disclose health information about you to other health care providers or to your health plan so that they can arrange for payment relating to your care. For example, if you have health insurance, we may need to share information about your office visit with your health plan in order for your health plan to pay us or reimburse you for the visit. We may also tell your health plan about treatment that you need to obtain your health plan's 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 our day-to-day operations and may disclose information about you to other health care providers involved in your care or to your health plan for use in their day-to-day operations. These uses and disclosures are necessary to run MHC and to make sure that all our patients receive quality care and assist other providers and health plans in doing so as well. For example, we may use health information to review the services that we provide and to evaluate the performance of our staff in caring for you.

We may also combine health information about our patients with health information from other health care providers to decide what additional services MHC should offer, what services are not needed, whether 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 patients are. We may disclose protected health information to our business associates who perform functions on our behalf or provide us with services if the protected health information is necessary for those functions or services. For example, we may use another company to do our billing or to provide transcription or consulting services for us. All our business associates are obligated, under contract with us, to protect the privacy of your protected health information.

Appointment Reminders. We may use and disclose your health information to contact and remind you of an appointment for treatment or medical care. When disclosing information, primarily appointment reminders and billing efforts, we may leave messages on your answering machine/voice mail.

We may also use and disclose health information:

- to assess your satisfaction with its services;
- to tell you about possible treatment alternatives;
- to tell you about health-related benefits or services;
- for population-based activities relating to improving health or reducing health care costs;
- for conducting training programs or reviewing competence of health care professionals; and
- to a Medicaid eligibility database, as applicable.

Health-Related Services and Treatment Alternatives. We may use and disclose health information to tell you about health-related services or recommend treatment options or alternatives that may be of interest to you. We may communicate to you via mailouts or other means regarding treatment options, health-related information, disease management programs, wellness programs, or other community-based initiatives or activities in which our facilities participate. Please let us know if you do not wish us to contact you with this information, or if you wish to have us use a different address when sending this information to you.

Fundraising Activities. We may use health information about you to contact you in an effort to raise money for our not-for-profit operations. We may disclose health information about you to a foundation related to MHC so that the foundation may contact you in raising money for the health center. We will only release contact information, such as your name, address, phone number, and the dates you received treatment or services from us. In the event, your minor child is the patient, or you are listed as the responsible party, the information released would pertain to you as the responsible party. Please let us know if you do not want us to contact you for fundraising efforts.

Family, Friends, or Individuals Involved in Your Care or Payment for Your Care. We may release health information about you to a friend or family member or others who are involved in your health care or the person who helps pay for your care. If you are unavailable and we determine that a limited disclosure is in your best interest, we may share limited health information with such individuals. For example, we may use our professional judgment to disclose your health information to your spouse concerning the processing of a claim. In the event of a disaster, we may disclose medical information about you to an entity assisting in a disaster relief effort (such as the Red Cross) so that your family can be notified about your

condition, status, and location. If you do not wish MHC to share your health information with your spouse, family, friends, or other individuals, you have the right to request a restriction on the disclosure of your health information.

Marketing. We may contact you to give you information about products or services related to your treatment, case management, or care coordination, or to direct or recommend other treatments, therapies, health care providers, or settings of care that may be of interest to you, provided we do not receive any payment for making these communications. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government-sponsored health programs. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communication without your prior written authorization.

Business Associates. Certain components of MHC services are performed through contracts with outside persons or organizations. For example, we may disclose your health information to a vendor who processes your claims and to a copy service to make copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. So that your health information is protected, however, we require the business associate to safeguard your information appropriately.

School Immunizations. We may disclose proof of immunization to a school where a state or other law requires it prior to admitting a student. Written authorization is no longer required, but an agreement must still be obtained, which can be oral.

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 a patient's need for privacy. Before we use or disclose health information for research, the project will have been approved through this special approval process, although 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.

Ryan White Grants/Other Special Population. We will disclose demographic information upon your authorization to assist you in receiving social services and/or housing.

Organ and Tissue Donation. If you are an organ donor, we may disclose health information about you to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

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.

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

Public Health Activities. We may disclose health information about you for public health activities. We may use and disclose medical information about you to agencies when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. 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.
- 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 about you 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. 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 that is not accompanied by a court or administrative order, 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 about you if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons, or similar process.
- to identify or locate a suspect, fugitive, material witness, or missing person.
- under certain limited circumstances, about the victim of a crime.
- about a death we believe may be the result of criminal conduct.
- about criminal conduct at MHC.
- 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 about our patients 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 to funeral directors as may be necessary for them 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 corrections 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.

Quality Assessment and Improvement Activities. We may disclose medical information about you, along with information concerning other patients, as part of our participation in other organized health care arrangements. For example, local hospitals and other types of health care providers may form an organized health care arrangement for the purpose of assessing and improving the quality of healthcare rendered in the community.

Other Uses and Disclosures of Your Protected Health Information:

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

Your Rights:

You have certain rights with respect to your personal health information. This section of our notice describes your rights and how to exercise them:

Right to Inspect and Copy: You have the right to inspect and copy the personal health information in your medical and billing records, or in any other group of records that we maintain and use to make health care decisions about you. This right does not include the right to inspect and copy psychotherapy notes, although we may, at your request and on payment of the applicable fee, provide you with a summary of these notes.

To inspect and copy your personal health information, you must submit your request in writing to our privacy contact person identified on the first page of this notice. If you request a copy of the information, we may charge a fee for the copying and mailing costs, and for any other costs associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If your request is denied, you may request that the denial be reviewed. We will designate a licensed health care professional to review our decision to deny your request. The person conducting the review will not be the same person who denied your request. We will comply with the outcome of this review. Certain denials, such as those relating to psychotherapy notes, however, will not be reviewed.

Right to an Electronic Copy of Electronic Health Records. If your Protected Health Information is maintained in an electronic format (known as an electronic health record or an electronic medical record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic health record.

Right to Get Notice of a Security Breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breach of your unsecured protected health information as soon as possible, but in any event, no later than sixty (60) days after we discover the breach. “Unsecured Protected Health Information” is protected health information that has not been made unusable, unreadable, and indecipherable to unauthorized users. The notice will give you the following information:

- a short description of what happened, the date of the breach and when it was discovered;
- the steps you should take to protect yourself from potential harm from the breach;
- the steps we are taking to investigate the breach, mitigate losses, and protect against further breaches; and
- contact information where you can ask questions and get additional information.

If the breach involves ten or more patients whose contact information is out of date, we will post a notice of the breach on our website or in a major print or broadcast media.

Right to Amend: If you feel that the health information, we maintain about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for any information that we maintain about you. To request an amendment, your request must be made in writing, submitted to the Health Information Management Department, and must be contained on one piece of paper legibly handwritten or typed. 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 organization that created the information is no longer available to make the amendment;
- is not part of the health information kept by or for MHC;
- 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 the health care professionals involved in your care and to others to carry out payment and health care operations, as previously described in this notice.

Right to Receive an Accounting of Disclosures. You have the right to receive an “accounting of disclosures.” This is a list of the disclosures we made of medical information about you to others except for purposes of treatment, payment, and healthcare operations.

To request an accounting of disclosures, you must submit your request in writing to our Health Information Management Department. Your request must state a time that may not be more 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.

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 may request that we do not disclose information about you to a certain doctor or other health care professional, or that we not disclose information to your spouse about certain care that you received.

We are not required to agree to your request for restrictions if it is not feasible for us to comply with your request or if we believe that it will negatively impact our ability to care for you. If we do agree, however, we will comply with your request unless the information is needed to provide emergency treatment. To request a restriction, you must make your request in writing to our privacy contact person identified on the first page of this notice. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.

Out of Pocket Payments. If you paid out-of-pocket in full for a specific item or service, you have the right to ask that your protected health information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will know that request.

Right to Receive Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way. For example, you can ask that we only contact you at work or by mail to a specified address.

To request that we communicate with you in a certain way, you must make your request in writing to our privacy contact person identified on the first page of this notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to a Paper Copy of this Notice. You have the right to receive a paper copy of this notice at any time. To receive a copy, please request it from our privacy contact person identified on the first page of this notice. You may also obtain a copy of this notice at our website, at www.memphishealthcenter.org.

Changes to this Notice:

We reserve the right to change this notice and to make the changed notice effective for all the health information that we maintain about you, whether it is information that we previously received about you or information we may receive about you in the future. We will post a copy of our current notice in our facility. Our notice will indicate the effective date on the first page, in the top right-hand corner. We will also give you a copy of our current notice upon request.

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. You may file a complaint by mailing, faxing, or emailing us a written description of your complaint or by telling us about your complaint in person or over the telephone:

**HIM Manager/Privacy Officer
Memphis Health Center, Inc.
360 E E.H. Crump Boulevard
(901) 261-2006 | Fax: (901)432-0512
jhoskins@mphshc.org**

Please describe what happened and give us the dates and names of anyone involved. Please also let us know how to contact you so that we can respond to your complaint. You will not be penalized for filing a complaint.

Other Uses and Disclosures of Your Protected Health Information:

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