

**■ Medicare Patients Only Statements to Permit Payment of Medicare Benefits to Provider, Physician and Patient** I request that payment of all Medicare benefits be made on my behalf to the facility for any services furnished to me by the facility and for any physician services billed by the facility, and to the radiologist and the pathologist for their services. I authorize any holder of medical or other information about me to release to Doctors' Same Day Surgery Center and its agents any information needed to determine these benefits for related services.

**■ Disclosures of Financial Interests** Pursuant to Louisiana law, please note that certain Physicians may have a financial interest in Surgical Specialty Associates, L.L.C., DBA Doctors' Same Day Surgery Center. If you are referred to this facility and have any questions, please discuss this with your physician directly. **■ Certification** I certify that I have read this entire form, have had the opportunity to ask questions about it and have them answered, and understand its content I certify that the information given to the facility is true, correct and complete to the best of my knowledge and belief.

#### Advance Directive Notification

In the state of Louisiana, all patients have the right to participate in their own health care decisions and to make Advanced Directives or to execute Power of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. Doctors' Same Day Surgery Center respects and upholds those rights.

However, unlike in an acute care hospital setting, the surgery center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after surgery.

Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance to you wishes, Advance Directive, or Healthcare Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or healthcare power of attorney.

If you wish to complete an advance directive, copies of the official state forms are available at our facility or you may obtain a copy via the state's website: ([www.usilvrigwillregistry.com](http://www.usilvrigwillregistry.com))

If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

If a patient is adjudged incompetent under the states laws, the rights of the patient are exercised by the person appointed and/or the legal representative designated on the patient's behalf. The center will accept a Court Appointed Guardian, Dual Power of Attorney, or a Health Care Surrogate.

#### Patient Complaint or Grievance

If you have a problem or complaint, please speak to the receptionist or your care provider. We will address your concern(s) promptly. If necessary, your problem or complaint will be advanced to the administrator and/or Quality coordinator for resolution. You will receive a letter or phone call to inform you of the actions taken to address your complaint.

If you are not satisfied with the response of Doctors' Same Day Surgery Center, you may contact:

Patient complaint or grievances may be filed through the State of Louisiana at 1-866-280-7737 or write to the address below:

The State Department of Health and Hospitals/  
Standards Section  
P.O. Box 3767, Baton Rouge, LA 70821  
located at 500 Laurel St., Suite 100, Baton Rouge, LA  
70801-1811

Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman. Visit the Ombudsman website at: ([www.cms.hhs.gov/center/ombudsman.asp](http://www.cms.hhs.gov/center/ombudsman.asp))

For additional information regarding patient rights, responsibilities, advance directives or health/safety you may visit: ([www.safecarecampaign.org](http://www.safecarecampaign.org))

#### Disclosure of Ownership

- Physician does not have financial interest in the facility.  
 Physician does have a financial interest in this facility.

Medical Malpractice Coverage:  
Your physician may not carry malpractice coverage.  
If you have questions about malpractice coverage, please discuss those with your physician.

Doctors' Same Day Surgery Center  
4633 Wichers Dr. Suite 200  
Marrero, LA 70072  
504-328-0000  
Fax 504-328-9101

#### Patient Rights

The patient has the right to: **■** Be informed of his/her rights in advance of, receiving care. The patient may appoint a representative to receive this information should he/she so desire. **■** Exercise these rights without regard to sex, culture, economic, education, religious background, physical handicap, or the source of payment for care. **■** Considerate, respectful, and dignified care, provided in a safe environment, with protection of privacy, free from all forms of abuse, neglect, harassment and/or exploitation and/or discrimination. The facility may not take punitive action against a person who exercises his/her rights. **■** Access protective and advocacy services or have these services accessed on the patient's behalf. **■** Appropriate assessment and management of pain. **■** Know the name of the physician who has primary responsibility for coordinating his/her care and the names of professional relationships of other physicians and healthcare providers who will see them. The patient has a right to request a change in providers if other qualified providers are available. **■** Receive complete information from his/her physician about his/her illness, course of treatment, alternative treatments, outcomes of care (including unanticipated outcomes) and prospects for recovery in terms that he/she can understand. **■** Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment. **■** Participate in the development and implementation of his/her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and /or refuse treatment. **■** Receive a copy of a clear and understandable itemized bill and receive an explanation of his/her bill regardless of source of payment. **■** Receive upon request, full information and necessary counseling on the availability of known financial resources for his/her care, including information regarding facility discounts and charity policies. **■** Know which facility rules and policies apply to his/her conduct while a patient. **■** Have all patient rights apply to the person who have legal responsibility to make decisions regarding medical care on behalf of the patient. **■** Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment. **■** The patient has the right to be advised as to the reason for the presence of any individual involved in her/her healthcare. **■** Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the facility. (cont.)

In the case of pediatric patients, a parent or guardian is to remain in the facility for the duration of the patient's stay at the facility. The patient's written permission will be obtained. Medical records can not be made available to anyone without prior written authorization from the patient. ■The patient will receive information in a manner that her/she understands. Communication with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment. ■Access information contained in his/her medical record within a reasonable time frame. ■Be advised if facility personnel/physician proposes to engage in or perform human experimentation affecting the care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services. ■Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trials. This includes the patient's rights to a full informed consent process as it relates to the research, investigation and/or clinical trials. All information provided to its subjects will be contained in the medical record or research file, along with the consent form(s). Be informed by his/her physician or a delegate, thereof, of the continuing healthcare requirements following their discharge from the facility. ■Be informed if Medicare eligible, upon request and in advance of treatment, whether the healthcare provider or healthcare facility accepts the Medicare assignment rate. ■Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. Receive upon request, prior to treatment, a reasonable estimate of charges for medical care. ■If the patient is adjudged incompetent by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf. ■If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law. ■The patient has the right to receive care in a safe setting that follows current standards of practice for patient environmental safety, infection control, and security.

#### **Patient Responsibilities**

■The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications (including over the counter products and dietary supplements), allergies and sensitivities and other matters relating to his/her health. The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do. ■The patient is responsible for following facility policy and procedures. ■The patient is responsible for his/her actions should he/she refuse treatment or not

follow their physician's orders. ■The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible.

■The patient has the responsibility for keeping appointments and for notifying the facility or physician when he/she is unable to do so. ■The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders. ■The patient is responsible to inform the facility about the patient's advance directives. ■The patient is responsible for being considerate to the rights of other patients and facility personnel. ■The patient is responsible for being respectful of his/her personal property and that of the persons in the facility. ■The patient is responsible for reporting to the health care provider any unexpected changes in his/her condition. The patient is responsible for providing a responsible adult to transport his/her home from the facility and remain with him/her for 24 hours unless exempted from that requirement by the attending physician.

### **CONDITIONS OF SERVICE / PATIENT GUARANTEE**

#### **Authorization and Consent for Treatment**

I voluntarily authorize and consent to examinations, tests, procedures and medical treatment by employees and agents of Doctors' Same Day Surgery Center, physicians and their designees, as deemed advisable in their professional judgement. I understand that risks may be associated with diagnosis and treatment, and acknowledge that no guarantees have been made to me regarding results of examinations or treatments. I hereby authorize the Facility to dispose of, at its convenience, any specimens, tissue or parts taken from my body in accordance with customary medical practice.

■**Personal Safety** I am made aware that some patients are at heightened risk of suffering falls because of their physical or mental condition or medication. I am instructed and encouraged, and agree to call for assistance when needed and to keep the protective bed rails up as necessary to avoid falling.

■**Relationship Between the Facility and Physicians** All physicians furnishing services to the patient, including radiologists, pathologists and anesthesiologists, are independent contractors with the patient and are not employees or agents of the Facility. The patient is under the care and supervision of his / her attending physician and it is the responsibility of the Facility and its nursing staff to carry out the instructions of such physician. Charges for services by physicians are generally not included in the Facility bill, but are billed separately by or on behalf of the physician.

■**Financial Obligations** The undersigned patient and the undersigned guarantor(s) hereby individually obligates himself or herself to pay the charges of the Facility in accordance with its regular rates within thirty (30) days of billing. Fees generated by providers are not governed by the provisions of the patient's insurance policy. If you are actively enrolled as a member of a group that is contracted with your provider of services, then the terms and conditions of the agreement between your provider and your group will supercede this billing policy. We will automatically mail a bill detailing by category the services you received. An itemized bill is available by request. However, if the patient is eligible to receive insurance or health plan benefits, the patient shall not be obligated to pay for services to the extent paid for pursuant to the

insurance plan, but shall be responsible for any unpaid balance due. If any excess funds remain after payment in full of the charges for services rendered during this hospital visit, the undersigned hereby authorizes the facility to apply such excess funds toward any other outstanding account(s) which the patient may have for any prior services rendered and for which the undersigned is responsible. Should the patient's account become delinquent and be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the rate of one percent (1%) per month from the date payment is due.

#### **Assignment of Insurance or Health Plan Benefits to Facility and Facility Based Physicians**

I assign and authorize direct payment of any insurance or health plan benefits otherwise payable to or on behalf of the patient for these outpatient services (1) to the Facility for charges at a rate not to exceed the Facility's regular charges, and (2) to the physicians who are Facility based or for whom the Facility bills for their professional services at a rate not to exceed such physician's regular charges. This assignment includes any attorney's fees, costs and penalties payable by the insurance company for late payment of the benefits assigned. In accordance with Louisiana law (La. R.S. 22:657) payment pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under the policy to the extent of such payment. If any excess funds remain after payment in full of the charges for services rendered during this visit, the undersigned hereby authorize the application of such excess funds toward any other outstanding account(s) which the patient may have for any prior services rendered or for which the undersigned is responsible. It is understood by the undersigned that he / she is financially responsible for charges not covered by this assignment.

■**Authorization to Release Information** I authorize physicians providing services on behalf of the patient to release all billing and medical information (including information concerning substance abuse and HIV Status, if applicable) to physicians or institutions providing follow-up care, the Social Security Administration, Medicare, Medicaid, and the insurance company, health maintenance organization, workmen's compensation insurance, person acting on behalf of a preferred provider arrangement or the named third party: \_\_\_\_\_, when such information is requested for payment, worker's compensation, utilization review, or coverage determination purposes. I understand that this authorization will remain in effect unless revoked by me in writing.

■**Personal Valuables** I have been instructed that the facility is not responsible for personal items brought into the facility and I have been advised to leave my valuables at home or give them to the party accompanying me. I understand that the facility shall not be liable for the loss or damage to any money, jewelry, documents, or other property.

**DOCTORS' SAME DAY SURGERY CENTER**  
4633 Wichers Drive, Suite 200  
Marrero, LA 70072  
504-328-0000 / Fax 504-328-9101

**NOTICE OF OUR HEALTH INFORMATION PRACTICES**

This notice describes how information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

**Understanding Your Health Record/Information:** Each time you visit a hospital, physicians, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care of treatment. It may also contain correspondence and other administrative documents. All of this information, often referred to as your health or medical records serve as a:

- BASIS FOR PLANNING YOUR CARE AND TREATMENT
- LEGAL DOCUMENTS DESCRIBING THE CARE YOU RECEIVED.
- MEANS BY WHICH YOU OR A THIRD-PARTY PAYER CAN VERIFY THAT SERVICES BILLED WERE ACTUALLY PROVIDED.
- A SOURCE OF INFORMATION FOR PUBLIC HEALTH OFFICIALS CHARGED WITH IMPROVING THE HEALTH OF THE NATION.
- MEANS OF COMMUNICATION AMONG THE MANY HEALTH PROFESSIONALS WHO CONTRIBUTE TO YOUR CARE.
- A TOOL IN EDUCATING HEALTH PROFESSIONALS.
- A TOOL WITH WHICH WE CAN ASSESS AND CONTINUALLY WORK TO IMPROVE THE CARE WE RENDER AND THE OUT COMES WE ACHIEVE.

**Your Health Information Rights:** Although your health record is the physical property of the healthcare practitioner of the facility that compiled it, the information belongs to you. You have the right to:

- INSPECT AND OBTAIN A COPY OF YOUR HEALTH RECORD.<sup>1</sup> TO DO THAT YOU MUST REQUEST THIS INFORMATION IN WRITING.
- REQUEST A RESTRICTION ON CERTAIN USES AND DISCLOSURES OF YOUR INFORMATION<sup>2</sup>, ALTHOUGH WE ARE NOT REQUIRED TO AGREE TO THOSE RESTRICTIONS. TO DO THAT, YOU MUST SUBMIT YOUR REQUEST IN WRITING.
- RECEIVE YOUR HEALTH INFORMATION THROUGH REASONABLE ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION.<sup>3</sup> TO DO THAT, YOU MUST SUBMIT YOUR REQUEST IN WRITING.
- REQUEST THAT YOUR HEALTH INFORMATION BE AMENDED WHEN YOU BELIEVE IT IS INCORRECT OR INCOMPLETE.<sup>2</sup> TO DO THAT, YOU MUST SUBMIT THE INFORMATION THAT YOU FEEL IS CORRECT IN WRITING.
- OBTAIN AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION.<sup>4</sup> TO DO THAT, YOU MUST SUBMIT YOUR REQUEST IN WRITING.

**Our Responsibilities:** This organization is required by law to:

- MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION
- ABIDE BY THE TERMS OF THIS NOTICE.
- NOTIFY YOU IF WE ARE UNABLE TO AGREE TO A REQUESTED RESTRICTION.
- PROVIDE YOU WITH A NOTICE AS TO OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO INFORMATION WE COLLECT AND MAINTAIN ABOUT YOU.
- ACCOMMODATE REASONABLE REQUESTS YOU MAY HAVE TO COMMUNICATE HEALTH INFORMATION BY ALTERNATIVE MEANS OR ALTERNATIVE INFORMATION.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our notice of health information practices change, we will make the new version available to you upon request.

WE WILL NOT USE OR DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION EXCEPT AS PROVIDED BY LAW OR DESCRIBED IN THIS NOTICE.

<sup>1</sup>As provided in R.S. 40:1299.96 and 45 CFR 164.524

<sup>2</sup>As provided in 45 CFR 164.528

<sup>3</sup>As provided in 45 CFR 164.522

<sup>4</sup>As provided in 45 CFR 164.528

<sup>5</sup>As provided in 45 CFR 164.522

FOR MORE INFORMATION OR TO REPORT A PROBLEM: IF YOU HAVE ANY QUESTIONS, YOU MAY CONTACT OUR PRIVACY OFFICER AT (504) 328-0000. IF YOU BELIEVE YOUR PRIVACY HAS BEEN VIOLATED, YOU CAN FILE A COMPLAINT WITH THE PRIVACY OFFICER OR WITH THE SECRETARY OF HEALTH AND HUMAN SERVICES. THERE WILL BE NO RETALIATION FOR FILING A COMPLAINT. EXAMPLE OF DISCLOSURE FOR TREATMENT, PAYMENT AND HEALTH OPERATION: PURSUANT TO LAW AND THE CONSENT FORM YOU HAVE SIGNED: **We will use your health information for treatment.** FOR EXAMPLE: INFORMATION OBTAINED BY PHYSICIANS, NURSES, OR OTHER MEMBERS OF YOUR HEALTHCARE TEAM WILL BE RECORDED IN YOUR RECORD AND USED TO DETERMINE THE COURSE OF TREATMENT THAT SHOULD WORK BEST FOR YOU. YOUR PHYSICIAN WILL DOCUMENT IN YOUR RECORD HIS OR HER EXPECTATIONS OF THE MEMBERS OF YOUR HEALTHCARE TEAM. MEMBERS OF YOUR HEALTHCARE TEAM WILL THEN RECORD THE ACTIONS THEY TOOK AND THEIR OBSERVATIONS. IN THAT WAY, THE PHYSICIAN OR SUBSEQUENT HEALTHCARE PROVIDER WILL KNOW HOW YOU ARE RESPONDING TO TREATMENT. WE WILL ALSO PROVIDE YOUR PHYSICIAN OR A SUBSEQUENT HEALTHCARE PROVIDER WITH COPIES OF VARIOUS REPORTS THAT SHOULD ASSIST HIM OR HER IN TREATING YOU ONCE YOU ARE DISCHARGED FROM THIS HOSPITAL. **We will use your health information for payment.** FOR EXAMPLE: A BILL MAY BE SENT TO YOU OR A THIRD-PARTY PAYER. THE INFORMATION ON OR ACCOMPANYING THE BILL MAY INCLUDE INFORMATION THAT IDENTIFIES YOU, AS WELL AS YOUR DIAGNOSES, PROCEDURES, AND SUPPLIES USED. IN THE EVENT THAT PAYMENT IS NOT MADE, WE MAY ALSO PROVIDE LIMITED INFORMATION TO COLLECTION AGENCIES, ATTORNEYS, CREDIT REPORTING AGENCIES AND OTHER ORGANIZATIONS AS IS NECESSARY TO COLLECT FOR SERVICES RENDERED. WE WILL USE YOUR HEALTH INFORMATION FOR REGULAR HEALTH OPERATIONS. FOR EXAMPLE: MEMBERS OF THE MEDICAL STAFF, THE RISK MANAGER, OR MEMBERS OF THE QUALITY IMPROVEMENT TEAM MAY USE INFORMATION IN YOUR HEALTH RECORD TO ASSESS THE CARE AND OUTCOME IN YOUR CASE AND OTHERS LIKE IT. THIS INFORMATION WILL THEN BE USED IN AN EFFORT TO CONTINUALLY IMPROVE THE QUALITY AND EFFECTIVENESS OF HEALTHCARE AND SERVICE. **Required by law:** AS REQUIRED UNDER THE LAW, WE MAY DISCLOSE YOUR HEALTH INFORMATION. **Business Associates:** THERE ARE SOME SERVICES PROVIDED IN OUR ORGANIZATION THROUGH CONTACTS WITH BUSINESS ASSOCIATES. EXAMPLES INCLUDE PHYSICIAN'S SERVICES IN THE RADIOLOGY AND LABORATORY TESTING, COLLECTION AGENCIES, AND A COPY SERVICE WE USE WHEN MAKING COPIES OF YOUR HEALTH RECORD. WHEN 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 FOR SERVICES RENDERED. TO PROTECT YOUR HEALTH INFORMATION, HOWEVER, WE REQUIRE THE BUSINESS ASSOCIATE TO APPROPRIATELY SAFEGUARD YOUR INFORMATION. **Directory:** UNLESS YOU NOTIFY US THAT YOU OBJECT, WE WILL USE YOUR NAME, LOCATION IN THE FACILITY, AND GENERAL CONDITION FOR DIRECTORY PURPOSES. THIS INFORMATION MAY BE PROVIDED TO PEOPLE WHO ASK FOR YOU BY NAME. **Notification:** WE MAY USE OR DISCLOSE INFORMATION TO NOTIFY OR ASSIST IN NOTIFYING A FAMILY MEMBER, PERSONAL REPRESENTATIVE, OR ANOTHER PERSON RESPONSIBLE FOR YOUR CARE, YOUR LOCATION, AND GENERAL CONDITION. **Communication with family:** HEALTH PROFESSIONALS, USING THEIR BEST JUDGEMENT, MAY DISCLOSE TO A FAMILY MEMBER, OTHER RELATIVE, CLOSE PERSONAL RESPONSIBLE FOR YOUR CARE, YOUR LOCATION, AND GENERAL CONDITION. **Health oversight activities:** WE MAY DISCLOSE YOUR HEALTH INFORMATION TO HEALTH AGENCIES DURING THE COURSE OF AUDITS, INVESTIGATION, INSPECTIONS, LICENSURE, AND OTHER PROCEEDINGS. **Judicial and Administrative proceedings:** WE MAY DISCLOSE YOUR HEALTH INFORMATION IN THE COURSE OF ANY ADMINISTRATIVE OR JUDICIAL PROCEEDINGS. **Deceased person information:** WE MAY DISCLOSE YOUR HEALTH INFORMATION TO CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS. **Public Safety:** WE MAY DISCLOSE YOUR HEALTH INFORMATION TO APPROPRIATE PERSONS IN ORDER TO PREVENT OR LESSEN A SERIOUS AND IMMINENT THREAT TO THE HEALTH OR SAFETY OF A PARTICULAR PERSON OR THE GENERAL PUBLIC. **Specialized government functions:** WE MAY DISCLOSE YOUR HEALTH INFORMATION FOR MILITARY AND NATIONAL SECURITY PURPOSES. **Organ Procurement Organization:** CONSISTENT WITH APPLICABLE LAW, WE MAY DISCLOSE HEALTH INFORMATION TO ORGAN PROCUREMENT ORGANIZATIONS OR OTHER ENTITIES ENGAGED IN THE PROCUREMENT, BANKING, OR TRANSPLANTATION OF ORGANS FOR THE PURPOSE OF TISSUE DONATION AND TRANSPLANT. **Marketing:** WE MAY CONTACT YOU TO PROVIDE APPOINTMENT REMINDERS OR INFORMATION ABOUT TREATMENT ALTERNATIVES OR OTHER HEALTH-RELATED BENEFITS AND SERVICES THAT MAY BE OF INTEREST TO YOU. **Food and Drug Administration (FDA):** WE MAY DISCLOSE TO THE FDA HEALTH INFORMATION RELATIVE TO ADVERSE EVENTS WITH RESPECT TO FOOD, SUPPLEMENT, PRODUCTS AND PRODUCT DEFECTS, OR POST-MARKETING SURVEILLANCE INFORMATION TO ENABLE PRODUCT RECALLS, REPAIRS OR REPLACEMENT. **Workers Compensation:** WE MAY DISCLOSE HEALTH INFORMATION TO THE EXTENT AUTHORIZED BY AND TO THE EXTENT NECESSARY TO COMPLY WITH LAWS RELATED TO WORKERS COMPENSATION OR OTHER SIMILAR PROGRAMS ESTABLISHED BY LAW. **Public Health:** AS REQUIRED BY LAW, WE MAY DISCLOSE YOUR HEALTH INFORMATION TO PUBLIC HEALTH OR LEGAL AUTHORITIES CHARGED WITH PREVENTING OR CONTROLLING DISEASE, INJURY OR DISABILITY. **Correctional Institutions:** SHOULD YOU BE AN INMATE OR A CORRECTIONAL INSTITUTION, WE MAY DISCLOSE TO THE INSTITUTION OR AGENT THEREOF HEALTH INFORMATION NECESSARY FOR YOUR HEALTH AND THE HEALTH AND SAFETY OF OTHER INDIVIDUALS. **Law Enforcement:** WE MAY DISCLOSE CERTAIN HEALTH INFORMATION FOR LAW ENFORCEMENT PURPOSES AS REQUIRED BY LAW OR IN RESPONSE TO A VALID SUBPOENA. **Change of ownership:** IN THE EVENT THAT THIS ORGANIZATION IS SOLD OR MERGED WITH ANOTHER ORGANIZATION, YOUR HEALTH INFORMATION WILL BECOME THE PROPERTY OF THE NEW OWNER. **Other disclosures:** FEDERAL LAW MAKES PROVISIONS FOR YOUR HEALTH INFORMATION TO BE RELEASED TO AN APPROPRIATE HEALTH OVERSIGHT AGENCY, PUBLIC HEALTH AUTHORITY OR ATTORNEY, PROVIDED THAT A WORK FORCE MEMBER OR BUSINESS ASSOCIATE BELIEVES IN GOOD FAITH THAT WE HAVE ENGAGED IN UNLAWFUL CONDUCT OR HAVE OTHERWISE VIOLATED PROFESSIONAL AND CLINICAL STANDARDS AND ARE POTENTIALLY ENDANGERING ONE OR MORE PATIENTS, WORKERS, OR THE PUBLIC. PATIENT IS HEREBY BEING PROVIDED WITH A COPY OF THE NOTICE OF PRIVACY PRACTICES AND HAS SIGNED AN ACKNOWLEDGMENT OF THE SAME. EFFECTIVE DATE: JUNE 17, 2003  
DISTRIBUTION: ORIGINAL TO PATIENT; ACKNOWLEDGMENT FILED IN PATIENT CHART.