Florida Medical Clinic

Your Life, Our Specialty

PATIENT INFORMATION

FIRST NAME _____ MIDDLE _____ LAST NAME _____

LOCAL ADDRESS _____ DATE OF BIRTH ____/____/____ SEX _____

CITY _____ STATE _____ ZIP _____ EMAIL ADDRESS _____

SOCIAL SECURITY _____ CELL PHONE ( ) _____

ETHNICITY: ___ NOT HISPANIC/LATINO ___ HISPANIC/LATINO ___ REFUSED HOME PHONE ( ) _____

RACE: ___ AMERICAN INDIAN/ALASKA NATIVE ___ ASIAN ___WHITE WORK PHONE ( ) _____

___ BLACK/AFRICAN AMERICAN ___ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER REFERRING PHYSICIAN _____

___ OTHER ___OTHER SPECIFIED _____ PRIMARY PHYSICIAN _____

PREFERRED LANGUAGE _____ PHONE ( ) _____

___ MARRIED ___ SINGLE ___WIDOWED ___ DIVORCED EMPLOYER _____

___ EMPLOYED ___ RETIRED ___ FULL TIME STUDENT ADDRESS _____

PERMANENT ADDRESS

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT

NAME _____ HOME PHONE ( ) _____

RELATIONSHIP _____ WORK PHONE ( ) _____

IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? ☐ YES ☐ NO IF NO PLEASE COMPLETE THIS SECTION

RELATIONSHIP _____ SEX _____ DAYTIME PHONE ( ) _____

FIRST NAME _____ MIDDLE _____ EMPLOYER _____

LAST NAME _____ ADDRESS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CITY _____ STATE _____ ZIP _____

IS THE REASON FOR YOUR VISIT THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO IF YES PLEASE COMPLETE THIS SECTION

NOTE: NOT ALL FMC OFFICES ACCEPT AUTO OR WORKMAN COMPENSATION PATIENTS.

PLEASE CHECK WHICH TYPE OF ACCIDENT: ☐ WORKMAN COMPENSATION ☐ AUTOMOBILE ☐ OTHER

DATE OF ACCIDENT ____/____/____ Place of accident _____ How did accident happen? _____

CLAIM # _____ CLAIM REPRESENTATIVE/ADJUSTER _____

IF WORKMAN COMPENSATION PLEASE COMPLETE THIS SECTION

EMPLOYER NAME _____ EMPLOYER PHONE( ) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE COMPANY _____ INSURED'S DOB _____

INSURANCE/CARD HOLDER'S NAME _____ RELATIONSHIP _____

ID# _____ GROUP # _____ PHONE ( ) _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY _____

INSURANCE/CARD HOLDER'S NAME _____ RELATIONSHIP _____

ID# _____ GROUP # _____ PHONE ( ) _____

SIGNATURE _____ DATE _____

Florida Medical Clinic
Your Life, Our Specialty

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Florida Medical Clinic, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Florida Medical Clinic, P.A. I understand that diagnosis or treatment of me by Florida Medical Clinic, P.A. may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have a right to review the Florida Medical Clinic, P.A. *Notice of Privacy Practices* prior to signing this document. The Florida Medical Clinic, P.A. Notice of Privacy Practices has been provided to me. The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Florida Medical Clinic, P.A. The *Notice of Privacy Practices* for Florida Medical Clinic, P.A. is also provided at 38135 Market Square, Zephyrhills, FL 33542. This *Notice of Privacy Practices* also describes my rights and the duties of Florida Medical Clinic, P.A. with respect to my protected health information. Florida Medical Clinic, P.A. reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices*.

I may obtain a revised *Notice of Privacy Practices* by requesting in writing from Florida Medical Clinic, P.A. or asking for one at the time of my next appointment.

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Florida Medical Clinic, P.A. (FMC) and or its affiliated entities for any charges not covered by healthcare benefits. It is my responsibility to notify FMC of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by FMC and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Florida Medical Clinic, P.A. (FMC) for all covered medical services and supplies provided to me during all courses of treatment and care provided by FMC and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with FMC, which will authorize and allow for direct payment to FMC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by FMC.

Initials _____

Ownership Disclosure

I understand that Florida Medical Clinic, P.A. is a physician-owned medical practice comprised of the offices of primary care physicians, specialty care physicians and associated ancillary services. These ancillary services include laboratory, pathology, radiology/diagnostic, physical therapy, infusion services, pharmacy and ambulatory surgery center services. During the course of my care, I may be referred to one or more of these ancillary departments. I have the right to choose where to receive these services. I understand I am not obligated to receive these services at a Florida Medical Clinic ancillary department. I may obtain these services in the out-patient department of the local hospitals, such as Florida Hospital Zephyrhills, Pasco Regional Medical Center, University Community Hospital or St. Joseph's Hospital North.

Acknowledgment of Receipt
Notice of Privacy Practices

I acknowledge that I have received a copy of Florida Medical Clinic's Notice of Privacy Practices, which describes how FMC will use and protect my health information. This Notice describes my rights under the Health Insurance Portability and Accountability Act (HIPAA) and FMC's policies on use and disclosure of my protected health information.

Name of Patient	Name of Guardian or Personal Representative
Signature of Patient	Signature of Guardian or Personal Representative
Date	Florida Medical Clinic, P.A.

Form: FMC00002-05012009

Florida Medical Clinic
Your Life, Our Specialty

Internal Medicine Dale Mabry
12500 North Dale Mabry, Suite E
Tampa, FL 33618
O: 813-261-8200 F: 813-377-1677
Tomas Figueroa-Nieves, MD American Board of Internal Medicine
Stephanie Pelaez, PA-C
Amanda Fitch, ARNP

CONFIDENTIAL

Patient Name: _____ **Date of Service:** _____

Age: _____ **Date of Birth:** _____ **Date of Last Examination:** _____

What is your reason for visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, numbness, weakness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____
Date of last Pap Smear _____
Have you had a mammogram? _____
Are you pregnant? _____
Number of children _____

Conditions

Check (✓) symptoms you currently have or have had in the past year

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problem
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease

Medications

List medications you are currently taking:

_____
_____
_____
_____

Pharmacy Name: _____ **Phone:** _____

Allergies

_____
_____
_____
_____
_____

Health History

Family History

Fill in information about your immediate family

Relation	Age	State of Health	Age at Death	Cause of death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if your blood relatives had any of the following:	
Disease	**Relationship to you**
Arthritis, gout	
Asthma, Hay fever	
Cancer	
Chemical dependency	
Diabetes	
Heart disease, strokes	
High blood pressure	
Kidney disease	
Tuberculosis	
Other	

Hospitalizations

Year	Hospital	Reason for hospitalization and outcome

Pregnancies

Year of Birth	Sex of Birth	Complications, If any

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates: _____

Serious Illness/Injuries	Date	Outcome

Health Habits

Check (✓) which you use and how much you use		
☐	Caffeine	
☐	Tobacco	
☐	Street drugs	
☐	Other	

Occupational

Check (✓) which you use and how much you use	
☐ Stress	☐ Hazardous substances
☐ Heavy lifting	☐ Other

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child ever have a change in health

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative **Relationship to Patient**

_____ _____

Reviewed by **Date**

Florida Medical Clinic, P.A.
Authorization to Share Protected Health Information

Patient Name:	Second Form of Identification (DOB/Account#)

I authorize the physicians and staff of:

- ☐ All FMC Departments
- ☐ The following FMC Departments

Specify:

_____

_____

_____

to share protected health information with the following persons:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

This includes (please check all areas that apply)

- ☐ All Medical Information
- ☐ Lab Results
- ☐ X-ray Results
- ☐ Medication (RX Renewal and Pickup)
- ☐ Telephone Consults
- ☐ Hospital Information
- ☐ Insurance Information
- ☐ Dialysis Clinic Information
- ☐ Appointment Information
- ☐ Other (please specify)

This authorization will be in effect until authorization is revoked.

Patient's Signature_____ Date_____

Witness _____

Florida Medical Clinic
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PATIENT AUTHORIZATION TO USE / DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION			
Name		Last 4 SSN	
Account #		Date of Birth	
Street Address			
City/State		Zip Code	

I authorize Florida Medical Clinic, PA to disclose the health information listed below to the following person, group, or entity

Name	Fax #/Mailing Address
1.	1.
2.	2.

Requesting Records for self

Method:	Mailing address/Fax number/E-mail address
☐ Mail	
☐ Fax	
☐ Email	

Please select the type of information to be used or disclosed (include dates where appropriate)

☐ Entire record	☐ Laboratory results
☐ Medication list	☐ X-ray and imaging reports
☐ Problem list	☐ Consultation reports from _____
☐ List of allergies	☐ Visits/encounters: _____
☐ Immunization records	☐ Records from non-FMC providers
☐ Most recent history and physical	☐ Other(specify):

I authorize Florida Medical Clinic, PA to also disclose the following to the entity listed above. By not selecting any of the options below, I understand this information will not be shared.

☐ Treatment for Alcohol or Drug use/abuse	☐ Mental Health information (excluding psychotherapy)
☐ Sexually Transmitted Diseases/HIV-Related Information	☐ Psychotherapy
☐ Genetic	☐ Other

This authorization for release of information covers the period of healthcare services rendered from:

☐ _____ - _____	☐ All past, present, and future periods

Unless otherwise revoked, this authorization will expire on the follow date, event, or condition. If no date is specified, I understand this authorization will expire one year from the date below.

☐ Expiration date:	☐ Automatic expiration after one year

I understand the information in my health record may include information relating to sexually transmitted disease and other reportable disease, AIDS/HIV. It may also include psychiatric or mental health services, and treatment for alcohol and drug abuse. By not selecting any of these options above, I understand sexually transmitted diseases, mental health, and drug abuse will not be disclosed.
I have the right to revoke this authorization at any time by contacting Florida Medical Clinic, PA. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
I understand signing this authorization is voluntary. I do not need to sign this form in order to receive treatment.
I understand I may inspect or copy this information to be used or disclosed, as provided in CFR 164.524.
I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
I understand there is a fee for obtaining medical records and I agree to pay for such charges.
If I have any questions about disclosure of my PHI I can contact Florida Medical Clinic's Privacy Officer at (352) 567-0188.

Signature:	Date:
Print Name:	Signature by: ☐ Patient ☐ Legal Guardian ☐Proxy

(Internal Use ONLY) Verbal consent was given by patient — Must obtain 2 patient identifiers

Name of employee:	Date:
Identifier 1:	Identifier 2:

Revised 10/12/2016

Florida Medical Clinic
Your life. Our specialty.

MEDICAL RECORDS TRANSFER/REQUEST FORM

PATIENT INFORMATION			
Name		Last 4 SSN	
Acct#		DOB	
Street address			
City/State		Zip Code	

FLORIDA MEDICAL CLINIC OFFICE REQUESTING MEDICAL RECORDS

PREFERRED METHOD TO RECEIVE RECORDS	
Method:	Mailing Address/Fax Number/Direct Messaging Address
☐ Mail	
☐ Fax	
☐ Direct Messaging	

FLORIDA MEDICAL CLINIC IS REQUESTING RECORDS FROM			
Name of Entity			
Street address			
City/State		Zip Code	

TYPE OF RECORDS FLORIDA MEDICAL CLINIC IS REQUESTING	
☐Entire record (including sensitive PHI patient signature required)**	☐Most recent history & physical
☐ Entire record (excluding sensitive PHI)**	☐Laboratory results
☐Medication list	☐X-ray and imaging reports
☐Problem list	☐Consultation reports from:
☐List of allergies	☐Visits/Encounters:
☐Immunization records	☐Other (specify):

** Sensitive PHI includes treatment for alcohol or drug use/abuse mental health, psychotherapy, sexually transmitted disease/HIV related information and reportable diseases, & genetic information.

PURPOSE		
☐ Continuity of Care	☐ Transfer of Care	☐ Other

As a covered entity, Florida Medical Clinic, PA is NOT required according to the HIPAA Privacy Rule at 45 CFR 164.501 to obtain the patient's authorization to receive medical records for the purposes of treatment.

If the medical record includes sensitive PHI (see above) the patient's signature must be obtained.

If you have any questions please contact Florida Medical Clinic's Privacy Officer at (352) 567-0188

Patient Signature:	Date:

Revised 10/12/2016

FLORIDA MEDICAL CLINIC, P.A.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact our Privacy Officer at 352-567-0188.

Florida Medical Clinic understands your privacy is important. This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to control your protected health information. Protected health information (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition or payment.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains personal demographic information, your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment;
- Means of communication among the many health professionals who contribute to your care;
- Legal document describing the care you received;
- Means by which you or a third party payer can verify that services billed were actually provided;
- A tool in educating health professionals;
- A source of data for medical research;
- A source of information for public health officials charged with improving the health of the nation;
- A source of data for facility planning and marketing; and
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy;
- Better understand who, what, when, where and why others may access your health information;
- Make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:

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

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522. However, we are not required to agree to the restriction;
- Inspect and copy your health record as provided for in 45 CFR 164.524 and Florida law. Usually this includes medical and billing records, but does not include psychotherapy notes. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- Amend your health record as provided in 45 CFR 164.526. To request an amendment, your request must be in writing and must provide a reason that supports your request. We may deny your request if you ask to amend information that:
    - Was not created by us;
    - Is not part of the medical information kept by FMC;
    - Is not part of the information which you would be permitted to inspect or copy; or
    - Is accurate or complete.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528. To request this list or accounting of disclosures, your request must be in writing and must state the time period which may not be longer than six years and may not include dates before April 13, 2003.
- Request communications of your health information by alternative means or at alternative locations;
- Receive confidential communications of protected health information as provided in 45 CFR 164.522 (b), as applicable;
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- Restrict the release of protected health information to your health plan if you are paying out of pocket in full. 45 CFR 164.522(a)(1)(vi).
- Restrict disclosure related to genetic testing for insurance underwriting purposes.

Copies of the regulations cited above may be requested from the Privacy Officer by calling 352-567-0188.

Our Responsibilities:

Florida Medical Clinic is required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction;
- Accommodate reasonable requests you may have to communicate health information by

alternative means or at alternative locations.

- Notify affected individuals following a breach of unsecured protected health information in writing.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information change significantly, we will post the new notice in each FMC location as well as on our Web site: www.floridamedicalclinic.com. You may also request a copy of our notice at any time.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the FMC Privacy Officer at (352) 567-0188.

If you believe your privacy rights have been violated, you can file a complaint by contacting the FMC Privacy Officer at 352-567-0188 or you may send a written complaint to the Secretary, U.S. Department of Health and Human Services. The FMC Privacy Officer can provide you with the appropriate address upon request. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Care Operations

We will use your health information for treatment. For example, information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Different departments within Florida Medical Clinic may share medical information about you in order to coordinate different services you need, such as prescriptions, lab work and X-rays. We may also disclose medical information about you to people outside FMC who may be involved in your medical care, such as hospitals, long-term care facilities, ambulatory surgery centers or home health agencies.

We will also provide a referring physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you.

We will use your health information for payment. For example, a bill may be sent to you or an insurance company (third party payer). The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

We will use your health information for regular healthcare operations. For example, in day-to-day business practices, trained staff may handle your physical medical record in order to have the record assembled or for filing reports into your record. Certain data elements are entered into our

computer system that processes most billing, schedules your appointments and for statistical reporting. As part of our improvement efforts to provide the most effective services, your record may be reviewed by professional staff to assure accuracy, completeness and organization.

This information may be shared by facsimile transmission.

Other Uses or Disclosures

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include our using an outside transcription service to type physicians' dictated notes or a copy service we may use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. So that your health information is protected, however, we require the business associate to agree in writing to appropriately safeguard your information.

Communication with Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

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 health information.

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

Organ Procurement Organizations: If you are an organ donor, 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.

Fundraising: We will not use or disclose PHI for fundraising purposes.

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.

Workers Compensation: We may disclose health information 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. These programs provide benefits for work-related injuries or illness.

Public Health: As required by law, we may disclose your health information to public health or legal authorities for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births or deaths;
- To report reactions to medications or problems with products;

- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure when you agree or when required or authorized by law.

Correctional Institution: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose to the institution or agents thereof, health information necessary for your health, and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law:

- In response to a court order, valid subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Clinic; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Disaster Relief: We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family or friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

Health Oversight Agency: Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

We will not use or disclose your health information without your authorization, except as described in this notice.

Other Uses and Disclosures of Your Information by Authorization Only

We are required to receive your authorization to use or disclose your PHI for any use other than treatment, payment or health care operations, and those specific circumstances outlined above. We use an Authorization to Use/Disclose form that specifically states what information will be given to whom, for what purpose, and is signed by you or your legal representative. You have the ability to revoke the signed authorization at any time by a written statement given to us to that effect.

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

- Uses and disclosures of PHI for marketing purposes;

- Disclosures that constitute a sale of your Protected Health Information.
- Psychotherapy notes if maintained by the provider.

This Notice of Privacy Practices is effective April 14, 2003, and revised September 1, 2013.

Welcome to the Florida Medical Clinic Patient Portal!

Convenient, safe and secure patient connectivity website that allows you to communicate with your provider office anytime, day or night. Our goal is to be your first choice in patient healthcare, by providing convenience and accessibility to our practice. We are not only committed to offer the best possible medical care to our patients, but we strive to continue to meet the needs of our patients in ways that are convenient for you. This website – your patient portal- is one of the ways we can provide excellent patient care.

The Patient Portal offers our patients online health services that include the ability to request appointments, request medication renewals, view lab results, receive visit summaries, access medical information, and much more. Our newest feature is the ability to do on line bill pay!

Your medical information is available to you on this web-site, and is secure, just as online banking and online stock accounts are secured via the Internet.

If you are currently a patient with our clinic, simply request your secure PIN number today from your participating physician office, go to our website at www.Floridamedicalclinic.com, click on the My Medical Records link, and follow the online instructions to "Get Connected".