Jacksonville Orthopaedic Institute

Authorization to Obtain Medication History

Patient Name:_____

Date of Birth: _____ **Social Security Number:** _____

Address:_____

_____

City: _____ **State:** _____ **Zip:** _____

By signing below, I hereby authorize ***Jacksonville Orthopaedic Institute*** to obtain the Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Jacksonville Orthopaedic Institute may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

_____
Date of Authorization

_____
Print Name: Patient/Legal Representative or Guardian

_____
Signature: Patient/Legal Representative Guardian

AUTHORIZATION FOR DISCLOSURE OF HEALTH CARE INFORMATION

Patient Information

Patient's Name: _____
First Name *Middle Initial* *Last Name*

Other Name: _____

SSN: ___ - ___ - ___ Date of Birth: ___ / ___ / ___
Month *Day* *Year*

JOI Account Number(s): _____ _____ _____
Account Number 1 *Account Number 2* *Account Number 3*

Authorized Individual Information

I hereby give authorization to Jacksonville Orthopaedic Institute to release healthcare information regarding myself, _____, to the party listed below:
Patient's Name

Name: _____
Authorized Individual(s)

Address: _____
Street Address

_____ _____ _____
City *State* *Zip Code*

Authorized Information - This authorization applies to the following selected range(s) of information:

☐ I authorize the release of all information regarding the status of my healthcare, including but not limited to treatment plan(s), & results of radiology tests, to the person listed above.

☐ I authorize the release of all Healthcare information to the person listed above. related to the following treatment, condition, dates, and/or procedure(s):

_____

☐ I authorize the release of my billing and/of financial records to the person listed above

☐ Other
(Please Specify): _____

Protected Healthcare Information (PHI)

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person listed above.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person listed above.

Telephone Contact & Message Authorization

Jacksonville Orthopaedic Institute will attempt to contact you via telephone regarding test results and/or appointments, at the phone number(s) you have provided to us. Please indicate below if you permit JOI to leave voicemail messages containing this information:

☐ I authorize Jacksonville Orthopaedic Institute to contact me by telephone.

☐ **DO NOT** leave a message on my answering machine ☐ Leave a message on my answering machine.

I understand that this authorization shall be valid for **ninety (90) days,** unless I revoke this authorization through written notice to Jacksonville Orthopaedic Institute, P.A. at the address listed above.

Patient or Patient's Representative Signature **Relationship to Patient**

Witness

Authorization Date **Authorization Expiration Date**

Jacksonville Orthopaedic Institute

Patient Demographic Information

Patient Name:_____

Date of Birth: _____

Patient Gender: ☐ **Male** ☐ **Female** ☐ **Refused to Answer**

Please check appropriate responses:

Preferred Language:

☐ **English** ☐ **Spanish** ☐ **Other** _____

Race:

☐ **American Indian/Alaska Native**

☐ **Asian**

☐ **Black / African American**

☐ **Native Hawaiian/Other Pacific Islander**

☐ **White**

☐ **Refused to Answer**

Ethnicity:

☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino** ☐ **Refused to Answer**

Financial Responsibility

Agreement to Pay Charges **JOI Account#_____**

I understand and agree that:

- It is my responsibility to provide accurate insurance information to Jacksonville Orthopaedic Institute (JOI). I understand that as a service to me, JOI will file most insurance and other third party payor claims.
- If the services provided by JOI are not "covered services" or are not "eligible" for payment under either insurance or due to JOI's not being a participating or eligible provider; then I am responsible for payment of JOI's charges connected with such services; provided that JOI is not precluded from imposing such charges by the terms of the agreement to which JOI is bound, or by applicable law or regulation.
- All co-payments, deductibles or, unless otherwise specifically agreed by JOI in writing, outstanding account balances are due and paid at the time of my visit. All charges connected with JOI's services not covered by any insurance coverage are due and payable within 30 days of services rendered. Amounts not paid within such 30 day period shall be deemed to be delinquent and may bear interest at the rate of 1.5% per month (18% per annum). If the delinquent account is referred for collection, I will pay JOI's attorney fees, court costs, and/or collection agency fees associated with the collection process. If litigation results, the amount of such attorney's fees will be determined by a court and not a jury. This Agreement has been executed and delivered in, and shall be interpreted, construed and enforced pursuant to and in accordance with the laws of the State of Florida without regard to choice of law considerations. The state court forum for any litigation shall be in Duval County, Florida, in the court of appropriate jurisdiction, and the federal court jurisdiction will be in the Middle District of Florida in Duval County, Florida.

- **Assignment of Insurance Benefits and Release of Medical Information**
- I hereby:
- Assign to JOI the benefits of all insurance policies otherwise payable to the patient for services rendered.
- Authorize JOI to submit insurance companies with respect to which JOI is a participating provider and to apply proceeds or other third-party payments for covered services to JOI, and to make refunds to insurance companies or other third-party payment plans or rules if refunds are due under the provision of such insurance policies or other third-party payments plans or rules.
- Assign all rights, as the insured, to bring an action against my insurance company for benefits due under the insurance policies or other third-party payor plans or rules.
- Authorize JOI to release information and/or copies of the patient's medical records to any guarantor of payment on my account; any insurance company (including worker's compensation carriers and patient's employer) or other third party payor(s) from which benefits may be available.

By signing my name below, I certify that I have read, understand and agree to the foregoing, received a copy thereof, and am personally empowered, or am duly authorized by the patient, as patient's parent or guardian agent, to execute and enter into this Agreement.

PATIENT	**GUARANTOR**
_____	_____
Patient Name (PRINT)	Unconditional Guarantor DATE (Other than patient or if different from parent/guardian)
_____	_____
Patient's Signature	DATE

_____ _____ _____

Parent or Guardian (PRINT) **Parent or Guardian Signature** **DATE**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Baptist Health and its subsidiary healthcare provider entities. Our Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read our full Notice. You may contact the BH Privacy Officer for further information about the complaint process or for further explanation of this document. The BH Privacy Officer (or his designee) may be contacted at:

Baptist Health Privacy Officer
841 Prudential Drive, Suite 1802
Jacksonville, Florida 32207
904.202.HIPA (4472) *telephone (anonymous reporting)*
904.202.4094 *facsimile*

ACKNOWLEDGEMENT OF RECEIPT: I acknowledge receipt of the *Notice of Privacy Practices* of Baptist Health and its subsidiary healthcare provider entities.

Signature: _____ Date: _____
Patient, Parent or Personal Representative

If other than the patient, specify relationship: _____

If interpreted: _____ _____ _____
Interpreter Signature ***Print Name*** ***Language***

_____ _____
Date ***Position/Relationship to Patient***

FOR STAFF USE ONLY: INABILITY TO OBTAIN ACKNOWLEDGEMENT

If staff is not able to obtain the patient's acknowledgement, record the good-faith effort made to obtain acknowledgement, and the reason acknowledgement was not obtained:

Reason acknowledgement was not obtained:

_ Patient refused to sign

_ Patient unable to sign

_ Other: _____

Staff: _____ _____ _____
Signature *Print Name* *Date*

JOI Beaches

Patient History

Patient Name:_____Age:_____

Which doctor referred you (if any):_____

Date of Onset/Injury/Accident:_____

Where did it happen: (home, school, beach, gym….)_____

Brief description of complaint:_____

Jacksonville Orthopaedic Institute
Jacksonville Beach, Florida

The JOI-Beaches surgeons are pleased to offer orthopaedic care to you and your family. In order to serve you better and expedite our care, we ask that you familiarize yourself with our office protocols outlined below.

Appointments:

- We are happy to fax, mail or email our paperwork to you. It can also be located online at www.joibeaches.com
- Please complete all forms with a black ink pen prior to your visit.
- Please arrive at least 20 minutes ahead of time to process paperwork/IPAD and keep your appointment on time.
- Be certain to bring your insurance cards, social security number, driver's license, & guarantor information.
- Remember to bring all x-rays, MRI's, reports and doctor notes that pertain to your current health issue. Our physician's need these to ensure a thorough medical evaluation and treatment plan.
- Please bring a list of all medications you are taking (dosages included please).

Co-pays, Deductibles and Self Pays

- Co-pays and deductibles are collected at the time of your visit.
- Patients who are 'self pay' are asked to pay in full at the time of service or will be asked to reschedule.

Referrals:

- Some Insurance companies require a referral from your primary care doctor **prior** to an appointment with a specialist. If your insurance company requires an authorization in order for us to see and treat you, and you are unable to secure an authorization before your appointment with us, please notify us immediately. We will gladly reschedule your appointment when the referral is received by our office.

Prescription Requests:

- Please call **at least 24 hours before running out of your medication**. We ask that you leave your first and last name, date of birth, the medication you will need and the ***pharmacy name and phone number*** where you would like the prescription filled.
- Requests may take 24 - 48 hours to process with your pharmacy. Always check with the pharmacy after 6:30 p.m. before attempting to repeat your request to our office.
- **Prescriptions requested on Friday after 12:00 noon will not be processed until the following Monday.**
- **Please note: Our office does not fill prescriptions after hours or on weekends due to medical/legal requirements.**

Voice Mail Messages:

- Our clinical staff is assisting patients during business hours. Please indicate the urgency of your need to our operators. When you are transferred to voicemail leave your first and last name, date of birth, a phone number where you can easily be reached and a detailed message stating your needs.

Completion of Insurance, Disability or Supplementary forms

- Please complete the patient portion of the forms before submitting them to our office.
- Bring the forms to your office visit.
- A $20 pre-pay fee is due ***for each form the office is asked to complete***. This service is not covered by your insurance company.
- Allow 7 - 10 business days to complete a form; additional forms may require extra time. Upon completion, we will gladly fax them to your insurance company.

Medical Record Request:

- In order to be compliant with federal requirements, a signed release form is necessary to obtain your medical record. Forms can be faxed, mailed or picked up at our office.
- Please allow 7 - 10 business days to process.
- A **$10 pre-pay fee is charged for each CD requested** of x-rays.

Calling After Hours:

- **Call 911 for any emergency situation.**
- Please call after hours with urgent matters only.
- Routine matters will be handled the next business day.

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS SUCH INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you receive care or treatment at a hospital or other healthcare facility, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment information, a plan for future care or treatment, identifying information and billing-related information, as recorded by hospital staff, your attending physician(s) and other healthcare providers. This Notice is provided to inform you regarding (i) how Baptist Health and its subsidiary healthcare provider entities set forth at the end of this Notice (collectively, "BH") may use or disclose medical information about you, (ii) with whom medical information about you may be shared, (iii) the safeguards BH has in place to protect medical information about you and (iv) your rights to access and amend medical information about you. For purposes of this Notice, "medical information about you" includes sexually-transmissible disease-related information (including HIV and AIDS), genetic information, alcohol and/or substance abuse information, mental health information and other specially protected health information that may be subject to additional confidentiality protections under applicable State and federal law.

BH is required to maintain the privacy of medical information about you and abide by the terms of this Notice (or the version currently in effect). Independent healthcare providers rendering care or treatment to you at BH, such as independent physicians practicing at BH hospitals, will also abide by the terms of this Notice (or the version currently in effect) with respect to medical information about you concerning care or treatment rendered to you at BH. Accordingly, such independent providers may use and disclose medical information about you concerning care or treatment rendered to you at BH for similar purposes (*e.g.*, their own payment activities) and to the same extent as BH may under the terms of this Notice. Such independent providers may, however, have different policies or notices regarding their use and disclosure of medical information maintained by them concerning care or treatment rendered to you outside of BH. Please note that such independent providers are neither employees nor agents of BH, but are joined under this Notice for the convenience of explaining to you your rights relating to the privacy of medical information about you concerning care or treatment rendered to you at BH.

BH reserves the right to change this Notice in the future. Its effective date is noted at the top of this page. BH reserves the right to make the revised or changed notice effective for health information it already has about you as well as any information it receives in the future. You may obtain a copy of the current version of this Notice at any time in the future by accessing the BH website at*www.baptistjax.com,* contacting the BH Privacy Officer and requesting a copy be mailed to you, or asking for a copy at your next visit to BH. You will be asked to provide a signed acknowledgment of receipt of this Notice. Since BH's intent is to make you aware of the possible uses and disclosures of medical information about you and your privacy rights, the delivery of your health care services will in no way be conditioned upon your signed acknowledgment of this Notice. If you decline to provide a signed acknowledgment, BH will continue to provide your treatment and will use and disclose medical information about you to the extent permitted by applicable law.

USE AND DISCLOSURE OF MEDICAL INFORMATION ABOUT YOU

For Treatment: BH may use medical information about you, as needed, to provide treatment or services to you. BH may disclose medical information about you to, and obtain your medical information from, doctors, nurses, technicians, medical students or other individuals, who are involved in taking care of you. For example, a doctor treating you at another hospital for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Medical information about you may also be shared between various BH facilities and departments in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

BH may also provide your physician or a subsequent healthcare provider with medical information about you (*e.g.*, copies of various reports) that should assist him or her in treating you in the future. BH may also disclose medical information about you to, and obtain your medical information from, Baptist Connect® (BH's own health information exchange) and other

health information exchanges in which you participate or for which you qualify for the purpose of its and the other participating providers' treatment, payment and healthcare operations. Health information exchanges (commonly referred to as HIEs) are electronic health information networks in which community healthcare providers (such as BH) may participate to facilitate the provision of care to patients (such as yourself). Information contained in HIEs may also be analyzed by the participating healthcare providers to improve their respective healthcare operations. BH may also obtain information about you from, or transmit information about you through, electronic equipment and systems, such as medical devices used in your care, video cameras/monitors on BH premises, BH's computer systems and any other applicable technology.

For Payment: BH may use and disclose medical information about you, as needed, to bill and collect payment from you, your insurance company or a third party payer for care or treatment rendered to you. For example, BH may need to give your insurance company information about your surgery so that it will pay BH or reimburse you for treatment provided by BH in connection with such surgery, or BH may need to give your surgeon information about you so that he or she can bill your insurance company for his or her professional services in connection with such surgery. BH may also tell your health plan about treatment you are going to receive to determine whether your plan will cover the cost of it. BH may also use and disclose medical information about you, as needed, to obtain reimbursement from any other entity or program for services or products provided to you by BH. For example, if BH provides a dose of medication to you, and such medication (which is not reimbursed by you or your insurance company) qualifies under a pharmaceutical manufacturer's "drug replacement program," then BH may disclose information about your care to such pharmaceutical manufacturer to the extent necessary to obtain a free or discounted replacement dose of such medication.

For Healthcare Operations: BH may use and disclose medical information about you, as needed, to support the daily activities related to its healthcare services. These activities include, but are not limited to, quality assessment activities; investigations; oversight of staff performance; healthcare education; licensing; fundraising; communications about a product or service, patient satisfaction surveys and focus groups, and conducting or arranging for other healthcare-related activities. For example, BH may disclose medical information about you to medical school students observing patients at BH, may call you by name in a waiting room when the physician or other provider is ready to see you, and may use or disclose medical information about you, as necessary, to contact you to remind you of an appointment. In addition, BH may permit various observers to accompany its staff or independent physicians as they provide care to you and other patients at the above-referenced hospitals. For example, BH may permit various federal, State and local officials or candidates for public office to accompany your physician in the hospital, in order to promote awareness regarding issues facing healthcare providers, such as overcrowding, nurse shortages or the need for additional government funding.

BH may share medical information about you, as needed, with independent "business associates" who perform various activities (for example, billing services, transcriptionists and survey entities) for BH, independent physicians practicing at the above-referenced hospitals or other providers of healthcare services to you. BH's business associates will also be required to protect any medical information BH provides about you. BH may also use or disclose medical information about you, as needed, to provide you with information about treatment alternatives or other health-related benefits and services that might be of interest to you. For example, your name and address may be used to send you a newsletter about BH and the services it offers or to send you information about products or services that BH believes might benefit you.

BH may use limited non-medical information about you (name, address, telephone number, dates of service, age and gender) to contact you in the future to inform you regarding philanthropic opportunities. BH may also disclose such limited information to the Baptist Health System Foundation for the same fundraising purposes. Money raised through such efforts is used to expand and improve the services and programs BH provides to the various Northeast Florida communities BH serves. **If you do not wish your information to be shared for these purposes, please contact the BH Privacy Office as set forth at the end of this Notice.**

BH may use and disclose in its inpatient directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people who ask for you by name. Only members of the clergy will be told your religious affiliation.

BH may disclose to a member of your family, a relative, a close friend or any other person you identify, medical information about you that directly relates to that person's involvement in your care. BH may also disclose information to someone who helps pay for your care. BH may use or disclose medical information about you to notify or assist in notifying a family member, personal representative or any other person who is responsible for your care, of your location, general condition or death. BH may use or disclose medical information about you to an authorized public or private entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your care.

As Permitted or Required by Law: BH may use or disclose medical information about you to the extent permitted or required by applicable law, including but not limited to:

For Public Health: BH may disclose medical information about you to a public health authority who is permitted by law to collect or receive such information. Such disclosure may be necessary to do the following:

- Prevent or control disease, injury, or disability;
- Report births and deaths;
- Report child abuse or neglect;
- Report reactions to medications or problems with products;
- Notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or
- Notify the appropriate government authority if BH believes a patient has been the victim of abuse, neglect, or domestic violence.

Regarding Communicable Disease: BH may disclose medical information about you, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.

For Health Oversight: BH may disclose medical information about you to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. These health oversight agencies may include State and federal government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

For Product Tracking: BH may disclose medical information about you to a person or company required by the Food and Drug Administration (FDA) to do the following:

- Report adverse events, product defects, or problems and biologic product deviations;
- Track products;
- Enable product recalls;
- Make repairs or replacements; or
- Conduct required post-marketing surveillance.

In Legal Proceedings: BH may disclose medical information about you during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized) and, in certain conditions, in response to a subpoena, discovery request, or other lawful process.

For Law Enforcement: BH may disclose medical information about you for law enforcement purposes, including the following:

- Responses to legal proceedings;
- Information requests for identification and location;
- Circumstances pertaining to victims of a crime;
- Deaths suspected from criminal conduct;
- Crimes occurring at BH; or
- Medical emergencies believed to result from criminal conduct.

To Coroners, Funeral Directors and Organ Procurement Organizations: BH may, if applicable, disclose medical information about you to coroners or medical examiners for identification, to determine the cause of death or for the performance of other duties authorized by law. BH may also disclose medical information about you to funeral directors, and to organ procurement organizations to facilitate cadaveric organ, eye, or tissue donations.

For Research: BH may use medical information about you or disclose medical information about you to researchers when authorized by law. For example, BH may disclose information about you to a researcher pursuant to an institutional review board (IRB) or privacy board approved protocol or retrospective review request that has been determined to pose minimal risk to your privacy.

For Health, Safety and National Security: BH may disclose medical information about you, in accordance with State and/or federal law, if it believes that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to the

health or safety of a person or the public. BH may disclose medical information about you if it is necessary for law enforcement authorities to identify or apprehend an individual. BH may also disclose medical information about you to authorized federal officials for conducting national security and intelligence activities.

Regarding Workers' Compensation: BH may disclose medical information about you to comply with workers' compensation laws and other similar legally-established programs.

Regarding Inmates: If you are an inmate of a correctional facility, BH may use or disclose medical information about you to such facility.

Other Uses: Uses and disclosures of your health information not covered by the Notice or otherwise permitted by applicable federal or state laws will be made only with your written authorization. In addition, BH must have your authorization to release psychotherapy notes, to release your information for marketing purposes or to sell your personal information for any purpose. If you authorize BH to use or disclose your health information, you may revoke that permission, in writing, at any time by contacting Health Information Management at the hospital you visited or at your physician or other healthcare provider's office.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You may exercise the following rights by submitting a written request to the BH Privacy Officer. Please be aware, however, that BH might deny your request, when legally permitted to do so.

Right to Inspect and Copy: For as long as BH maintains medical information about you, you may inspect and obtain (for a reasonable, cost-based fee) a copy of medical information about you contained in certain medical and billing records maintained by BH. This right does not include inspection and copying of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and medical information about you that is subject to a law that prohibits access to medical information about you.

Right to Request Restrictions: You may ask BH not to use or disclose medical information about you for treatment, payment, or health care operations (as described in this Notice). Your request must be submitted in writing to the BH Privacy Officer. In your request, you must specifically state (i) what information you want restricted; (ii) whether you want to restrict BH's use, disclosure, or both; (iii) to whom you want the restriction to apply, for example, disclosures to your spouse; and (iv) an expiration date. If BH believes that the restriction is not in the best interest of either party, or BH cannot reasonably accommodate your request, BH is not required to agree. If the restriction is agreed to by BH, BH will not use or disclose medical information about you in violation of that restriction, unless it is needed to provide emergency treatment. You may revoke a previously agreed upon restriction, at any time, in writing. Contact Health Information Management at the hospital you visited or the office manager at your physician or other healthcare provider's office to request a restriction.

Right to Restrict Certain Health Information: You may ask BH not to disclose information about you for payment purposes if: (i) the restriction is not otherwise prohibited by law, (ii) the disclosure is to a health plan for purposes of carrying out payment or healthcare operations, (iii) the information pertains solely to a service or healthcare item for which you paid out of pocket in full, and (iv) you made the request in writing prior to the information being released. Contact Patient Financial Services at 904.202.2092 or the office manager at your physician or other healthcare provider's office to exercise this right.

Right to Request Confidential Communications: You may request that BH communicate with you using alternative means (*e.g.*, e-mail) or at an alternative location (*e.g.*, post office box). BH will not ask you the reason for your request, and will accommodate reasonable requests, when possible. If you request communication via unencrypted e-mail, please be aware that receiving or forwarding unencrypted e-mail could make that communication vulnerable to third party interference.

Right to Request Amendment: If you believe that the information BH maintains about you is incorrect or incomplete, you may request an amendment to such information. While BH will accept requests for amendment, BH is not legally required to agree to an amendment.

Right to an Accounting of Certain Disclosures: You may request that BH provide you with an accounting of certain disclosures it has made of medical information about you. This right applies to disclosures made for purposes other than treatment, payment or health care operations (as described in this Notice). To be accountable, the disclosure must have been made after April 14, 2003 and no more than 6 years from the date of your request. This right excludes disclosures made to you, for a BH directory, to family members or friends involved in your care or for notifications required by law (including

disclosures for law enforcement, national security or intelligence purposes). The right to receive this information is subject to additional exceptions, restrictions, and limitations as described earlier in this Notice.

Right to Obtain a Copy of this Notice: You may obtain a paper copy of this Notice (or the version currently in effect) from BH or view it electronically via the BH website at *www.baptistjax.com*.

PRIVACY LAWS

This Notice is provided to you as a requirement of the rules created under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). There are several other State and federal privacy laws that also apply to medical information about you including the Freedom of Information Act, the Privacy Act and the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act. To the extent not preempted by HIPAA, BH has taken such laws into consideration in developing its privacy policies and this Notice.

COMPLAINTS

If you believe BH has failed to comply with this Notice or that BH has violated these privacy rights, you may file a written complaint with the BH Privacy Officer (and if your complaint involves a non-BH provider governed by this Notice, the BH Privacy Officer will forward your request to such provider's Privacy Officer) or the Department of Health and Human Services. BH will not retaliate against you for filing a complaint. If BH determines that your privacy rights have been violated, you will be notified by the BH Privacy Officer (or his designee).

CONTACT INFORMATION

You may contact the BH Privacy Officer for further information about the complaint process or for further explanation of this document. The BH Privacy Officer (or his designee) may be contacted at:

Baptist Health Privacy Officer
841 Prudential Drive, Suite 1802
Jacksonville, Florida 32207
904.202.HIPA (4472) *telephone (anonymous reporting)*
904.202.4094 *facsimile*

To contact Health Information Management at any BH hospital, call 904.202.2000, then ask for HIM at the location you visited.

COVERED ENTITIES

All BH subsidiary healthcare providers are covered by this Notice, including, but not limited to the following:

Baptist AgeWell Institute
Baptist Behavioral Health
Baptist Emergency Center Clay
Baptist Endocrinology
Baptist ENT Specialists
Baptist Heart Specialists
Baptist Home Health Care
Baptist Infectious Diseases
Baptist Infusion Therapy
Baptist Medical Center Beaches
Baptist Medical Center Jacksonville
Baptist Medical Center Nassau
Baptist Medical Center South
Baptist Neurology Group
Baptist Obstetrics and Gynecology
Baptist Occupational Health
Baptist Pediatrics
Baptist Pharmacy Beaches
Baptist Pharmacy Children's
Baptist Pharmacy Lane Avenue
Baptist Pharmacy Nassau
Baptist Pharmacy Pavilion
Baptist Pharmacy San Marco
Baptist Pharmacy South
Baptist Primary Care
Baptist Pulmonary Services
Baptist Respiratory Services
Baptist Rheumatology
Baptist Urology Group
Jacksonville Orthopedic Institute
Lyerly Baptist
Psychiatric & Psychological Care
Wolfson Children's Hospital
Wolfson Children's Specialty Center