MODOC MEDICAL CENTER
A Public Entity
Healing Hands Close To Home
Last Frontier Healthcare District

FAMILY PRACTICE CLINIC

P: 530-708-8820
F: 530-233-4302

Please bring the following to your first appointment:

1.) Insurance Cards and Valid ID
2.) All Attached Documents-Completed
3.) Recent Medical Records
4.) Prescription Bottles
5.) Co-Payment

Please arrive 15 minutes before your appointment time.

Modoc Medical Center Clinic
1111 N Nagle Street, Alturas CA 96101
P: (530) 708-8820 F: (530) 233-4302

PATIENT REGISTRATION

Patient Information: (Please print clearly) Name must match what is on your insurance card or ID.

Last Name:_____ **First:**_____ **M:**_____

Sex/Gender Identity: ❑F ❑M **Transgender:** ❑Male/Female to Male ❑Female/Male to Female ❑Choose not to disclose ❑Other_____

Birthdate:_____ **SSN#**_____ **Marital Status:** ❑S ❑M ❑D ❑W ❑SEP

Mailing Address:_____ **City:**_____ **ST:**_____ **Zip:**_____

Physical Address (if different)**:**_____ **City:**_____ **ST:**_____ **Zip:**_____

Primary Phone: _____ **Work:** _____ **Cell:** _____

Message #:_____ **Email Address:** _____

Occupation:_____ **Retired?** ❑Yes ❑No **Date:** _____

Preferred Method of Contact: ❑Home Phone ❑Work ❑Cell ❑Message Phone ❑Text ❑Email **Okay to Text:** ❑Yes ❑No

Emergency Contact:_____ **Phone:** _____

Relationship:_____ **Does this person know that you are a patient at MMC Clinic?** ❑Yes ❑No

Parent or Guardian (if patient is minor) or Spouse Information:

Parent or Spouse Name:_____ **SSN#**_____

Address (if different than patient)**:**_____ **City:**_____ **ST:**_____ **Zip:**_____

Phone (if different than patient)**: Home:**_____ **Work:** _____

Cell: _____ **Birthdate:** _____ **Sex:** ❑F ❑M **Marital Status:** ❑S ❑M ❑D ❑W ❑SEP

Insurance Information:

Primary Insurance: _____

Subscriber Name:_____ **DOB:**_____ **Sex:**_____

Relationship to Patient:_____ **Subscriber ID:**_____ **Group:** _____

Secondary Insurance: _____

Subscriber Name:_____ **DOB:**_____ **Sex:**_____

Relationship to Patient:_____ **Subscriber ID:**_____ **Group:** _____

Financially Responsible Party: ❑Patent info above ❑Parent/Guardian/Spouse info above

Last Name:_____ **First Name**_____

Address:_____ **City:**_____ **ST:**_____ **Zip:**_____

Relationship to Patient:_____ **Phone:** _____

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Patient Last Name:_____ **First Name:** _____

Patient Demographics: To enable us to qualify for our grants and meet our Federal and State reporting requirements, along with possibly allowing us to offer more services, we ask for the following information. Your answers are strictly confidential. Your name will not be used. Please Circle or Check the appropriate box.

Language Spoken in your Home: ❑English ❑Spanish ❑Other: _____

Race (Check all that apply): ❑White ❑Black/African American ❑Native Hawaiian/Pacific Islander ❑Asian ❑Chinese ❑American Indian/Alaskan Native ❑Filipino ❑Japanese ❑Korean ❑Other ❑Declined

Ethnicity: ❑Hispanic/Latino ❑Non-Hispanic/Latino ❑Declined

Are you a Veteran?: ❑Yes ❑No **Agricultural (Farm) Worker?:** ❑Yes ❑No **If yes, are you:** ❑Seasonal ❑Migrant

Homeless?: ❑Yes ❑No **If yes, currently living in:** ❑Shelter ❑Transitional Housing ❑Doubled Up ❑Street ❑Other

Sexual Orientation (over 18 years old): ❑Heterosexual (Straight) ❑Gay or Lesbian ❑Bisexual ❑Choose not to disclose

Does the patient require a caregiver? ❑Yes ❑No If yes, Name of Caregiver: _____

Would you like information from your provider on Advanced Healthcare Directives? ❑Yes ❑No

Other health specialists Involved in patient's care:

Name	*City*	*Phone*
Name	*City*	*Phone*

Pharmacy Information:

What pharmacy do you use?_____ **Location:**_____

Sign and Authorize: The information I gave on this form is true and correct to the best of my knowledge.

_____ _____
Patient or Responsible Party Signature *Date*

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PATIENT MEDICAL HISTORY HANDOUT

Patient Name: _____

Date: _____

Medications (*including vitamins and supplements*)

Name of Medication	Dose	Frequency

Medical Problems

Name of Medical Condition: _____

Surgical History

Name of Surgery	Date	Facility Performed

Family History

Mother's Medical Conditions: _____

Father's Medical Conditions: _____

Number of Brothers: _____ Medical Conditions: _____

Number of Sisters: _____ Medical Conditions: _____

Other Family Members with Pertinent Medical History: _____

_____

Social History

Hometown: _____

Married/Single/Widowed/Divorced/Partnered: _____

Number of Children: _____ Number of Grandchildren and Great-Grandchildren: _____

Occupation (current or prior): _____

Current Living Situation (*alone, with spouse, partner, children, etc*): _____

_____

Alcohol, Tobacco, and Recreational Substances

Do you, or have you ever, regularly used tobacco (*cigarettes, snuff, cigars, etc*)? Yes/No

If yes, how much? _____ For how many years? _____

Do you, or have you ever, regularly drunk alcohol? Yes/No

If yes, how much and how often? _____ For how many years? _____

Do you, or have you ever, regularly used recreational substances? Yes/No

If yes, what, and how much? _____ For how many years? _____

_____ _____

_____ _____

Hospitalizations

Reason for Hospitalization	Date	Facility
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pregnancy History

Pregnancies: _____ # Term Deliveries: _____ # Pre-Term Deliveries: _____

Terminated Pregnancies (*spontaneous or induced*): _____ # Living Children: _____

Pregnancy Complications: _____

Age of Menopause: _____ Hormone Replacement (*type and duration*)? _____

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M/R#_____

AUTHORIZATION FOR TREATMENT

AUTHORIZATION FOR TREATMENT: The patient is under the care of their attending physician or the emergency room physician on duty and Modoc Medical Center (MMC) is not liable for any acts of omission in following the instructions of said physicians. The patient consents to an X-Ray examination, laboratory procedures, anesthesia, medical or surgical treatment or hospital services rendered to the patient under the general and special instructions of the physicians. The patient recognizes that all medical doctors furnishing services, including emergency room doctors, radiologist, pathologists, and the like are independent contractors and are not employees or agents of MMC.

RELEASE OF INFORMATION: MMC may disclose all or any part of the patient's record to any person or corporation that is, is or may be liable under a contract or otherwise responsible to MMC, to the patient, or to a family member or employer of the patient, for all or part of MMC's charges. This includes, but is not limited to, MMC or medical services companies, insurance companies, worker compensation carriers, welfare funds or the patient's employer.

MEDICARE ASSIGNMENT OF BENEFITS: If applicable, the patient certifies that the information given by me in applying for payment under Title XVII (Medicare) of the Social Security Act is correct. The patient authorizes any holder of medical or other information to release to the Social Security Administration, its intermediaries, or carriers any information needed for this or a related Medicare claim. The patient requests that payment of authorized benefits be made on my behalf to MMC.

FINANCIAL AGREEMENT: The patient agrees, whether they sign as an agent or a patient, that in consideration of the services rendered to the patient, they hereby individually obligate themselves to pay the account at MMC. The patient understands that if the charges are covered by insurance of any type, it is nevertheless my personal obligation to pay for all charges billed that are not covered by their insurance.

HOSPITAL-WIDE CONSENT FOR HIV BLOOD TESTING: If health care personnel involved in the patient's care and treatment become exposed to certain bodily fluids, resulting in the possibility of transmission of blood borne disease, the patient's blood will be tested in order to detect whether or not the patient has antibodies to the Human Immunodeficiency Virus (HIV). This is the probable causative agent of Acquired Immune Deficiency (AIDS). The patient understands that this test is performed by with drawing blood and using a substance to test the blood. The patient also understands that there will be no charge for the performance of this test if occupational exposure occurs. If, during the course of treatment, the physician orders this test for diagnostic purposes, the patient will be charged accordingly.

The test and its accuracy and reliability are still uncertain, and the test results may, in some cases, indicate that a patient has antibodies to the virus when the patient does not (false Positive) or fail to detect that a patient has antibodies to the virus when the patient has antibodies (false Negative). A positive blood test result does not mean that the patient has AIDS and that in order to diagnose AIDS other means must be used in conjunction with the blood test. The patient may ask the responsible physician any questions regarding the nature of the blood test, its risks, and alternative testing before the test takes place.

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The patient understands that the result of this blood test will only be made available to the Medical Records director and Infection Control Officer for employee follow up and to the patient's treating physician and will be kept strictly confidential.

By signing, I acknowledge that I have read the above "Authorization for Treatment." I also give consent for the performance of a blood test to detect antibodies to the HIV, without a physician's order as discussed above. I further understand that during my treatment, my physician may order an HIV test for diagnostic purposes, regardless of this consent.

PATIENT SIGNATURE _____

AUTHORIZED AGENT_____RELATIONSHIP_____

WITNESS_____DATE_____

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M/R#_____

Chief of Staff: Edward P. Richert, MD

OFFICE PROCEDURES

1. Name: It is procedure to address you by first or last name. How would you like to be addressed?
   _____

2. Phone Confirmations: It is procedure to have you call 24-hours before your appointment to cancel.
   a. We may also call you regarding medical issues. List two phone numbers where you can be reached:
      Phone 1:_____
      Phone 2:_____
   b. If we cannot reach you at either number, may we call you at home? Yes / No
   c. If no one is home, may we leave a message on your answering machine? Yes / No

3. Verbal Authorization: It is procedure to get verbal authorization from all new patients to confirm appointments and leave messages if the patient is not available.

4. List those who we may share your medical information with: (Patient to initial all that apply)

Initial	Name	Phone Number
Initial	Name	Phone Number
Initial	Name	Phone Number

5. Our office is HIPAA-compliant, and the staff has been trained in the HIPAA Privacy Act. We will do everything we can to protect your Patient Health Information and appreciate your help with this.

   PATIENT NAME_____

   SIGNATURE_____DATE_____

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AUGMEDIX TECHNOLOGY

The providers at **Modoc Medical Center Family Practice Clinic (MMC Clinic)** are using a new technology called AUGMEDIX. AUGMEDIX is a technology that uses a remote assistant/scribe to assist the provider with documenting your visit. This assistant/scribe will assist to create your electronic medical record in real time.

I have read the Frequently Asked Questions sheet given to me by the MMC Clinic staff and have had all my questions answered by the health center staff.

I have also been informed that it is my choice whether I want AUGMEDIX utilized during my visit with the provider.

By signing below, I am consenting to the use of AUGMEDIX technology. This consent is valid from the date I sign and for all future visits. At any point in time, it is my right to decline the use of AUGMEDIX.

Patient Name_____Date of Birth_____

Patient Signature_____

Date _____

Front Office Staff _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

M/R#_____

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information. You have a legal right to review our "Notice of Privacy Practices." Before you sign this consent, we encourage you to read it in full. If you have any questions regarding the "Notice of Privacy Practices," you are encouraged to contact the Privacy Officer and they will assist you.

Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice from our Admissions Clerk.

_____

Patient Signature (Name if Unable to Sign) **Date**

_____

Parent/Conservator/Guardian (Relationship to the patient if signed by someone other than patient) **Date**

If the Patient (Parent/Conservator/Guardian) is unable to sign, explain the reason, and two staff members must sign and date.

Explanation: _____

_____

_____

Staff Member **Date**

_____

Staff Member **Date**

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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 carefully.

WHO WILL FOLLOW THIS NOTICE?

This notice describes our practices and that of:

- Any health care professional authorized to enter information into your medical record.
- All departments of the facility.
- Any volunteer we allow to help you while you are in the facility.
- All employees, staff, and other personnel.

All entities that are located on the facility campus will follow the terms of this notice. In addition, the entities on the facility campus may share medical information with each other for treatment, payment, or health care operation purposes described in this notice.

We Have a Legal Duty to Safeguard Your Protected Health Information (PHI)

We are legally required to protect the privacy of your health information. We call this information "Protected Health Information" or "PHI" for short. PHI includes information that can be used to identify you that we have created or received about your past, present, or future health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose you PHI. With some exceptions, we may not disclose any more of you PHI than necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policy, we will promptly change this notice and post a new notice in the facility lobby. You can request a copy of this notice from the admissions clerk.

How We May Use and Disclose Your Protected Health Information

We use and disclosed health information for many different reasons. Below, we describe the different categories of our uses and disclosures and give you some examples of each category.

1. For Treatment. We may disclose your PHI to physicians, nurses, medical students, and other health care personnel who provide you with health care services or are involved in your care. For example -if you are being treated for a knee surgery, we m ay disclosed your PHI to the physical therapy department in order to coordinate your care.

2. To Obtain Payment for Treatment. We may use and disclosed your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies, and others that process our health care claims.

3. For Health Care Operations. We may disclose your PHI in order to operate this hospital. For example, we may use your PHI in order to evaluate the quality of health care services that you received. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we are complying with the laws that affect us.

4. When a disclosure is required by federal, state, or local law, judicial or administrative proceedings, or law enforcement -For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot and other wounds; or when ordered in a judicial or administrative proceeding.

5. Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful order from the court.

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

7. For Public Health Activities. For example, we report information about births, deaths, and various diseases to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.

8. For Health Oversight Activities. For example, we will provide PHI to assist the government when it conducts and investigation or inspection of a health care provider or organization.

9. Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official. This release would be necessary:
    - For the institution to provide you with health care.
    - To protect your health and safety or the health and safety of others.
    - For the safety and security of the correctional institution.

10. For Purpose of Organ Donation We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

11. For Research Purposes In certain circumstances, we may provide PHI in order to conduct medical research. Before we use or disclose medical information for research the project will have been approved through a research approval process. We will ask for your permission if the research will have access to your name, address or other information that reveals who you are.

12. To Avoid Harm In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

13. For specific Government Functions We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PH for national security purposes, such as protecting the president of the United States or conducting intelligence operations.

14. For Workers' Compensation Purposes We may provide PHI or order to comply with workers' compensation laws.

15. Appointment Reminders and Health-Related Benefits or Services. We may use PHUI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.

16. Two Uses and Disclosures Require You to Have the Opportunity to Object

- Patient Directories -We may include your name, location in this facility, and religious affiliation, in our patient director for use by visitors who ask for you by name, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

- Disclosures to Family, Friends, or Others - We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your healthcare, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

- Inquiries from Clergy -We may provide you name, locations in the facility, and religion to clergy members, unless you object in whole or part.

What Rights You Have Regarding Your PHI

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI -You have the right to ask that we limit how we use and disclose your PHI. We will consider your written request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may limit the uses and disclosures that we are legally required or allowed to make.

B. The Right to Choose How We Send PHI to You -You have the right to ask that we send information to you to an alternate address (for example, sending information to your work address rather than your home address) or be alternate means. We must agree to your written request as long as we can easily provide it in hie format you requested.

C. The Right to See and Get Copies of Your PHI -In most cases you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we do not have your PHI but we know who does, we will tell you how to get it. We will respond to you within 5 working days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

D. The Right to Get a List of the Disclosures We Have Made -You have a right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures used for treatment, payment, health care operations, or authorization releases made by you. The list will also not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or before April 14, 2003.

   We will respond within 60 days of receiving your request. The list we will give you will include disclosures made after April 14, 2003, or for a period no longer than six years unless you request a shorter time. The list will include the date of disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year a reasonable fee may be requested once each calendar year.

E. The Right to Correct or Update Your PHI - If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reasons for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is:

   (i) Correct and complete,

   (ii) Not created by use,

   (iii) Not allowed to be disclosed, or

   (iv) Not part of your records.

Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and or our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your bill, notify you that the change was made, and notify others that need to know about the change in your PHI.

How to Express a Concern About Our Privacy Practices

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the Privacy Officer who can be contacted at the following address or phone number:

Risk Management
PO Box 190
1111 N. Nagle Street
Alturas, CA 96101
(530) 708-8888

You also may send a written complaint to the Office for Civil Rights, U.S. Department of Health and Human Services, 50 United Nations Plaza -Room 322, San Francisco, CA 94103. We will take no retaliatory action against you if you file a complaint about our privacy practices.

Person to Contact for Information about This Notice or to Complain About our Privacy Practices

It is the policy of Modoc Medical Center to provide quality services to all of our customers. In order to improve patient safety and quality of care we welcome all comments. If you have complaints or concerns about patient safety or quality of care you, please contact our Risk Manager at the same phone number and address as listed above for our Privacy Officer. We will make every effort to assist you. If you do not believe your issue has been resolved, you are encouraged to contact hospital administration. You are also encouraged to contact the State of California Department of Public Health (CDPH) at (800) 554-0350, to report concerns.

Other Uses of Medical Information

Other uses and disclosures of PHI not covered by this notice or the laws that apply to use will be made only with your written permission. If you provide us permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your PHI 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.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice at any time. You may obtain a copy of this notice from the Admitting Department or if after hours the Nursing Department.

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REQUEST FOR RECORDS

Prior to scheduling an establishing appointment, the Clinic at Modoc Medical Center (MMC Clinic) will need to obtain your primary care records. The MMC Clinic would also like to have records from any specialty provider to aid in your care. The following page needs to be completed in full and signed appropriately. The MMC Clinic will fax or mail the requests as appropriate.

INSTRUCTIONS:

1. Complete the *Authorization for Release of Protected Health Information*.
2. Should you have more than one care provider, feel free to make a copy of this page for each individual provider.
    a. MAKE SURE TO COMPLETE THE FOLLOWING IN FULL:
        i. Patient Information Section
        ii. Facility Name Section
        iii. Documents to be Disclosed/Released Section
3. Complete the last page with your signature, printed name, and date. If someone other than the Patient is signing, you must attach the legal document that gives permission to sign on behalf of the Patient.

Please Note: Failure to complete the Authorization forms in full may cause a delay in your care. Authorizations for Records are governed by HIPPA laws. If not completed fully and properly, your request may be rejected by your previous care providers.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I understand that information disclosed pursuant to this authorization could be redisclosed by the recipient and that such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal law (HIPAA).

Completion of this document authorizes the disclosure and/or use of health information about you. Please be sure to provide all information requested, failure to do so may invalidate this authorization.

PATIENT INFORMATION:

Patient Name:		Last 4 of SS#:
Address:	City:	State:
Zip Code:	Telephone:	Date of Birth:

I HEREBY REQUEST AND AUTHORIZE:

Name: MODOC MEDICAL CENTER CLINIC

Address: 1111 N NAGLE ST	City: ALTURAS	State: CA	Zip Code: 96101
Telephone: 530-708-8820	Fax: 530-233-4302		

CHECK ONE BOX: ☐ To **release** to ☒ To **request** from

Name:			
Address:	City:	State:	Zip Code:
Telephone:	Fax:		

In the following manner:

☒Copies by mail **or**
☒Copies by fax
☐Copies to be picked-up
☐Other_____

For the following purpose(s):

☒Continuity of care/Treatment
☐Legal/Attorney
☐Personal/Patient Request
☐Insurance
☒Other Transfer of Care

**** Documents to be disclosed/released: ****

Initial as appropriate

☐_____ Alcohol/Drug treatment
☐_____ STD, HIV & AIDS
☐_____ Sexual Assault
☐_____ Child/Elder Abuse/Neglect
☐_____ Mental Health (Exclude psychotherapy notes) *

*** A separate authorization is required to release Psychotherapy notes.**

☐ **Hospital Records**
Or
☐ **Clinic Records**
(Separate form is required for each.)

Type of Records being released/requested:

_____

_____

_____

DOS: _____

This authorization will expire on:

☒ **Twelve months from date signed** **or** ☐ **Other**_____

My authorization is given freely with the understanding that:

- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing.
- I have the right to receive a copy of this authorization.
- It is my right to be from retaliation or other penalty for failing to sign the authorization.
- This authorization is valid for a 12-month period from the date it is signed unless otherwise specified.
- A photocopy or fax of this authorization is as valid as the original.
- Modoc Medical Center, its directors, officers, employees, agents, and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- Substance Abuse Records are covered by 42 CFR Part 2, Which prohibits further disclosure of the information for which this release has authorized.
- Provider must release records within 15 business days of receiving a valid written request.
- I understand that I may be charged a reasonable fee for the costs of labor for copying, postage, supplies as permitted by HIPAA Privacy Rule and state law.

_____ _____

Signature of Patient or Authorized individual Date

_____

Print Name

_____

If signed other than by patient, please indicate relationship

(Verification of identity and/or authority to act on patient's behalf will be required.)