UNIVERSITY CLINICAL HEALTH

PATIENT REGISTRATION FORM

FOR OFFICE USE ONLY:

CHART NO:

MRN: DATE OF APPT: CLINIC: DOCTOR :

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)	SEX	DATE OF BIRTH	MARITAL STATUS	RACE	SOCIAL SECURITY NUMBER

PATIENT ADDRESS	CITY,	STATE ZIP	PRIMARY PHONE NUMBER

EMPLOYER ADDRESS	CITY,	STATE ZIP	WORK PHONE NUMBER

PRIMARY CARE PHYSICIAN	ADDRESS	CITY	STATE ZIP	PHONE NUMBER

EMAIL ADDRESS	HOW DID YOU HEAR ABOUT US?

EMPLOYER NAME/SCHOOL NAME

EMERGENCY CONTACT INFORMATION

SPOUSE / GUARDIAN (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER

SPOUSE / GUARDIAN ADDRESS	CITY,	STATE	ZIP	SPOUSE / GUARDIAN PHONE NUMBER

RESPONSIBLE PARTY

GUARANTOR (LAST, FIRST, MIDDLE INITIAL)	RELATIONSHIP TO PATIENT *SELF* *DEP CHILD* *SPOUSE* *STUDENT* *OTHER*	GUARANTOR SS NUMBER

GUARANTOR ADDRESS	CITY,	STATE	ZIP	PRIMARY PHONE NUMBER

GUARANTOR EMPLOYER

GUARANTOR EMPLOYER ADDRESS	CITY	STATE	ZIP	WORK PHONE NUMBER

INSURANCE INFORMATION

SUBSCRIBER NAME	EXPIRATION DATE	RELATIONSHIP TO INSURED
		SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

PRIMARY INSURANCE COMPANY	ADDRESS	CITY	STATE	ZIP

GROUP NO. POLICY # ID # OR CERTIFICATE #	EFFECTIVE DATE	**FSC#** _____ **IC#** _____ **INS #** _____

SECONDARY INSURANCE COMPANY	ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO INSURED
					SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

GROUP NO. POLICY # ID # OR CERTIFICATE #	EFFECTIVE DATE	**INS #** _____

IS THIS VISIT RELATED TO AN ACCIDENT — DATE OF INJURY

AUTO ***JOB RELATED***

REFERRING PHYSICIAN NAME	ADDRESS	CITY	STATE ZIP	PHONE NUMBER

PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST FOR PHOTOCOPYING

PATIENT RESPONSIBILITIES: I understand that as the patient, parent, or guardian, I am legally responsible for payment of all charges relating to my care. Patient and/or guarantor(s) agree to pay reasonable attorney's fee and cost of collection if patient's account is placed in the hands of an attorney for handling.

PATIENT'S CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act, or under other insurance coverage, is correct. I authorize any holder of medical or other information about me to release to S.S.A. or its intermediaries or carriers and/or the State in which I reside or it's Fiscal Agents, or the Insurance Company, or its representatives, any information needed for this or a related Medicare/Medicaid Claim, or other insurance claim. In consideration of services rendered, I transfer and assign to University Clinical Health any payment which may become due to me for medical and/or surgical services under policies applicable to me or my dependent.

_____ Patient Signature (Signature must be marked by witnessed)

_____ Guarantor Signature

UNIVERSITY CLINICAL HEALTH

Review of Systems

Please Answer **ALL** Questions

MRN
CHART NO
NAME
DOB

Patient Stamp Above

Have you experienced any of the following in the last 6 months?

Date: _____

CONSTITUTIONAL	○ All No
No	Yes
		Good general health lately
		Recent weight change
		Fever
		Fatigue
		Headaches
		Night Sweats or Chills

ENT	○ All No
No	Yes
		Hearing Loss
		Ringing in the Ears
		Earaches or Drainage
		Sinus Problems/ Pain
		Nose Bleeds
		Mouth Bleeds
		Mouth Sores
		Bleeding Gums
		Bad Breath or Bad Taste
		Sore Throat or Voice Change
		Swollen Glands in Neck/ Lymph nodes

CARDIOVASCULAR	○ All No
No	Yes
		Heart Trouble
		Chest Pains
		Sudden Heart Beat Changes
		Swelling of Feet, Ankles, or Hands

RESPIRATORY	○ All No
No	Yes
		Frequent Coughing
		Spitting Up Blood
		Shortness of Breath
		Asthma or Wheezing

GASTROINTESTINAL	○ All No
No	Yes
		Loss of Appetite
		Change in Bowel Movements
		Nausea or Vomiting
		Frequent Vomiting
		Frequent Diarrhea
		Painful Bowel Movements or Constipation
		Blood in Stool
		Stomach Pain
		Constipation
		Heartburn

GENITOURINARY	○ All No
No	Yes
		Frequent Urination
		Burning or Painful Urination
		Blood in Urine /Dark Urine
		Change of Force of Strain when Urinating
		Incontinence or Dribbling
		Kidney Stones
		Male- Testicle Pain
		Female- Pain with Periods
		Female- Irregular Periods
		Female- Vaginal Discharge
		Female- # pregnancies
		Female- # miscarriages
		Is it possible that you are pregnant?
Female- Date of Last Pap Smear		
Female- Findings of last Pap Smear		
○ Normal ○ Abnormal		

MUSCULOSKELETAL	○ All No
No	Yes
		Joint Pain
		Joint Stiffness or Swelling
		Weakness of Muscles or Joints
		Muscle Pain or Cramps
		Back Pain
		Cold Extremities
		Difficulty in Walking
		Arthritis

SKIN	○ All No
No	Yes
		Rash or Itching
		Change in Skin Color
		Change in Hair or Nails
		Varicose Veins
		Breast Pain
		Breast Lump
		Breast Discharge
		Easy Bruising or Bleeding

NEUROLOGICAL	○ All No
No	Yes
		Frequent or Reoccurring Headaches
		Light headed or Dizzy
		Convulsions or Seizures
		Numbness or Tingling Sensations
		Tremors
		Paralysis
		Stroke

PSYCHIATRIC	○ All No
No	Yes
		Memory Loss or Confusion
		Nervousness/ Anxiety
		Depression
		Suicidal Thoughts
		Sleep Problems

METABOLIC/ENDOCRINE	○ All No
No	Yes
		Glandular or Hormone Problem
		Thyroid Disease
		Excessive Thirst or Urination
		Heat or Cold Intolerance
		Dry Skin
		Change in Hat or Glove size

OCULAR	○ All No
No	Yes
		Decreased Night Vision
		Dry Eyes
		Light Sensitivity
		Blurred Vision
		Burning Eyes

Please list your 3 chief complaints for today's visit:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Signature:

_____

Provider Signature:

_____

Past Medical History: (Check all that apply)

No	Yes		No	Yes		No	Yes	
		Anxiety			Coronary Artery Disease			Multiple Sclerosis
		Arthritis			Depression			Osteoporosis
		Asthma			Diabetes			Phlebitis
		Atrial Fibrillation			Eczema			Renal Disease
		Blood Clots			Elevated Lipids			Seizure Disorder
		Cancer:			Gastrointestinal Disease			Skin Cancer
		Cardiovascular disease			Glaucoma			Thyroid Disease
		Congestive Heart Failure			Hepatitis/Liver Disease			Tuberculosis
		COPD			Hypertension			HIV
					Mental Disorder			Other:

Past Surgical History: (Check all that apply)

No	Yes		No	Yes		No	Yes	
		Blood Transfusion			Hysterectomy			Electronic Implanted
		CABG			Knee Replacement			Bone/Brain Stimulators
		Cardiac Pacemaker			Liver Biopsy			Other:
		Hip Replacement			Organ Transplant			

Family History: (Check all that apply)

No	Yes		No	Yes		No	Yes	
		Abnormal Moles			Depression			Psoriasis
		Acne			Diabetes			Renal Disease
		Allergies			Eczema			Rosacea
		Arthritis			Elevated Lipids			Seizure Disorder
		Asthma			Genetic Disease			Stroke
		Basal Cell Carcinoma			Hypertension			Thyroid Disorder
		Blood Disorder			Inflammatory Bowel Disease			Melanoma
		Cancer:			Keloids			Other:
		COPD			Liver Disease			
		Coronary Artery Disease						

Alcohol Use:
Never
Current
Former
Amount used _____
Date Started _____
Date Stopped _____

Tobacco Use:
Never
Current
Former
Amount used _____
Date Started _____
Date Stopped _____

Drug/Other Allergies

Pediatric Patients Only:

With whom does patient live? _____

Who has guardianship of patient? _____

Does anyone smoke in the household? Yes No

FOR OFFICE USE ONLY

Ht:_____in. Wt:_____lbs. Temp:_____F BP:_____/_____ HR:_____bpm R:_____bpm

New Patient: ☐ **Yes** ☐ **No** ☐ **M** ☐ **F** ☐ **Full Exam** ☐ **Focused Exam** ☐ **Gown**

>18yo ☐ **Yes** ☐ **No** Parent or Guardian Present or consent ☐ **Yes** ☐ **No**

Resident Physician Consent ☐ **Yes** ☐ **No**

UNIVERSITY CLINICAL HEALTH

Medicine List

Patient Name: _____

Date of Birth: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Specialty Pharmacy Name: _____

Specialty Pharmacy Address: _____

Specialty Pharmacy Phone Number: _____

Name of Medicine	Strength	Frequency (How often do you take this?)	Why do you take this medicine?	Start Date (When did you start taking this medicine?)	Do you have any problems with this medicine? (Yes/No)	Prescribing Doctor

MRN

Name

DOB

Patient stamp or label above

UNIVERSITY CLINICAL HEALTH

Consent and Agreement

Part I. Medical Treatment Consent:

I (the undersigned, and/or the parent or legal guardian) consent to the administration of reasonable and necessary services in connection with treatment of the above-mentioned patient at University Clinical Health (UCH). This consent includes, but is not limited to, laboratory procedures, medication administration, infusions, procedures, and/or services rendered to a patient by members of the medical staff, their representatives, and/or associates and employees under the instruction of the physician. I acknowledge that no guarantees have been made to me regarding to the results of treatments or examination in the clinic.

Part II. Release of Information, Assignment of Insurance Benefits, and Financial Agreement:

Release of Information: I hereby authorize UCH and any physician who has rendered services to release any and all information pertaining to my (or the patient's) treatment to enable the collection of benefits for the services rendered. The authorization includes release of information to insurance companies or healthcare providers, in whole or in part, for payment in exchange for services rendered, whether such payment is in exchange for services rendered by UCH or by the physicians. Release of Information is also authorized to any providers for follow-up medical care. A copy of UCH's *Request for Restrictions Form* must be submitted in writing to terminate this agreement.

Assignment of Benefits: I hereby authorize and assign payment directly to UCH for benefits, including secondary benefits, due to me for medical services. I understand that I am financially responsible for charges not covered by any insurance or medical benefit payor. I further acknowledge that any benefits, when received by and paid to UCH will be credited to my account in accordance with this assignment.

Financial Agreement: I understand and agree that I am financially responsible to UCH, and/or physician for any charges not covered by the authorization below or charges not covered by insurance.

I agree that in order to collect any amounts I may owe for services provided by UCH, UCH or its designee may contact me via telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in cellular charges. We may also contact you by sending text messages or e-mails, using any e-mail address you provided to us. Methods to contact may include using pre-recorded/artificial voice messages and or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree that UCH and/or its designee for collecting any amounts I may owe UCH may contact me as described above.

In addition, with respect to future treatments at UCH, this document is ongoing in nature and will remain in effect until revoked by me in writing.

I hereby give permission to receive services and treatment by my physician (and/or associates) at UCH. I authorize the release of information including protected health information as needed to file for payment for services incurred. I fully understand my Financial Responsibility for services rendered at UCH.

Signature of Patient or Personal Representative*

Printed Name of Patient or Personal Representative*

Date

*Relationship to Patient (if Personal Representative)

*If Personal Representative, the patient is unable to sign because (check one): ❑ Minor ❑ Incompetent

❑ Other (explain): _____

For Office Use Only: **Date received** _____ **Received by:** _____

Check if applicable: ❑ Patient refused to sign Consent and Agreement (explain): _____

20. **Correctional Institutions/Law Enforcement Custodians.** Should you be an inmate of a correctional institution or be in the lawful custody of a law enforcement official, we may disclose your Health Information to the institution or the official if necessary for your health, the health and safety of other inmates or law enforcement, and the safety of the institution at which you reside.

21. **Required by Law.** We may use or disclose your Health Information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. If required by law, you will be notified of any such uses or disclosures.

22. **Child Abuse and Neglect.** We may disclose your Health Information for public health activities and purposes to a public health authority or other governmental authority that is authorized by law to receive reports of child abuse or neglect.

23. **Other Abuse and Neglect.** We may disclose your Health Information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, if you do not agree to the disclosure, the disclosure will be made consistent with the requirements of applicable federal and state laws, and only if required or authorized by law.

24. **Communicable diseases.** We may disclose your Health Information for public health activities and purposes to a person who may be at risk of contracting or spreading a disease, if such disclosure is authorized by law.

25. Workplace Health Surveillance. We may disclose your Health Information for public health activities and purposes to your employer, for the purposes of conducting an evaluation of medical surveillance of the workplace or for the purposes of evaluating whether your have a work-related illness or injury.

26. Health Oversight Activities. We may disclose your Health Information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and entities subject to the civil rights laws.

27. Judicial and Administrative Proceedings. We may use or disclose your Health Information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, or in certain conditions in response to a subpoena, discovery request or other lawful process not accompanied by an order of a court or administrative tribunal, subject to any applicable privileges.

28. Law Enforcement. We may disclose your Health Information for a law enforcement purpose to a law enforcement official if certain conditions are met.

29. Averting a Threat. We may, consistent with applicable law and standards of ethical conduct, use or disclose your Health Information if we believe that the use or disclosure is necessary to prevent or lessen a serious threat to the health or safety of a person or the public; provided that, if a disclosure is made, it must be to a person(s) reasonably able to prevent or lessen the threat. We may also use or disclose your Health Information if we believe that the use or disclosure is necessary for law enforcement authorities to identify or apprehend an individual who: (i) admits to participation in a violent crime that we reasonably believe caused serious physical harm to the victim, or (ii) appears to have escaped from a correctional institution or lawful custody.

30. Certain Uses and Disclosures for which an Authorization is Required. Certain uses and disclosures by us of your medical information require that we obtain your prior written authorization. These include:

a. Psychotherapy Notes. If Psychotherapy Notes are created for your treatment, we must obtain your prior written authorization before using or disclosing them, except (1) if the creator of those notes needs to use or disclose them for treatment, (2) for use or disclosure in our own supervised training programs in mental health, or (3) for use or disclosure in connection with our defense of a proceeding brought by you. "Psychotherapy Notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. "Psychotherapy Notes" excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

b. Marketing. If we use or disclose your Health Information for marketing purposes, we must first obtain your written authorization to do so, except if the communication is face-to-face by us to you, or is a promotional gift of nominal value.

c. Sale of your medical information. If a disclosure of your Health Information would constitute a sale of it, we must first obtain your written authorization to do so.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions or would like additional information, you may contact our Privacy Officer at (901) 866-8517. Communications may also be sent by mail addressed to: UCH Privacy Officer, 1407 Union Avenue, Suite 700, Memphis, TN 38104-3673. You may also call our confidential compliance hotline at (844) 840-0005. If you believe your privacy rights have been violated, please file a complaint with the Privacy Officer, as listed above, or with the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

THE POLICIES IN THIS NOTICE BECAME EFFECTIVE ON: September 23, 2013
Earlier versions: April 14, 2003

UNIVERSITY CLINICAL HEALTH

Health Information Management - Medical Records 1407
Union Avenue, Suite 700
Memphis, Tennessee 38104-3600
901-866-8400 • Fax: 901-302-2400

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 READ IT CAREFULLY.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit University Clincal Health (UCH) a record of your visit is made. It usually includes information about your symptoms, examination, test results, diagnoses, treatment, and a plan for future care and treatment. This information is often called your "medical record." This information and other information relating to your care are referred to in this Notice as "Health Information."

The Health Information contained in your medical record is useful for many reasons. For example, this information:

- Serves as a basis for planning your care and treatment
- Provides a means of communication among the many health care professionals who are part of your care
- Describes the care you receive
- Allows you, your insurance company or other third-party payer to make sure that the services billed were provided to you
- Allows health care professionals and organizations involved in your care to conduct treatment, payment, and health care operations
- Contains information we will need to contact you about appointment reminders, treatment alternatives, or other health-related benefits

Understanding what is in your record and how your Health Information is used helps you to understand who, what, when, where, and why others may access your Health Information and to make sure that it is correct. This, in turn, allows you to make better decisions about its use and disclosure.

YOUR HEALTH INFORMATION

Even though your Health Information at our offices belongs to UCH, you have certain rights relating to this information. As a patient, you generally have the right to:

- Request a copy or summary of your Health Information or to inspect it
- Request an amendment to your Health Information if you feel there is an error
- Request a restriction on uses and disclosures of your Health Information 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 involved in your care or the payment for your care, like a family member or a friend. We will inform you of our decision on your request. Requests should be submitted in writing to our Privacy Officer whose address is listed at the end of this notice. Unless otherwise required by law, we must comply with a request from you not to disclose your Health Information to a health plan, if the purpose for the disclosure is not related to treatment, and the health care items or services to which the information applies (such as a genetic test) have been paid for out-of-pocket and in full; otherwise, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. Except for restrictions that we must comply with relating to health plans, we may terminate our agreement to a restriction at any time by notifying you in writing, but our termination will only apply to information created or received after we sent you the notice of termination, unless you agree to make the termination retroactive.
- Obtain an accounting of when and with whom we have shared or disclosed your Health Information for some types of disclosures (a fee will be charged to fulfill repeated requests for such accountings)
- Request that we communicate with you about your Health Information in a particular way or at a certain location
- Obtain a paper copy of our Notice of Privacy Practices
- Revoke a previous authorization to certain uses and disclosures of your Health Information by us, except where actions have already been taken by us relating to that authorization or where the authorization was obtained as a condition of obtaining insurance coverage, and other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- File a complaint if you believe that your privacy rights have been violated

Any requests or questions about the rights listed above should be directed to: Privacy Officer, University Clinical Health, at 1407 Union Avenue, Suite 700, Memphis, TN 38104-3673, (901) 866-8517, Fax: (901) 302-2400. You may also call our confidential compliance hotline at (844) 840-0005.

OUR RESPONSIBILITIES

UCH is required to:

- Protect the privacy of your Health Information
- Provide you with a copy of this Notice describing our privacy policies and legal duties
- Abide by the terms of our current Notice
- Notify you if we are unable to agree to, or to comply with, your request for: access or changes to your Health Information, an accounting of disclosures of your Health Information, restrictions on disclosures of your Health Information, confidential communications with you about your Health Information, or your revocation of your authorization
- Accommodate reasonable requests to communicate with you about your Health Information in a particular way or at a certain location
- Notify you following a breach of your unsecured Health Information
- Obtain written authorization from you for any types of uses and disclosures not mentioned in this Notice. You may revoke any authorization you have given us at any time by sending a letter to: UCH Privacy Officer at 1407 Union Avenue, Suite 700, Memphis, TN 38104-3673. Revocations will not be effective to the extent we used and disclosed your Health Information in reliance on the authorization prior to receiving your revocation or where the authorization was obtained as a condition of obtaining insurance coverage, and other law provides the insurer with the right to contest a claim under the policy or the policy itself.

We reserve the right to change our Notice and our privacy practices and to make the new provisions effective for all Health Information we keep. Should our privacy practices change, we will post our revised Notice at all of our clinics and on our website at **www.univerityclinicalhealth.com**. An updated version may also be provided at your request during a return visit to UCH or from our Privacy Officer.

We will not use or disclose your Health Information without obtaining your authorization, except as described in this Notice or as otherwise required or permitted by law (for example, in emergency treatment situations).

Although other health care providers may provide treatment to you (for example, hospitals or other physician groups), we are not jointly managed with or owned by such providers. They will have their own policies and procedures for handling your Health Information.

WAYS WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

Under Tennessee law, we may not divulge your name, address, or other identifying information except for (a) statutorily required reporting to health or government authorities, (b) responding to a subpoena or court order, (c) responding to a request for information authorized by state or federal law; and (d) allowing access by insurance companies or other payers for utilization review, case management, peer review or other administrative functions. Within these parameters, the following categories describe some of the ways in which we may use and disclose your Health Information:

1. **Treatment.** We will use your Health Information to treat you. For example, information obtained by a nurse, physician, or other member of your UCH health care team will be recorded in your record and used to determine your course of treatment.

Some of our clinics may keep your Health Information in an electronic medical record (EMR), and this Health Information may be shared across our clinics for treatment. EMRs may be equipped with patient portals, which allow some patients or those persons they authorize to access certain portions of their record, pay statements online, and view open accounts. Patient portals will be governed by separate documents and may be deactivated by UCH in its discretion.

Except where restricted by applicable law or where UCH has approved your written request to the contrary, UCH may also provide copies of your Health Information to other health care providers who care for you.

We may share your Health Information with the MidSouth eHealth Alliance in a community-wide health information system in which some health care providers may access your Health Information when treating you. As a patient, you have the right to not share your Health Information in the Alliance. This is called "Opting Out." However, if you choose to opt out, health care providers may not have access to Health Information that may be important and useful in making choices about your medical care.

Any questions about EMRs, the patient portals, or the Alliance should be directed to our Privacy Officer at (901) 866-8105.

2. **Payment.** We will use and disclose your Health Information to bill and collect payment for the services you receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits, including the range of benefits. We may also provide your insurer with details regarding your treatment or to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your Health Information to bill you directly.

3. **Health Care Operations.** We will use your Health Information in our business operations. For example, we may use your Health Information to evaluate the quality of care you receive from us, to train residents, students or other health care professionals, and to make business plans for our practice. However, we will limit the use and disclosure of your medical records, images, videos or pictures intended to be used for appropriate medical educational purposes, even if your information has been de-identified.

4. **Vendors.** Some of our services are provided by outside vendors. For example, we might use a copy service to make copies of patient records for us. We may disclose Health Information to our vendors so that they can perform the job we have asked them to do. To protect your Health Information, we require these vendors to agree in writing to keep your Health Information safe using many of the same standards that we are required to observe.

5. **Organized Health Care Arrangements.** We may participate in arrangements with other health care entities to conduct joint health care-related activities (for example, quality assurance, utilization review). In these arrangements, your Health Information may be shared between the participants for treatment, payment, and certain operations purposes. Participants in these arrangements remain separate entities from each other and will have their own policies and procedures for handling your Health Information.

6. **Appointment Reminders & Treatment Alternatives.** We will use your Health Information to remind you of an appointment or to tell you about treatment alternatives and other health-related benefits or services.

7. **Communication with Family and Others/Notification.** We may disclose to a family member or other relative, close personal friend, or other person you identify, Health Information that is relevant to that person's involvement in your care or payment for your care. We may also disclose your Health Information to disaster relief authorities so that your family can be notified of your location and condition. If you would like to request a restriction on such disclosures, please contact our Privacy Officer at (901) 866-8517.

8. **Persons under the Age of 18.** Good medical practice, payment requirements, or state law may make it necessary to tell your parents or guardian about your visit or provide them with all or part of your Health Information. This does not apply if you are or have been married or have by court order or otherwise been freed from the care, custody and control of your parents.

9. **Limited Data Sets and De-identified Information.** In some instances where we use or disclose information for purposes of research, public health, health care operations, or other activities, certain information (names, social security numbers, etc.) will be removed to help protect your identity.

10. **Research.** We may use or disclose your Health Information for research purposes in certain circumstances. For example, when you have provided a written authorization, for activities preparatory to research, and/or when a research protocol has been designed and approved by an Institutional Review Board (IRB) or privacy committee (for example, the IRB for The University of Tennessee Health Science Center or an IRB at Methodist Healthcare Foundation).

11. **Deceased Patients.** We may release Health Information to coroners, medical examiners or funeral directors to permit them to carry out their duties, or otherwise with the approval of an authorized representative for the deceased patient.

12. **Organ or Tissue Donation.** We may disclose your Health Information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ, eye or tissue donation and transplantation.

13. **News Gathering Activities.** A member of your health care team may contact you or one of your family members to discuss whether or not you want to participate in a media or news story. For example, a reporter working on a story about a new therapy may ask whether any of our patients undergoing that therapy would be willing to be interviewed. In such a case, we might contact you to ask whether you would be willing to be interviewed and ask for your authorization in writing before giving the reporter your name.

14. **Fundraising.** Someone from The University of Tennessee Health Science Center or another business associate of UCH may wish to contact you as part of a fund-raising effort on our behalf. We may use, or disclose to a business associate or The University of Tennessee Health Science Center, the following information to contact you for our fundraising activities: your name, address, other contact information, age, gender and date of birth, the department(s) where you received services, your treating physician, your outcome information, your health insurance status, and the dates you received services. You have the right to opt out of receiving our fundraising communications. If you opt out of receiving fundraising communications, you can always choose to opt back in with respect to specific campaigns or ask to be contacted for our fundraising efforts by calling us at (901) 866-8400. We do not condition treating you on your choice of whether to receive fundraising communications.

15. **Food and Drug Administration (FDA).** We may disclose your Health Information to a person subject to the jurisdiction of the FDA, for public health purposes related to the quality, safety, and effectiveness of FDA-regulated products and activities (for example, relating to adverse events with respect to food or supplements, products and product defects or post-marketing surveillance information to enable product recall, repair or replacement of regulated items).

16. **Workers Compensation.** We may disclose your Health Information to comply with laws relating to workers compensation or other similar programs established by law.

17. **Public Health.** We may disclose your Health Information, as provided by law, to public health officials or legal authorities charged with improving health or preventing or controlling disease, injury, or disability.

18. **Military Service.** We may use or disclose your Health Information if you are in the Armed Forces for activities deemed necessary to assure proper execution of military missions, provided certain conditions are met. If you are a member of a foreign military force, we may use your Health Information or disclose it to your appropriate foreign military authority for activities deemed necessary to assure proper execution of military missions, provided certain conditions are met.

19. **National Security and Intelligence Activities.** We may disclose your Health Information to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act and implementing authority. We may also disclose your Health Information to authorized federal officials for the protection of the President or other persons, or for certain federal investigations.

UNIVERSITY CLINICAL HEALTH

Office Use Only

Name: _____

DOB: _____ Age: _____

MRN: _____

AGREEMENT AND CONSENT FORM

Please initial your acknowledgement and consent by each statement below:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I have received a copy of the Notice of Privacy Practices as required by HIPAA Privacy Regulations, developed in 2013. **You may read it now or later.** In either case, let us know if you have any questions after reviewing it.

_____ _____

Print Patient Name Patient Signature

AUTHORIZATION TO SEND APPOINTMENT REMINDERS OR OTHER ALERTS VIA TEXT MESSAGE, EMAILS or AUTOMATED VOICE MESSSAGE

I hereby authorize UCH to send appointments to me via text message, email or automated voice message system. It is my responsibility to provide the clinic with the most up to date contact information. If you have signed up for the patient portal, you will also receive appointment reminders via the portal. ☐YES ☐ NO

_____ _____

Phone Number, if YES Email, if YES

FAMILY AND FRIENDS RELEASE AGREEMENT

Please provide a list of anyone besides yourself who has permission to receive information regarding any of the contents of your medical record. This can include any family member, spouse, or friend.

Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number

MEDICAL PHOTOGRAPHY

_____ I hereby authorize UCH to take and use photography of me for medical and/or educational purposes.

_____ I decline UCH to take and use photography of me for medical and/or educational purposes.

I understand that I may revoke this authorization at any time by sending my written request to: UCH Privacy Officer at 1407 Union Ave, Ste. 700 Memphis, TN 38104-3673; 901-866-8517. This revocation will be effective from the date it is received in this office and will not apply retroactively.

Signature Patient, Parent, or Guardian **Relationship to Patient** **Date**