North Florida OB GYN LLC

Confidential Patient Information Form - Form must be filled out completely to ensure correct claim processing.

Social Security _____**Patient** _____
(Last) (First) (Middle Initial)

Date of Birth_____**Address**_____
(Street #) (City) (State) (Zip)

Home Tel#: _____**Work Tel#:** _____**Patient Cell #** _____

If Cell # is provided, the office may text you appointment reminders. **Employer**_____

Patient E-Mail_____ **Marital Status** _____ **Employment Status** _____
(S M D W Sep) **(***FT PT Ret N/A)*

How did you hear about our office? _____ **Student**_____ *(FT PT)*

Referring Physician _____**Primary Care Physician** _____

Emergency Contact _____ **Phone #** _____

Spouse's name or other responsible party:_____ **Phone #** _____

Pharmacy Name, Phone #, Fax # and address_____

Primary Insurance: _____**Subscriber (Insured) Name** _____

Subscriber: Date of Birth_____ Social Security # _____Employer_____

ID#_____ **Group Name & #**_____ **Patient Relationship to Insured**_____
(Self, Spouse, Child)

Insurance Address_____
(City) (State) (Zip)

Second Insurance: _____ **Subscriber (Insured) Name**_____

Subscriber: Date of Birth_____ Social Security # _____Employer_____

ID#_____ **Group Name & #**_____ **Patient Relationship to Insured**_____
(Self, Spouse, Child)

Insurance Address_____
(City) (State) (Zip)

I understand that I am directly and primarily responsible to North Florida Obstetrical & Gynecological Associates, P.A., the parent company of North Florida OB GYN, LLC, for its customary fee for the services rendered to me by North Florida OB GYN, LLC. I realize that if my insurance company fails to pay or if there is any delay in paying North Florida Obstetrical & Gynecological Associates, P.A., it is my responsibility to pay my doctor's bill directly. I further understand and agree if I fail to make timely payments to North Florida Obstetrical & Gynecological Associates, P.A., that I will be responsible for any and all reasonable cost of collection including filing fees as well as any reasonable attorney's fee(s).

For the services rendered by North Florida OB GYN, LLC, I authorize the release of any medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination or treatment. I also request payment of government benefits either to myself or the party who accepts assignment (North Florida Obstetrical & Gynecological Associates, P.A.). I authorize payment of medical benefits to the physician who submits the claim. I agree to hold North Florida OB GYN, LLC harmless from any and all costs, liability and damages of and nature whatsoever including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent. North Florida OB GYN, LLC and other PA subsidiaries may share one electronic medical record. To facilitate the provision of my medical care, I consent for North Florida OB GYN, LLC to access my medical records maintained by any other PA subsidiary.

I understand the office may employ an Advanced Registered Nurse Practitioner ("ARNP"), Midwife ("ARNP/CNM") or Physician Assistant ("PA"), and if I am scheduled with them, I am willing to see them instead of the doctor. I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I consent to electronic access to my medication history.

This form was last modified on **10/1/2015**. I acknowledge that I have read this authorization and fully understand its contents.

Signature_____Date_____

North Florida Obstetrical & Gynecological Associates, P.A.

Consent for Medical Information Release

There are times we are asked to give family members or others information on test results, especially if you will not be available to receive them. If you would like for us to give out information regarding your treatment and/or test results to your family or friends, please fill in their name and their relationship to you. **Please designate which type of information each person may receive** by checking the items we may release and any item we should not disclose. Make your own notes if necessary for clarification.

Definitions:

All Information: Any and All information we have in our file related to you which may include billing information, appointments, treatment, test results, etc. and information on sexually transmitted disease; HIV/AIDS, birth control, pregnancy and mental health information

Appointment Only: Only information related to appointment dates and times.

STD's/HIV: Information related to sexually transmitted disease including HIV, AIDS, HPV, dysplasia, abnormal paps, herpes, GC, Chlamydia, syphilis, vaginitis, Trichomonas, etc.

Preg/Ab: Information related to pregnancy and abortion.

BC: Information related to preventing pregnancy including birth control pills, diaphragms, condoms, IUD's, etc.

Relationship	Name of person allowed to receive information	Type of information which may be released
Mother	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
Father	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
Husband	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
_____	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
_____	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC

□ **NO INFORMATION TO BE RELEASED**

This consent to release information will remain in effect until revoked in writing.

Signature Patient_____ Date _____

_____ _____ **Division**:_____

Staff Witness Date

«PName» **DOB: «PDOB»**

North Florida OB/GYN

Well Woman
Annual Examination Consent

It is our understanding that your appointment today is for an Annual Well Woman Examination. This does not include treatment for any problem and only provides you with a preventative checkup to ensure you do not have any problems that need to be addressed during a future visit.

Some insurance policies cover the annual exam and pay 100% of the charge.

Some insurance policies, such as **Medicare**, **DO NOT** cover preventative care and will not pay for it. In this case, you would be responsible for payment of today's charges.

If you have a problem and you are **NOT** here for an annual exam, please advise the check-in staff so that your appointment can be changed to a problem visit and our billing will reflect a problem visit.

If you wish to have a problem addressed **AND** have your annual exam done today, and time permits, you will be charged for an office visit **IN ADDITION** to the annual preventative charge. This means, if your insurance company covers your annual exam at 100%, you will still be responsible for the additional charges that may be your co-insurance and /or your deductible for the "problem portion" of the visit.

Additionally, it is now standard of care for patients who are in the age group of 30-64 to receive a Pap and HPV test for routine cervical cancer screening. Our practice firmly supports the guidelines and will perform this test **unless you specifically request not to be tested.**

This letter is our attempt to explain our method of billing for annual and problem visits so there is no misunderstanding after the visit. Please feel free to ask our staff if you have any questions.

Please sign below indicating that you are aware of our billing policies in regard to Well Woman examinations and problem visits and that you acknowledge you may be responsible for payment of any copayments and/or deductibles not covered by your insurance.

Print name:_____ DOB:_____

Patient signature:_____ Date:_____

Patient account #:_____

NORTH FLORIDA OB GYN, LLC ("North Florida")

CONSENT FOR TREATMENT OF A MINOR

According to Florida law, a parent or legal guardian must consent to the treatment of a minor (any person under 18 years of age) except under certain circumstances. The exceptions are listed below under the Consent by Minor section. In circumstances when the minor has the legal right to consent, Florida law prohibits the release of the minor's medical records for such treatment without the minor's written consent.

CONSENT BY PARENT/LEGAL GUARDIAN

I, the undersigned, as the parent or legal guardian of _____ (the "minor") have the legal authority to give consent for the treatment of this minor. I, hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any medical condition. I agree that treatment may be provided in my absence. This consent shall remain in effect unless revoked in writing.

Minor's Name_____ DOB_____ Relationship_____

_____ _____

Signature of Parent or Legal Guardian Date

CONSENT BY MINOR PATIENT (under limited circumstances)

I, _____, consent to such diagnostic, medical and/or surgical treatment by North Florida providers. I have the legal authority to consent to such treatment because I am (check one or more of the following):

- □ an emancipated minor (emancipated by court (must provide court order), or I do not reside with my parents and I am financially independent). I can consent to any treatment.
- □ married, divorced or widowed (must provide copy of court document). I can consent to any treatment.
- □ a mother consenting to treatment of my child. (ex: Minor consenting to her child's circumcision)
- □ pregnant and consenting to treatment of my pregnancy.
- □ consenting to treatment of sexually transmitted diseases.
- □ consenting to treatment related to family planning (birth control and/or pregnancy).

_____ _____

Signature of Minor Patient Date

CONSENT BY MINOR FOR RELEASE OF MEDICAL INFORMATION OF TREATMENT THAT MINOR PROVIDED CONSENT

Often times we are asked to give family members or others information on test results, etc. especially if you are not available to receive them. If you would like us to give out information regarding your treatment and/or test results to family or friends, please fill in their relationship to you and their name and check which type of information each person may receive. **If you do not allow us to discuss with the person financially responsible for your treatment, you, the minor, are responsible for payment in full prior to any testing and treatment for STD, HIV, BC & pregnancy.**

Name	Relationship						
		□ ALL INFO	□ STD's	□ HIV/AIDS	□ BC	□ PREG/AB	□ APPTS
		□ ALL INFO	□ STD's	□ HIV/AIDS	□ BC	□ PREG/AB	□ APPTS
		□ ALL INFO	□ STD's	□ HIV/AIDS	□ BC	□ PREG/AB	□ APPTS
		□ ALL INFO	□ STD's	□ HIV/AIDS	□ BC	□ PREG/AB	□ APPTS

Legend: **ALL INFO**: any information on file related to you, including but not limited to STDs, HIV/AIDS, BC, PREG/AB and APPTS; **STDs**: information related to sexually transmitted diseases; **HIV/AIDS**: information related to the AIDS virus (HIV); **PREG/AB**: information related to pregnancy and/or abortion; **BC**: information related to birth control; **APPTS**: only information related to appointment times and dates

☐ **I consent to the provider sending a bill and discussing the service provided to my parent or guardian who is responsible for payment.** (Checking the box provides your consent to this statement.)

By signing this agreement, I acknowledge that I have carefully read, understand and agree to the above terms and conditions.

_____ _____

Signature of Minor Patient Date

Written Patient Name:_____ Date of Birth:_____

Family History Questionnaire for Hereditary Breast & Ovarian Cancer Syndrome

Patient Name: _____ Date of Birth: _____
Physician: _____ Date Completed: _____

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal and father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Mother Father Brothers Sisters Children Uncles Aunts Nieces Nephews Grandmothers Grandfathers First Cousins

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary breast and ovarian cancer syndrome and Lynch Syndrome. Share this information with your healthcare professional to help determine your hereditary cancer risk.

	COLON AND UTERINE CANCER	Self	Family Member	Age at Diagnosis
Y N	Uterine (endometrial Cancer) before age 50	_____	_____	_____
Y N	Colorectal cancer before age 50	_____	_____	_____
Y N	Two or more lynch syndrome cancers in the same person or on the same side of the family	_____	_____	_____

(*Lynch Syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas)

	BREAST AND OVARIAN CANCER	Self	Family Member	Age at Diagnosis
Y N	Breast cancer at age 50 or younger	_____	_____	_____
Y N	Ovarian cancer at any age	_____	_____	_____
Y N	2 primary (unrelated) breast cancers in the same person or same side of the family	_____	_____	_____
Y N	Triple negative breast cancer (ER-/PR-/HER2- pathology)	_____	_____	_____
Y N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family	_____	_____	_____
Y N	Male breast cancer at any age	_____	_____	_____
Y N	Ashkenazi Jewish ancestry with breast, Ovarian or pancreatic cancer in the same person or on the same side of the family	_____	_____	_____
Y N	A known BRCA mutation in the family	_____	_____	_____

Y N Have you or any member of your family ever been tested for hereditary risk of cancer?
If yes, please explain:

_____

☐ **Patient not a candidate for genetic testing:** _____
Healthcare provider's signature **Date**

☐ **Patient accepts genetic testing:** _____
Patient's signature **Date**

☐ **Patient declines genetic testing:** _____
Patient's signature **Date**

Patient Name: _____ NORTH FLORIDA OB GYN, LLC FINANCIAL AGREEMENT

PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have had the opportunity to review a copy of **North Florida OB GYN LLC's Privacy Notice** dated **September 01, 2013** ("Notice"). I understand that I am responsible to read this Notice and notify North Florida OB GYN, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. I understand the notice included electronic access to my medication history. North Florida OB GYN has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times and on their website at www.nfobgyn.com. North Florida OB GYN will provide me with a copy of its most recent Notice upon my request.

Patient Signature: _____ Date of Birth:_____

Parent, Guardian or Legal Representative Signature:_____

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at North Florida OB GYN, LLC. I am responsible for any applicable deductible, co-insurance or co-payments prior to the provision of services. For surgery and pregnancy, North Florida OB GYN LLC will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, procedure or pregnancy, this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. Any patient credits will be applied to my other outstanding patient balances prior to any refund issued. I further understand that such payment is not contingent on any insurance, settlement or judgment payment

North Florida OB GYN, LLC is a wholly owned subsidiary of North Florida Obstetrical & Gynecological Associates, P.A. (“PA”) who may file a claim for payment and accept assignment with my insurance company as required by contractual agreement. If the insurance company fails to pay in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all fees for collection, including a reasonable attorney's fee.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is **my responsibility** to provide North Florida OB GYN with a copy of my **current insurance** card and, if required by my insurance, **to obtain a referral** from my Primary Care Physician. North Florida OB GYN is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. **I will notify North Florida OB GYN immediately upon any change to my insurance**.

INSURANCE WAIVER , NON-COVERED SERVICES WAIVER and OUTSIDE LAB SERVICES

I understand that if I do not have a copy of a current insurance card and/or valid referral, North Florida OB GYN is not obligated to see me. But if I still wish to be seen, I can be seen as a "Private Pay" patient. I agree that neither the PA, nor I, will file a claim for the visit. I will be required to pay the total cost of the visit in advance. In addition, there may be a service I desire, suggested or provided that is not covered under my insurance plan “Non-Covered Services”; I understand I must pay for Non-Covered Services. If feasible, a waiver will be completed for each Private Pay visit or Non-Covered Service. I understand services sent to an outside lab are billed to my insurance or me by the lab and I will receive a separate invoice from the lab.

ANNUAL EXAMS (Including Medicare Annual Visits)

Annual "well-women" exams are preventive visits and are not paid for by all insurance carriers. Medicare only pays for a portion of this exam (Pap, Pelvic and Breast Exam) once every two (2) years. I understand I am responsible for payment, if the exam or portion of the exam is not covered by my insurance.

Annual exams do not typically include problems I may be having – as problem visits may require longer time. If I am experiencing problems, the office may be required to reschedule another visit to address these concerns.

CONSENT TO TREAT

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. North Florida OB GYN, LLC and other PA subsidiaries may share one electronic medical record ("EMR"). To facilitate the provision of my medical care, I consent for North Florida OB GYN, LLC to access my medical records maintained by any other PA subsidiary.

ADDITIONAL INFORMATION

Payment may be made to the PA in the form of: Cash, Check, Debit and Credit Cards. In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to me by North Florida OB GYN, LLC. Patient credits are applied to other outstanding patient balances prior to any refunds that may be issued, including balances owed to other wholly owned subsidiaries of the PA.

I understand additional charges are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. I may also be charged if I do not cancel my scheduled appointment, for not paying my co-pay and/or co-insurance or patient responsibility including deductible at the time of service, for telephone management services, for educational materials, for payment agreements which extend beyond 12 months, and for other administrative expenses not covered by my insurance plan.

ASSIGNMENT OF BENEFITS

For the services rendered by North Florida OB GYN, LLC, I authorize the release of any medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination or treatment. I also request payment of government benefits either to myself or to the party who accepts assignment (North Florida Obstetrical & Gynecological Associates, P.A.). I agree to hold North Florida OB GYN, LLC harmless from any and all costs, liability and damages of and nature whatsoever including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent.

SIGNATURE

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient's Printed name _____Patient's Date of Birth:_____

Patient's Signature:_____ Date signed:_____

Parent, Guardian or Legal Representative Signature:_____

Employee's signature who reviewed intake of form:_____

NORTH FLORIDA OB GYN, LLC
www.nf0bgyn.com

NOTICE OF PRIVACY 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.

At North Florida OB GYN, LLC ("North Florida"), we are committed to treating and using protected health information ("PHI") about you responsibly. This Notice of Privacy Practices ("Notice") describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This Notice has been updated in accordance with the HIPAA Omnibus Rules effective March 26, 2013. It applies to all PHI as defined by federal regulations.

North Florida participates in an Organized Health Care Arrangement ("OHCA") for the provision of office surgery. An OHCA is an arrangement or relationship, recognized in the HIPAA privacy rules, that allows two or more Covered Entities who participate in joint activities to share the PHI about their patients in order to manage and benefit their joint operations. North Florida will share PHI with participants in the OHCA for treatment, payment and health care operations of the OHCA. The other participant in North Florida's OHCA is the anesthesiology group which provides anesthesia during the office surgeries. This Notice is provided as a joint notice made by North Florida and the anesthesiology group. Each of them will abide by the terms of this Notice**.**

Understanding Your Health Record/Information

Each time you visit North Florida; 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 or treatment. This information may be used or disclosed to:

- Plan your care and treatment.
- Communicate with other providers who contribute to your care.
- Serve as a legal document.
- Receive payment from you, your plan, or your health insurer.
- Assess and continually work to improve the care we render and the outcomes we achieve.
- Comply with state and federal laws that require us to disclose your PHI.

Understanding what is in your record and how your PHI is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your PHI, and make more informed decisions when authorizing disclosure to others.

Our Responsibilities

North Florida is required to:

- Maintain the privacy of your PHI.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of the Notice currently in effect
- Notify you in writing if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate PHI by alternative means or at alternative locations.
- Notify you in writing of a breach where your unsecured PHI has been accessed, acquired, used or disclosed to an unauthorized person. "Unsecured PHI" refers to PHI that is not secured through the use of technologies or methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, such revised Notices will be made available to you.

We will not use or disclose your PHI without your written authorization, except as described in this Notice:

Treatment: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment that should work best for you. North Florida may also provide a subsequent healthcare provider with PHI about you (e.g., copies of various reports) that should assist him or her in treating you in the future. North Florida may also disclose PHI about you to, and obtain your PHI from, electronic health information

networks in which community healthcare providers may participate to facilitate the provision of care to patients such as yourself.

North Florida may use a prescription hub which provides electronic access to your medication history. This will assist North Florida health care providers in understanding what other medications may have been prescribed for you by other providers.

Payment: 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, diagnosis, procedures, and supplies used.

Health Care Operations: We may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: We may contract with third parties to perform functions or activities on behalf of, or certain services for, North Florida that involve the use or disclosure of PHI and disclose your PHI to our business associate so that they can perform the job we've asked them to do. We require the business associate to appropriately safeguard your information.

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 from Offices: We may call your home or other designated location and leave a message on voice mail, or by email or mail, in reference to any items that assist North Florida in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, insurance items and any call pertaining to your clinical care. We may mail to your home or other designated location any items that assist North Florida in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, patient satisfaction surveys and patient statements.

Communication with Family/Personal Friends: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, PHI relevant to that person's involvement in your care or payment related to your care. When a family member(s) or a friend(s) accompany you into the exam room, it is considered implied consent that a disclosure of your PHI is acceptable.

Baby Photos: North Florida may post within its office photographs submitted by patients.

Open Treatment Areas: Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, others may overhear some patient information while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our Privacy Officer.

To Avert a Serious Threat to Health or Safety: We may use your PHI or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual. North Florida may use a single compound authorization to combine conditioned and unconditioned authorizations for research (e.g. participation in research studies, creation or maintenance of a research database or repository), provided the authorization: (i) clearly differentiates between the conditioned (provision of research related treatment is conditioned on the provision of a written authorization) and unconditioned research components; and (ii) provides the individual with an opportunity to opt in to the unconditioned research activities. From time to time your physician may be the principal investigator of a research study. North Florida may engage a Business Associate to act under the direction of or on behalf of your physician to come to your physician's office to review medical records to identify potential candidates for your physician's research study. The Business Associate must comply with the following restrictions: (i) the use or disclosure is requested solely to review PHI as necessary to prepare a research protocol or for similar purposes preparatory to research; (ii), the PHI will not be removed from the North Florida office in the course of review, and (iii) the PHI for which use or access is requested is necessary for the research. The Business Associate shall provide your physician with a list of his or her patients who have been identified as potential candidates for such research study. North Florida staff or Business Associate under the direction of, or on behalf of your physician, may contact you to offer the opportunity to participate in the research study.

Coroners, Medical Examiners and Funeral Director: In the unfortunate event of your death, we may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

Deceased Individuals: In the unfortunate event of your death, we are permitted to disclose your PHI to your personal representative and your family members and others who were involved in the care or payment for your care prior to your death, unless inconsistent with any prior expressed preference that you provided to us. PHI excludes any information regarding a person who has been deceased for more than 50 years.

Organ Procurement Organizations: Consistent with applicable law, we may disclose PHI to organ procurement organizations, federally funded registries, 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 by mail, e-mail or text to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. However, we must obtain your prior written authorization for any marketing of products and services that are funded by third parties. You have the right to opt-out by notifying us in writing.

Fund Raising: We may contact you as part of a fund-raising effort. We may also disclose certain elements of your PHI, such as your name, address, phone number and dates you received treatment or services at North Florida, to a business associate or a foundation related to North Florida so that they may contact you to raise money for North Florida. If you do not wish to receive further fundraising communications, you should follow the instructions written on each communication that informs you how to be removed from any fundraising lists. You will not receive any fundraising communications from us after we receive your request to opt out, unless we have already prepared a communication prior to receiving notice of your election to opt out.

Sale of PHI: North Florida may not "sell" your PHI (i.e., disclose such PHI in exchange for remuneration) to a third party without your written authorization that acknowledges the remuneration unless such an exchange meets a regulatory exception.

Health Oversight Activities: We may release your PHI to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs, such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability..

Workers Compensation: We may disclose PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Law Enforcement: We may disclose PHI for law enforcement purposes as required by law.

Inmates and Correctional Institutions: If you are an inmate or you are detained by a law enforcement officer, we may disclose your PHI to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety at the place where you are confined.

Lawsuits and Disputes: We may disclose your PHI if we are ordered to do so by a court that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

As Required by Law: We may use or disclose your PHI if we are required by law to do so.

Your Health Information Rights

Although your health record is the physical property of North Florida, the information belongs to you. Some of our Divisions use an electronic medical record ("EMR"); other Divisions utilize a paper medical record or combination of both. You have the right to request to:

- Access, inspect and copy your health record. You have the right to inspect and/or request a paper copy of your medical record. If a Division of North Florida maintains an EMR, you have the right to access your health record in a machine readable electronic format. You have the right to access your health record in a machine readable electronic format. You have the right to request an electronic copy of your medical record be given to you or transmitted to another individual or entity. North Florida may charge you a reasonable, cost-based fee for the labor and supplies associated with copying or transmitting the electronic PHI.
- Amend your health record which you believe is not correct or complete. North Florida is not required to agree to the amendment if you ask us to amend information that is in our opinion: (i) accurate and complete; (ii) not part of the PHI kept by or for North Florida; (iii) not part of the PHI which you would be permitted to inspect and copy; or (iv) not created by North Florida, unless the individual or entity that created the information is not available to amend the information. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.
- Obtain a written accounting of certain non-routine disclosures of your PHI. We are not required to list certain disclosures, including (i) disclosures made for treatment, payment, and health care operations purposes, (ii) disclosures made with your authorization, (iii) disclosures made to create a limited data set, and (iv) disclosures made directly to you. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years prior to the date of your request. If we maintain your medical records in an EMR system, you may request that the accounting include disclosures for treatment, payment and health care operations for the three (3) years prior to the date of such request.. You must submit your request in writing to the Practice Administrator at the telephone number of the specific Division where you receive services. The first list you request within a 12-month period is free of charge, but North Florida may charge you for additional lists within the same 12-month period. North Florida will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
- Communications of your PHI by alternative means (e.g. e-mail) or at alternative locations (e.g. post office box).
- Place a restriction to certain uses and disclosures of your information. In most cases North Florida is not required to agree to these additional restrictions, but if North Florida does, North Florida will abide by the agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). North Florida must comply with a request to restrict the disclosure of PHI to a health plan for purposes of carrying out payment or health care operations if the PHI pertains solely to a health care item or service for which we have been paid out of pocket in full.
- Revoke your authorization to use or disclose PHI except to the extent that action has already been taken.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact:

Privacy Officer
North Florida OB GYN, LLC
11437 Central Parkway Suite 105
Jacksonville, Florida 32224
Telephone: (904) 472-2300

If you believe your privacy rights have been violated, you can file a written complaint with North Florida's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the address. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

September 1, 2013