UPTOWN PHYSICIANS
GROUP
2801 Lemmon Ave, Ste 400, Dallas TX 75204
P (214) 303-1033 F(214)303-1032

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION

Date: _____

Preferred Name: _____ **First Name:** _____

Last Name: _____ **Email:** _____

Address: _____ **Phone:** _____

_____ **DOB:** _____/_____/_____

County: _____ **SSI #:** _____

Sex assigned at birth: ☐Male ☐Female
(Circle or check one)

Gender ID: ☐Man ☐Transwoman ☐Woman ☐Intergender ☐Transman ☐Other
(Circle or check one)

Sexual Orientation: ☐Straight ☐Intersex ☐Not easy to categorize ☐Lesbian ☐Gay ☐Bisexual ☐Queer ☐Questioning ☐Asexual
(circle or check one)

Race: _____ **Ethnicity:** ☐Hispanic ☐Non-Hispanic
(Circle or check one)

INSURANCE INFORMATION

Primary Insurance	_____	Guarantor	_____
Group Number	_____	Policy Number	_____
Effective Day	_____	Referral	☐Y ☐N
Verified by	_____	Date	_____
Secondary Insurance	_____	Guarantor	_____
Group Number	_____	Policy Number	_____

Income: _____ **per week**

# of people in Household who depend on income: _____ **(including patient)**
Based on income reported: (***check one)***: UPG Staff Member

☐< 100% of the federal poverty level
☐Between 101-200% of the federal poverty level
☐Between 201-300% of the federal poverty level
☐Between 301-400% of the federal poverty level
☐> 400% of the federal poverty level

Signature: _____

UPTOWN PHYSICIANS
GROUP

Patient ID: _____

PATIENT SERVICES CONSENT FORM

I. Consent to Receive Services from Uptown Physician Group

I consent to receive the services listed below from Uptown Physician Group (UPG) I understand. that UPG offers a menu of services and that my providers and I will discuss which services are appropriate for me.

Outpatient Medical Care and Treatment:

I do hereby voluntarily consent to UPG performing reviews of my risk behaviors, physical assessments or examinations, conduct laboratory or other tests (which may include HIV testing), give injections, medications, and other treatments, and render other health services. I understand that UPG will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. In order to follow the progress of treatment it may be necessary to utilize photographs uploaded into the EMR to visually assess progress. I authorize UPG to perform any additional or different treatment that is thought necessary if in an emergency situation, a condition is discovered that was not known previously. If I am of childbearing age and I receive a positive pregnancy test, I agree to seek prenatal care as soon as possible.

Case Management and HIV Prevention Services:

I understand that if case management services are offered to me that the goal will be to promote competency and self-sufficiency, and that I have certain responsibilities towards meeting that goal. I understand that key case management activities include assessing my needs, providing me with information, referring and linking me to appropriate services, advocating on my behalf when necessary, and monitoring the services I receive. I understand that HIV prevention services may have specific program requirements which will be explained to me if it is determined that I am eligible to participate in the program.

Behavioral Health Services

I understand that if assigned a behavioral health provider, they will work with me to determine which services are appropriate for me, which may include individual and group therapy, brief therapy, crisis intervention, psychiatric evaluation and psychiatric medication management. I understand that UPG offers short-term counseling and emphasizes a brief treatment approach. I acknowledge that UPG cannot address all mental health needs, and that if it is determined that I require treatment resources or services beyond what UPG can provide, UPG can assist me with a referral to an appropriate behavioral health provider.

II. Telemedicine & Telehealth Consent

Telemedicine and telehealth services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites. I understand that:

(1) The same standard of care applies to a telemedicine visit as applies to an in-person visit.

(2) I will not be physically in the same room as my healthcare provider. I will be notified, and I must consent for anyone other than my healthcare provider to be present in the room.

(3) There are potential risks to using technology, including service interruptions, interception, and technical difficulties. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.

(4) I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.

(5) The laws that protect privacy and the confidentiality of health care information apply to telemedicine services.

(6) My health care information may be shared with other individuals for scheduling and billing purposes.

- My insurance carrier will have access to my medical records for quality review/audit.
- I will be responsible for any out-of-pocket costs such as co-payments or co-insurances that apply to my telemedicine visit.
- Health plan payment policies for telemedicine visits may be different from policies for in-person visits.

(7) This document will become a part of my medical record.

(8) I am responsible for maintaining confidentiality on my side of the telemedicine conference.

I also attest that:

(1) The risks, benefits and alternatives to telemedicine have been shared with me and my questions have been answered to my satisfaction; and

(2) I am located in the state of Texas and will be in Texas during my telemedicine visit(s)

III. Notice of Access to Medical Records and Medication History

I understand that UPG has the ability to access my electronic medical records and prescription medication history from other providers, hospitals, and pharmacies outside of UPG where I receive services. Under the ***Health Insurance Portability and Accountability Act of 1996*** ("HIPAA") healthcare providers are permitted to use and disclose your health information for treatment purposes. This sharing of information allows UPG to better coordinate my care. Only those records that are NOT marked sensitive or confidential may be accessed and imported into my UPG patient chart. Similarly, other providers may access my UPG medical records that are NOT marked sensitive or confidential.

IV. Consent to Receive Digital Communications

UPG has several secure, electronic methods to communicate and share information with you about your treatment, including the **Patient Portal, Secure Short Message Service (SMS) messaging, and electronic quality improvement surveys.** Participation in any of these forms of digital communication is completely voluntary and declining to participate will not affect your eligibility to receive services. You may decline to participate anytime by unsubscribing from the communications or notifying UPG in writing.

V. Acknowledgements

I acknowledge that I have been offered a copy of the following documents:

- Patient Rights & Responsibilities
- Notice of Privacy Practices
- Disruptive Behavior Policy
- Patient Complaint Procedure

By signing this document, I am giving the consents and authorizations outlined above of my own free will. I acknowledge that I was asked if I wanted to discuss this document in a language and format I understand. These consents and authorizations will remain in effect until I provide a written statement revoking them or terminating my services with UPG. Written revocations of consent may be given to a UPG staff member.

Patient First Name and Middle Initial	**Patient Last Name**
Patient Date of Birth (MM/DD/YYYY)	
E-mail Address	**Cell Phone**
Signature of Patient (or Legal Representative)	**Date**
Printed Name of Patient's Legal Representative (*if applicable*)	**Relationship to Patient** *(if applicable)* ☐ Parent ☐ Court appointed guardian ☐ Power of Attorney
UPG Staff Signature	**Date**

Patient ID: _____

UPTOWN PHYSICIANS GROUP

RIGHTS AND RESPONSIBILITIES

Engaging in services at Uptown Physicians Group (UPG) is a partnership. This means that we must work together, and your full participation and cooperation is required for you to meet your goals related to your health. As a partner in this process, you have the following rights and responsibilities:

Rights:

- The right to receive all services offered by UPG for which you are eligible regardless of age, sex, race, color, national origin, religion, creed, political affiliation, sexual orientation, gender identity or disability.
- The right to confidentiality within the limits of the law.
- The right to be informed about how you can file a complaint.
- The right to withdraw as a client of UPG at any time.
- The right to access your medical records, correct errors or omissions, and be informed of how personal information is shared and used.
- The right to informed consent.
- The right to make your own decisions about your life and how you live it.
- The right to be treated with professionalism and respect.

Responsibilities:

- The responsibility to maintain ongoing contact with your assigned care providers (Case Manager, Care Coordinator, Care Specialist, Promotor de Salud, MAI Education Outreach Specialist, and/or UPG medical clinic personnel).
- The responsibility to keep track of and attend all appointments that are scheduled with you.
- The responsibility to update your eligibility information every 6 months including proof of residency and proof of income in order to maintain those services if you are accessing Ryan White funded services at UPG.
- The responsibility to provide accurate information to UPG and to update any changes to this information as it occurs, including changes to address, phone number, and income.
- The responsibility to provide accurate health insurance information to UPG and update any changes to health insurance status: Medicare, Medicaid, private insurance or Affordable Care Act marketplace plan.
- The responsibility to follow up on referrals.
- The responsibility to notify UPG if you cannot keep a scheduled appointment. UPG staff members will not wait longer than 15 minutes for you unless you have notified them of a reasonable cause for the delay.
- The responsibility to treat all UPG staff members with the same respect that you expect and deserve.
- The responsibility for the choices you make in your life.

I have read, understood, and agreed to follow these rights and responsibilities. I have received a copy of this form.

Patient: _____ UPG Staff: _____

Date: _____ Date: _____

UPTOWN PHYSICIANS
GROUP

STI Clinic Attestation

I _____ understand that I will be tested and/or treated for Sexually Transmitted Infections and not any other chronic health conditions.

_____ _____
Signature Date

2801 Lemmon Ave, Se 400 Dallas TX 75204 **P** (214) 303-1033 **F** (214) 303-1032

UPTOWN PHYSICIANS

GROUP

AUTHORIZATION OF PATIENT FINANCIAL RESPONSIBILITY

ASSIGNMENT OF BENEFITS

By signing this document, I am confirming my financial responsibility for this medical visit including any ordered labs, or prescription medication due to the following reasons listed below.

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize UPG (Uptown Physicians Group), its medical practices and providers including physicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner{s).

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly to the UPG provider of service (s) furnished to me. I authorize UPG to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to UPG. I hereby authorize that photocopy of this form to be valid as the original.

NON-COVERED SERVICES: I understand that if my insurance does not cover some/or all the services received, I will be responsible for any/all charges not covered. This includes.

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through UPG medical practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of an UPG billing statement whether it is an interim or final bill. If I fail to make full payment or fail to comply with other payment arrangements made with UPG's approval, I understand that appropriate collection measures may be initiated.

SELF-PAY: Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate. It is always the patient's responsibility to know if our office is participating with their plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

NON-COVERED SERVICES: Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

RYAN WHITE: I understand that Ryan White documentation must be current. It is my responsibility to provide the required eligibility documents in a timely manner as requested by staff. Failure to do so may result in a Self-Pay status, thus I will be responsible for payment for my visit at time of service.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

Patient Signature: _____ Date: _____

Print Name: _____

Relationship to Patient: _____

Uptown Physicians Group Clinic
2801 Lemmon Ave, Ste 400
Dallas Texas 75204

P (214) 303-1033 **F** (214) 303-1032

Patient ID: _____

UPTOWN PHYSICIANS
GROUP

Disruptive Behavior Procedures

Disruptive behavior is any behavior which threatens the safety of staff members, clients, and others. Such behavior may include but is not limited to the following:

a. Verbal abuse including swearing and use of aggressive, threatening and disrespectful language.
b. Physical abuse including causing physical harm or intending to harm.
c. Emotional abuse including name calling and harassment.
d. Sexual abuse including making sexual comments, asking for or offering sex.
e. Possession of illegal substances and/or drug supplies, as well as being under the influence of a drug when meeting with staff.
f. Bringing handguns or other lethal weapons to meetings with staff.
g. Calling or emailing staff excessively and for inappropriate reasons.

If any of the above behaviors occur:

a. The patient will receive a verbal and/or written warning.
b. If the behavior continues the client will be suspended from Uptown Physicians Group (UPG) services temporarily or permanently and given a referral to another agency if possible.
c. If necessary, the police will be called.

In all situations of disruptive behavior, the Community and Client Services Director and/or Clinic Administrator will be informed and will be part of the decision-making process to help make the best decision for both the client and UPG.

I have read and understand the UPG policy regarding disruptive behavior, and my questions have been answered.

_____ _____
Patient/Guardian Signature **Date**

_____ _____
UPG Staff Signature **Date**

Patient ID: _____

UPTOWN PHYSICIANS
GROUP

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information (PHI). Please read the entire authorization carefully before signing.

Uptown Physicians Group (UPG) will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that UPG may use or disclose your health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment for the purpose(s) of:

-planning my care and treatment
-communicating to other health care professionals who contribute to my care
-applying my diagnosis to my bill
-third party payors verifying services billed were actually provided
-assessing quality and reviewing the competence of healthcare professionals.

By signing this authorization, you agree that UPG or its Business Associates may disclose your personal health care information.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand UPG's Notice of Privacy Practices containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While UPG has reserved the right to change the terms of its Notice of Privacy Practices, copies of the Notice of Privacy Practices as amended are available from UPG by sending a written request with your return address to: Compliance Officer, Uptown Physicians Group, 351 W. Jefferson Blvd., Suite 300, Dallas, TX 75208.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by UPG for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that UPG has taken action in reliance on it. A revocation is effective upon receipt by UPG of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of UPG, or (d) six years from the date this authorization was executed.

By signing this authorization, you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

UPG will provide _____ with a copy of this signed authorization.

Acknowledged and agreed to by:

_____ **Signature of Client or Legal Representative**	_____ **Date**
_____ **Printed Name of Client's Representative (*if applicable*)**	**Relationship to Client (*if applicable*)** ☐ Court appointed guardian ☐ Power of Attorney

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FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

_____ but acknowledgment could not be obtained because:

☐ Client/Representative refused to sign
☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
☐ Communication barriers prohibited obtaining acknowledgement (Explain):

_____

_____

_____

_____

_____

☐ Other (Specify):

_____

_____

_____

UPTOWN PHYSICIANS
GROUP

Patient Name _____ Patient ID: _____

Address _____

City_____

Date of Birth _____

Telephone # _____

Last 4 of SS _____

Authorization for Release of Information

I hereby authorize Uptown Physicians Group (UPG) to request and/or release the information specified below from the medical record(s) of the above-named client in the following ways: verbally, in writing, and/or through secure (encrypted) email.

The information shall be requested from and/or released to:

FROM: _____
Name of Person/Organization

_____
Address, City, State, Zip code

_____ _____
Phone Number Fax Number

TO: _____
Name of Person/Organization

_____
Address, City, State, Zip code

_____ _____
Phone Number Fax Number

Client information is needed for (*Please select only one*):

☐ Continuing Medical Care ☐ Legal Purposes ☐ Insurance/Billing/Claims

☐ Social Security/Disability ☐ Other (explain)_____

Information to be released or accessed (*Please check all that apply*):

☐ Progress Notes Only
☐ History and Physical Exam
☐ Diagnostic Imaging Reports
☐ Diagnostic Test Results
☐ Discharge Summary
☐ Most Recent Laboratory Tests
☐ Letter of HIV Diagnosis

☐ Medication/Prescription Information
☐ Common Intake Form (CIF)
☐ Proof of Income, Residency, Picture ID
☐ Psychosocial History
☐ Alcohol/Drug Use History & Treatment
☐ Criminal Justice History/Probation/Parole
☐ Psychiatric History & Treatment

☐ Hospitalization Records from dates: _____
☐ Emergency Room Visit on: _____
☐ Clinic Visits from dates: _____
☐ Other: _____

In addition, I authorize that this will include health information relating to (check if applicable):

☐ HIV/AIDS infection ☐ Drug/Alcohol abuse ☐ Genetic Testing

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that UPG has relied on this authorization. The written revocation should be addressed to my assigned Uptown Physicians Group staff member, at 2801 Lemmon Ave, Suite 400, Dallas, Texas 75204 (fax# 214-303-132). Unless otherwise revoked, I understand that this authorization expires in three hundred sixty-five (365) days from the date of signature or on _____. A copy of this authorization is considered as valid as the original.

I understand that the recipient authorized to receive the health information is not a covered entity (e.g., non-health care provider) the released information may be redisclosed and may no longer be protected by federal and state privacy regulations.

I understand that UPG will not condition treatment, payment, enrollment, or eligibility for benefits based on completion of this form. I understand I may be charged a fee for copies of medical records.

_____ **Signature of Client or Legal Representative**	_____ **Date**
_____ **Printed Name of Client's Representative (*if applicable*)**	**Relationship to Client (*if applicable*)** ☐ Court appointed guardian ☐ Executor or administrator of decedent's estate ☐ Power of Attorney

UPTOWN PHYSICIANS
GROUP

Patient ID _____

Release Authorization

Except as described in the Notice of Privacy Practices provided to you, federal and Texas law prohibits us from discussing your medical care with anyone unless we have your written permission. If you wish to give us permission to discuss your care with a friend, family member, caregiver, or health and human service agency, please list those persons or agencies below and sign below.

1. Network Affiliates: **For Ryan White eligible patients ONLY**, by initialing below, you are authorizing Uptown Physician Group to disclose and obtain your health information from Network Affiliates. You will receive a list of network affiliates at the time of signing.

_____	_____
Client Initials	Date

	Person or Agency	Telephone number	Relationship to you (if person)	Are they aware of your diagnosis? (Y/N)
2.				
3.				
4.				
5.				
6.				

I hereby authorize Uptown Physicians Group (UPG) To release my health information including my diagnosis, whit the persons or agencies listed on this form.

This release will expire 365 days from the date it was signed unless I have indicated a shorter time-period in the following space (_____ days).

_____ _____

Signature of patient (or legal representative)

Date

_____

Printed Name of Patient's Legal representative (if *applicable*)

Relationship to the *(if applicable)*

- ☐ Parent
- ☐ Court appointed guardian
- ☐ Power of atttorney

UPTOWN PHYSICIANS
GROUP

Notice of Privacy Practices
Effective: October 6, 2022

Your Information. Your Rights. Our Responsibilities.

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

You have the right to:

- Get a copy of your paper or electronic health record.
- Correct your paper or electronic health record.
- Request confidential communication.
- Ask us to limit the information we share.
- Get a list of those with whom we have shared your information.
- Get a copy of this privacy notice.
- Choose someone to act for you.
- File a complaint if you believe your privacy rights have been violated.

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition.
- Provide disaster relief.
- Include you in a hospital directory.
- Provide mental health care.
- Market our services and sell your information.
- Raise funds.

We may use and share your information as we:

- Treat you.
- Run our organization.
- Bill for your services.
- Help with public health and safety issues.
- Do research.
- Comply with the law.
- Respond to organ and tissue donation requests.
- Work with a medical examiner or funeral director.
- Address workers' compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your health record

- You can ask to see or get an electronic or paper copy of your health record and other health information we have about you. **Ask us how to do this.**
- We will provide a copy or a summary of your health information, usually within 15 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your health record

- You can ask us to correct health information about you that you think is incorrect or incomplete. **Ask us how to do this.**
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we have shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone healthcare power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting completing a Patient Complaint Form or contacting a member of the Compliance Department at compliance@prismntx.org or 214-521-5191
- You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again about fundraising.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

- Treat you. We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
- Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues. We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safe

Conduct research. We can use or share your information for health research.

Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Any concerns or questions concerning these privacy practices may be addressed by writing or calling Prism Health North Texas' Compliance Department:

Prism Health North Texas
Attn: Compliance Department
3900 Junius Street, Suite 300
Dallas, Texas 75246
compliance@prismntx.org
214-521-5191