SILVER CITY
HEALTH CENTER
An Affiliate of KU HealthPartners

Patient Information Form for Child

PATIENT INFORMATION

Patient Name: _____ D.O.B. _____

Address: _____ City: _____ State: _____ Zip _____

Home #: _____ Cell #: _____ Work #: _____

SS#: _____ M F Email: _____

EMERGENCY CONTACT

Name: _____ *Phone #:* _____ *Relationship:* _____

Is the reason you need medical care for a result of an accident? Y/N Is the injury work related? Y/N

Please circle the following for the patient:

RACE: American Indian or Alaska Native Black or African American White Asian
Native Hawaiian or Other Pacific Islander Other Prefer not to Answer

ETHNICITY: Hispanic/Latino Not Hispanic/Latino Other _____

PREFERRED LANGUAGE: English Spanish Other: _____

PARENT's INFORMATION

Biological Mother's Name: _____ D.O.B. _____

Address: _____ City: _____ State: _____ Zip _____

Home #: _____ Cell #: _____ Work #: _____

SS#: _____ Email: _____

Biological Father's Name: _____ D.O.B. _____

Address: _____ City: _____ State: _____ Zip _____

Home #: _____ Cell #: _____ Work #: _____

SS#: _____ Email: _____

PARENT's MARITAL STATUS: Please circle the one that applies

Married- Living together *Never Married- Living together*

Single-Never Married *Married-Currently Separated*

Divorced *Widowed* *Other* _____

31/03/2016

Patient Name: _____

Please list the persons who live in the household with patient:

LAST NAME *FIRST NAME* *DOB* *RELATIONSHIP TO CHILD*

_____

_____

_____

_____

GUARANTOR INFORMATION: (The person financially responsible for the patient). If different from person listed above or if the patient is a minor, please complete the following:

Please circle Relationship to patient: Parent Legal Guardian Other _____

Name: _____ D.O.B. _____

Address: _____ City: _____ State: _____ Zip _____

Home #: _____ Cell #: _____ Work #: _____

SS#: _____ M F Email: _____

INSURANCE INFORMATION: If you do not have medical insurance please complete the Request for Discounted Services. You must provide proof of income, proof of residence, and a photo I.D. A list of acceptable documents will be provided.

Primary Insurance: Insurance Plan Name: _____ Policy ID# _____

Group #: _____ Relationship to patient: Self Spouse Child Other _____

Subscriber Name: _____ DOB _____

Secondary Insurance: Insurance Plan Name: _____ Policy ID# _____

Group #: _____ Relationship to patient: Self Spouse Child Other _____

Subscriber Name: _____ DOB _____

PRINTED NAME OF PERSON COMPLETING THIS FORM: _____

Relationship to patient: _____

Signature: _____ Date: _____

31/03/2016

KU SILVER CITY HEALTH CENTER
1428 SOUTH 32ND ST SUITE 100
KANSAS CITY, KS 66106

DATE_____

NAME_____ DOB_____
ADDRESS_____ PHONE#_____

Have you ever been seen in our office before? YES/NO Referred by_____

Father_____	DOB___/___/____	Health_____
Mother_____	DOB___/___/____	Health_____
Siblings_____	DOB___/___/____	Health_____
_____	DOB___/___/____	Health_____
_____	DOB___/___/____	Health_____

Other persons living in the home_____

Birth History: Birth Weight_____ Birth Length_____ Mother's Total # of Pregnancies____
Number of this child____ Number of miscarriages____ Vaginal delivery or C-section (Circle One)

Any problems during pregnancy?_____
Any problems during newborn period? Jaundice? Oxigen given?_____

PAST HISTORY Hospitalizations_____
Surgeries: Ear tubes, Tonsils/Adenoids, Appendix, Hernia (Circle if Appropriate)
Other_____
Broken bones/Major accidents_____
Other Health Problems_____

CURRENT MEDICATIONS_____
_____
ALLERGIES (MEDICATION)_____**OTHER**_____

DEVELOPMENT
Has your child done things at the same age as other children? YES/NO
Do you have concerns about your child's development? YES/NO

FAMILY HISTORY-Any one within 2 generations (parents,grandparents, aunts, uncles,siblings,cousins)
(Cirlce any that apply)

High Blood Pressure	Learning Problems	Mental Illness	Anemia
Emotional Problems	High Cholesterol	Seizures/Epilepsy	Allergies
Heart Attack/Stroke	Inherited Disease	Birth Defects	Cancer
Crib Death/SIDS	Arthritis	Asthma	Diabetes

ENVIRONMENT

Car seat/belts used routinely	YES/NO	Any guns at home	YES/NO
Do you have furnace checked yearly	YES/NO	Any foreign travel	YES/NO
Does either parent smoke	YES/NO	Can your child swim	YES/NO
Daycare or Mother's day out	YES/NO		

MEDICAL HISTORY QUESTIONNAIRE

SCHOOL AGE CHILDREN **ADOLESCENTS (10 YEARS AND OLDER)**

Grade_____School_____Number of days missed last year?_____

Do you feel your child has a problem with:(check all that apply)

Getting along at school__ Getting along with class mates____ Getting along at home____
Tantrums/Breathholding_ Paying attention____ Sexuality____ Drugs and Alcohol_____
Any bedwetting__ Mood Swings_____ Dating_____ School performance_____
Any special classes_____

REVIEW OF SYSTEMS (PLEASE INDICATE ANY PERSONAL HISTORY BELOW)

CONSTITUTIONAL SYMPTOMS	
Good general health lately	Yes/No
Weight gain or loss	Yes/No
Chane in appetite	Yes/No
Fever/night sweats	Yes/No
Weakness/falling	Yes/No
Headaches	Yes/No
Feeling tired	Yes/No
EYES	
Eye disease or injury	Yes/No
Wear glasses/contacts	Yes/No
Blurred or double vision	Yes/No
EARS/NOSE/THROAT	
Problems hearing or ear ringing	Yes/No
Ear pain or drainage	Yes/No
Sinus problems	Yes/No
Nose bleeds	Yes/No
Mouth sores	Yes/No
Sore throat or voice change	Yes/No
Swollen glands in neck	Yes/No
CARDIOVASCULAR	
Heart disease	Yes/No
Chest pain	Yes/No
RESPIRATORY	
Chronic or frequent cough	Yes/No
Exposure to tuberculosis	Yes/No
Shortness of breath	Yes/No
Asthma or wheezing	Yes/No
GASTROINTESTINAL	
Change in bowel movements	Yes/No
Change in stools/loose stools	Yes/No
Nausea	Yes/No
Pain with bowel movements	Yes/No
Constipation	Yes/No
Rectal bleed/blood in stool	Yes/No
Abdominal pain	Yes/No
ENDOCRINE	
Hormone problem	Yes/No
Thyroid disease	Yes/No
High Cholesterol	Yes/No
Diabetes (insulin/non insulin)	Yes/No
Increased thirst or urination	Yes/No
Feeling hot or too cold	Yes/No

ALLERGIC/IMMUNOLOGIC	
Allergic reaction to penicillin	Yes/No
Allergic reaction to vaccinations	Yes/No
Allergic reaction to other medicines	Yes/No
Allergic reactionor other antibiotics	Yes/No
Food allergies	Yes/No
Other allergies	Yes/No
GENITOURINARY	
Urination too often	Yes/No
Burning or pain with urination	Yes/No
Awaken at night to urinate	Yes/No
Change in force of stream when urinating	Yes/No
Poor bladder control or dribbling	Yes/No
Female pain with periods	Yes/No
Male testicle pain/lumps	Yes/No
MUSCULOSKELETAL	
Joint pain	Yes/No
Joint stiffness or swelling	Yes/No
Weakness of muscles or joints	Yes/No
Back pain	Yes/No
Difficulty in walking	Yes/No
Broken bones	Yes/No
INTEGUMENTARY (SKIN, BREAST)	
Rash or itching	Yes/No
Change in skin color	Yes/No
Breast lump or pain	Yes/No
NEUROLOGICAL	
Headaches often	Yes/No
Lightheaded or dizzy	Yes/No
Convulsions or seizures	Yes/No
Numbness or tingling sensations	Yes/No
Paralysis	Yes/No
Head injury	Yes/No
PSYCHIATRIC	
Feeling confused/forgetting things	Yes/No
Feeling scared or upset	Yes/No
Feeling sad	Yes/No
Trouble sleeping	Yes/No
HEMATOLOCIC	
Slow to heal after cuts	Yes/No
Bleeding or bruise easily	Yes/No
Anemia/Swollen glands/Transfusion	Yes/No

KU HEALTHPARTNERS
The University of Kansas

Authorization

Consent for Medical Treatment: I consent to treatment as deemed necessary and appropriate by clinical providers of KU HealthPartners, Inc.

Date _____ Patient Signature _____ Witness Signature _____

Printed Full Name _____

Patient Name (if different from above) _____

Consent for Use and Disclosure of Health Information for Treatment, Payment and Operations

By signing below, I consent to the use and disclosure of my protected health information by KU HealthPartners, Inc., its staff and business associates for the purposes of treatment, payment and health care operations. My protected health information includes any information that reasonably identifies me and relates (1) to the provision of healthcare to me, (2) to any of my past, present or future health conditions, or (3) to the past, present or future payment for any provision of healthcare to me. The information that is protected includes information related to my physical or mental health.

I understand that I have the right to request that KU HealthPartners restrict its uses and disclosures of my protected health information that KU HealthPartners is otherwise permitted to make for treatment, payment and health care operations. KU HealthPartners however, is not required to agree to these restrictions. Nevertheless, if KU HealthPartners agrees to any restrictions, those restrictions are binding on it. Finally, I understand that I have the right to revoke this consent in writing, except to the extent that KU HealthPartners has acted in reliance on it.

Date _____ Patient Signature _____ Witness Signature _____

Social Security _____ Printed Full Name _____

Patient Name (if different from above) _____

Assignment of Benefits to KU HealthPartners, Inc.

I certify that the information I have given to KU HealthPartners is true and correct to the best of my knowledge. I promise to pay to KU HealthPartners all charges and expenses for services provided to me by KU HealthPartners in accordance with its current fees and charges to the extent that those fees and charges are not covered or paid by my insurance or by another payment source such as Medicare or Medicaid. I request that payment of authorized benefits under any private or government insurance program that covers me, including the Medicare program, be made on my behalf to KU HealthPartners for any services furnished to me by KU HealthPartners. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine my Medicare benefits, if any, for services furnished by KU HealthPartners. KU HealthPartners may pursue collection of these benefits in my name or in the name of KU HealthPartners. I also authorize the use of a copy of this authorization in place of the original. I understand that possession of medical insurance does not relieve me of financial responsibility to KU HealthPartners. I will personally be responsible for all charges for services that are not covered by my health insurance provider.

Date _____ Patient Signature _____

This Consent must be signed by the patient, by a parent of a minor, or by a guardian if the patient is incapacitated.

Confidential Communications Request Form

*Pt. Name*_____

*MRN*_____

KU HealthPartners, Inc. Silver City Health Center
1428 South 32nd Street, Suite 100
Kansas City, KS 66106

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. KU HealthPartners Inc. will do its best to accommodate all reasonable requests.

I, _____(print name), SS#_____
request the use of certain methods for the confidential communication of information related to my personal health, treatment or payment for treatment:

Alternate Phone Number:_____

Alternate Address:

Street _____ City _____

State_____ Zip Code _____ E-mail address _____

Description of special communication methods to be used or prohibited:

Approved Communication	Type of Communication
o Voice Mail/Cell	o Lab Results
o Answering Machine	o Radiology Results
o Spouse _____	o Medication Instructions
o Other: _____	o Other Instructions:_____

_____ _____
Signature of patient or patient's Personal Representative Date

Please do not write below this line.

- ☐ The terms of this request will not be complied with.
- ☐ The terms of this request can be complied with as requested.
- ☐ The terms of this request can be complied with if the following modification is agreed to.

_____
_____
_____
_____

Patient's Signature Approving Modification: _____ Date:_____

KUHP Employee Name:_____ Signature:_____ Date:_____

This decision may be reviewed and modified by Privacy Officials of the KU HealthPartners Inc. and/ or K. U. Medical Center Organized Health Care Arrangement.
The original of this form will be kept in the patient's Designated Medical Record.

3901 Rainbow Boulevard Kansas City, Kansas 66160 **The University of Kansas Medical Center Notice of Privacy Practices**	Do not write in this box 	Name:_____ DOB:_____ MR#_____

I have been offered the Notice of Privacy Practices for KU Medical Center Organized Health Care Arrangement

Me han ofrecido el Aviso sobre las Normas de Privacidad del KU Medical Center Organized Health Care Arrangement

Мне было предложено "Заявление о правилах конфиденциальности" **Медицинского центра Канзасского университета** Обеспечение организованных медицинских услуг

के यू चिकित्सकीय केन्द्र संगठित स्वास्थ्य सेवा व्यवस्था (KU Medical Center Organized Health Care Arrangement)-मा गोपनीयतासम्बन्धी प्रयोगमा ल्याइने प्रक्रिया बारे मलाई जानकारी उपलब्ध गराइयो

_____

Signature (*Firma*) (*Подпись*) हस्ताक्षर

_____

Date (*Fecha*) (*Дата*) तारिख

FOR TREATMENT OF A MINOR CHILD

I, _____, of city
(Name)

_____, county _____ state _____, do hereby state that I am

the parent or legal guardian of _____,
(Name)

a minor, age _____ born _____ who resides with me at

_____.
(Street Address) (City) (State)

I authorize _____, an adult who
(Name)

resides at _____ in the city
(Street Address)

of _____ county of _____ state of _____ to consent to:

☐ Vaccinations

☐ Well-child care visits

☐ Any necessary examination, anesthetic, medical diagnosis, surgery, treatment, and/or hospital care to be rendered to the above-named minor under the general or direct supervision and on the advice of any physician or surgeon licensed to practice medicine in the state(s) where the care is to be provided.

This authorization will expire one year from the date this form is signed, unless otherwise specified below.

Signature of parent or guardian _____

Signature of adult witness _____

Dated this _____ day of _____, 20____.
(Month) (Year)

I authorize use of this form from _____, 20____,
(Date) (Year)

to _____, 20____.
(Date) (Year)

SILVER CITY
HEALTH CENTER
An Affiliate of KU HealthPartners

Silver City Health Center
1428 S. 32nd St., Suite 100, Kansas City, KS 66106
Phone :(913) 945-7300; Fax :(913) 945-7350
www.silvercityhealthcenter.org

Patient Rights and Responsibilities

As a patient of Silver City Health Center, you have the right to:

- Dignity and respect when you are at our clinic.
- Quality medical care, no matter what your gender, age, cultural, educational, or religious background.
- Privacy. Your medical record is kept private. We do not share information about you without your permission.
- Information about your clinic tests and procedures.
- Review your medical and dental records. Our medical provider will help you do this.
- Request medical records from other clinics. You can also ask for a transfer of records from our clinic to other clinics.
- Know about possible side effects of treatment.
- Ask for another medical provider within the clinic.
- Consent to or refuse any care or treatment.
- Make suggestions and tell us your concerns about our services.

You have the responsibility to:

- Be honest about your medical history.
- Tell us if you don't understand our explanations, advice, and instructions.
- Follow health advice and medical instructions.
- Respect our clinic policies and procedures.
- Keep your appointments. If you can't keep an appointment, you must cancel or reschedule it at least 24 hours in advance.
- Tell us if your health changes from the last time we talked with you.
- Tell us if there is a change in your address, telephone number or health insurance.

We welcome your suggestions, concerns, and complaints. Please let us know how we can improve our services to you. All information is kept confidential.

- By Phone: Mary Icenogle, RN, Clinic Nurse Manager, at (913) 945-7300.
- Send us a letter to: Silver City Health Center, 1428 S. 32nd St., Suite 100, Kansas City, KS 66106.

Patient Signature: _____ Date: _____

Silver City Health Center

NOTICE OF PRIVACY PRACTICES

Revised: June 15, 2014

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.

You may call the Patient Relations office if you have questions about this Notice. The number is (913) 588-1290.

Who Will Follow This Notice

The KU Medical Center is made up of the health care providers listed below. To serve you better, we give you this Notice about our privacy practices and your privacy rights. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) guarantees your privacy rights. Each provider will follow the terms of this Notice. This Notice applies to our various sites of service. If you ask, we will give you a list of our sites that are subject to this Notice.

The KU Medical Center includes:

- The University of Kansas Hospital (its affiliates, including: Mid-America Cardiology, Inc.; Mid-America Cardiothoracic Surgeons, Inc.; Ambulatory Surgery Center, LLC; Jayhawk Primary Care, Inc.; and The University of Kansas Cancer Center),
- The University of Kansas Medical Center,
- The University of Kansas Physicians, and affiliated Clinical Foundations, and
- KU HealthPartners, Inc.

These providers include their employees, staff, trainees, volunteer groups and other health care workers.

We may share medical information with each other for treatment, payment and operational purposes. The law allows us to do so to provide efficient health care services.

Important Disclaimer

The above providers are giving you this joint Notice. Each provider in this joint Notice is its own health care provider. Each provider is individually responsible for its own activities. This includes complying with privacy laws and all health care services it provides. We are not providing health care services mutually or on each other's behalf. We may share health information as allowed by law.

Our Pledge Regarding Medical Information

We know that your medical information is personal. We will protect your medical information. We create a record of the care and services you receive at KU Medical Center. We need this record to give you complete and comprehensive care. We also need this record to comply with the law. This Notice applies to records we create for your care at KU Medical Center.

This Notice tells you about the ways that we may use and share your medical information. It also describes your rights.

We are required by law to:

- make sure that medical information that identifies you is kept private,
- give you this Notice of our legal duties and privacy practices concerning your medical information, and
- follow the terms of this Notice currently in effect.

How We May Use and Share Your Medical Information

We may use and share your medical information as listed below. Not every possible use or disclosure will be listed. However, all of the ways we may use and share information falls into one of these areas.

- **For Treatment.** We may use your medical information to give you medical care. We may share your medical information with doctors, nurses, technicians, students or other KU Medical Center workers. For example, departments may share your medical information to plan your care. This may include prescriptions, lab work, and x-rays. We may share your medical information with people not at KU Medical Center. This may include referring physicians and home health care nurses who are treating you.

- **For Payment.** We may use and share your medical information with your insurance plan or others who help pay for your care. For example, we may tell your health plan about a treatment you are going to receive. We do this to find out if your plan will pay for the treatment.

- **For Health Care Operations.** We may use and share your medical information for our operations. These uses and disclosures help us run our programs and make sure our patients receive quality care. For example, we may use medical information to review our treatment and services. We may use medical information to measure the performance of our staff and how they care for you. We may share medical information with doctors, nurses, technicians, students, and other health care workers for teaching purposes or preparatory to research.

- **Business Associates.** We may contract with outside businesses to provide some services for us. For example, we may use the services of transcription or collection agencies. Under such contracts, we may share your medical information with them to do the job we have asked them to do. These contracts require businesses to protect the medical information we share with them and to provide you with access to your medical information and a list of any of your medical information that they disclose.

- **Appointment Reminders.** We may contact you to remind you about your appointment for medical care.

- **Treatment Alternatives.** We may use and share medical information to tell you about different types of treatment available to you. We may use and share medical information to tell you about other benefits and services related to your health.

- **Hospital Directory.** We may include limited information about you in the hospital directory while you are a patient in the hospital. This information may include your name, location in the hospital, general condition (fair, stable, etc.), and religion. We may share the directory information, except for religion, with people who ask for you by name. We provide this service so your family, friends and others close to you can visit you and generally know how you are doing. If you do not want people to know that you are in the hospital, we will not share this information. You must let the Admitting Department know that you do not want this information to be shared. Call the Admitting Department at (913) 588-7431 if you do not want this information to be shared.

- **People Involved In Your Care.** Unless you ask us not to, we may share your medical information with a family member or friend who helps with your medical care. We may share your medical information with a group helping with disaster relief efforts. We do this so your family can be told about your location and condition. If you are not present or able to say no, we may use our judgment to decide if sharing your information is in your best interest.

- **Research.** As an academic medical center, we may use and share your medical information for research. We may share your medical information with 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 medical information. We may also share your medical information with people preparing to conduct a research project. We may also use and

share your medical information to contact you about the possibility of enrolling in a research study.

- As Required By Law. We will share your medical information when required to do so by federal, state or local law.

- Fundraising Activities. We may use your information to contact you for efforts to raise funds for KU Medical Center. We may share your information with foundations and other entities related to KU Medical Center. Such foundations or entities may contact you to raise funds. For example, you may get invitations to fundraising events. You may get annual reports and other types of mailings for programs to raise funds. We may share contact information. We may also share the following types of information: dates of service, treating physician and department, outcome and health insurance status. You may call KU Endowment at (913) 588-5249 or the Hospital Fund Development office at (913) 588-2800 if you do not want us to contact you for KU Medical Center fundraising purposes.

- To Prevent A Serious Threat To Health Or Safety. We may use and share your medical information to prevent a serious threat to your health and safety and that of others. We will only share your medical information with persons who can help prevent the threat.

How We May Use and Share Your Medical Information
Special Situations

- Organ and Tissue Donation. We may share medical information with groups that handle and monitor organ donations and transplants.

- Military. If you are in the U.S. or foreign armed services, we may share your medical information as required by the proper military authorities.

- Workers' Compensation. We may share your medical information for workers' compensation or programs like it. We may do this to the extent required by law.

- Public Health Risks. We may share your medical information for public health activities. We may do so as required by law. For example, we may share your medical information:
  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medicines or problems with products;
  - to tell you about product recalls;
  - to tell you if you have been exposed to a disease or may be at risk for catching or spreading a disease or condition; and
  - to tell the proper government department if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only share this information when ordered or required by law.

- Health Oversight Activities and Registries. We may share your medical information with government agencies that oversee health care. We may do so for activities approved by law. For example, these activities include: audits, investigations, inspections and licensure surveys. The government uses these activities to monitor the health care system. It also monitors the outbreak of disease, government programs, compliance with civil rights laws, and patient outcomes. We may share medical information with government registries.

- Lawsuits and Disputes. If you are in a lawsuit or a dispute, we may share your medical information in response to a court order, legal demand or other lawful process.

- Law Enforcement. We may share medical information if asked to do so by a law enforcement official:
  - to report certain types of wounds;

- to respond to a court order, 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 victim's agreement;
- about a death we believe may be caused by a crime;
- about suspected crimes on our premises; 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 may have committed the crime.

- **Coroners, Medical Examiners and Funeral Directors.** We may share medical information with a coroner or medical examiner. For example, we may do this to identify a deceased person or to determine the cause of death. We may share medical information with funeral directors as necessary to carry out their duties.

- **National Security.** We may share your medical information with the proper federal officials for national security reasons.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

- **Right To Access and To Receive Copies.** You have the right to look at and to receive copies of the medical information used to make decisions about your care, including information kept in an electronic health record, and/or to tell us where to send the information. Usually, this includes medical and billing records. It does not include some records such as psychotherapy notes.

  To look at and to receive copies of medical information used to make decisions about you, you must submit your request in writing. We may charge a fee for the costs of processing your request. If the copies provided are in an electronic form, we can only charge you for our labor costs. Call Release of Information at (913) 588-2454 to get more details.

  In some limited cases, we may say no to your request, such as a request for psychotherapy notes. You may ask that such a decision be reviewed. To ask for a review, contact Patient Relations at (913)588-1290.

- **Right To Amend.** You have the right to ask for an amendment of your protected health information or your record. To ask for a change to your record, you must make your request in writing and submit it to the Director of Medical Records; 3901 Rainbow Blvd.; Kansas City, KS 66160. Also, you must give a reason that supports your request.

  We may say no to your request for an amendment to your record. We may do this if it is not in writing or does not include a reason to support the request. We also may say no to your request if you ask us to amend information that:
  - we did not create, unless the person or entity that created the information is no longer available to make the amendment;
  - is not part of the records used to make decisions about you;
  - is not part of the information which you are permitted to inspect and to receive a copy; or
  - is accurate and complete.

- **Right To an Accounting of Disclosures.** You have the right to get a list of the disclosures we made of your medical information including medical information we maintain in an electronic health record. This list may not include all disclosures that we made. For example, this list will not include disclosures that we made for treatment, payment or health care operations purposes.

  You have the right to request a list of disclosures from us and any of our business associates. Any accounting will not include disclosures made before April 14, 2003, or disclosures you specifically approved.

To ask for this list you must submit your request in writing on the approved form. We will give the form to you upon request.

- Right To Request Restrictions. You have the right to ask for a restriction or limitation on the medical information we use or share for treatment, payment or health care operations. In addition, you have the right to request that we restrict disclosure of your medical information if the disclosure is to a health plan for the purpose of carrying out payment or health care operations (and is not for the purpose of carrying out treatment) and the medical information pertains solely to a health care item or service for which you have paid out of pocket in full. You also have the right to ask for a limit on the medical information we share with someone who is involved in your care or in the payment for your care. Such a person may be a family member or friend. We do not have to agree to your request. If we do agree, we will fulfill your request unless the information is needed to provide you with emergency treatment.

  To ask for restrictions, you must make your request in writing on a form that we will give you upon request. You must tell us:
  - what information you want to limit,
  - how you want us to limit the information, and
  - to whom you want the limits to apply.

- Right To Request Confidential Communications. You have the right to ask us to communicate with you about medical matters in a certain way or at certain places. You must make your request in writing on a form that we will give you upon request. We will fulfill all reasonable requests.

- Right To a Paper Copy of This Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to get this Notice electronically, you still have a right to a paper copy of this Notice.

Revisions To This Notice

We may update this Notice to show any changes in our privacy practices. We reserve the right to make the updated Notice effective for medical information we already have about you. It also will be effective for any information we receive in the future. We will post a copy of the current Notice in the places where you receive services. The effective date of this Notice is on the first page, in the top, right-hand corner.

Complaints

If you think your privacy rights have been violated, you may file a complaint with KU Medical Center or with the Secretary of the Department of Health and Human Services. If you want to file a complaint with KU Medical Center, contact the Privacy Officials of KU Medical Center through the office of Patient Relations at (913) 588-1290. You will not be penalized for filing a complaint.

Notification of Breach

We will keep your medical information private and secure as required by law. If any of your medical information which is acquired, accessed, used or disclosed in a manner that is not permitted by law we will notify you within 60 days following the discovery of a breach.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or by other laws that apply to us will be made only with your written permission. The following is a description of some situations, but not all, where our use and disclosure of your medical information will require your written permission:

- Psychotherapy Notes. Most uses and disclosures of your psychotherapy notes will require your written permission. Generally speaking, psychotherapy notes are notes that are made by a mental health professional documenting or analyzing the contents of his or her conversations with you during a counseling session and that are kept separate from the rest of your medical record.

- **Marketing Purposes.** Subject to limited exceptions, uses and disclosures of your medical information for marketing purposes will require your written permission.

- **Sale of Medical Information.** Disclosures that would constitute the sale of your medical information will require your written permission.

If you give your permission to use or share your medical information, you may cancel that permission, in writing, at any time. If you cancel your permission, we will no longer use or share your medical information for the reasons covered by your written permission. We cannot take back any disclosures we have already made with your permission. We are required to keep records of the care that we provided to you.

Your Rights Regarding Electronic Health Information Exchange

KU Medical Center participates in the electronic exchange of health information with other healthcare providers and health plans through an approved health information organization (HIO). Through our participation, your PHI may be accessed by other providers and health plans for the purposes of treatment, payment, or health care operations. The approved HIO is required to maintain safeguards to protect the privacy and security of PHI. The approved HIO may only allow authorized personnel to access PHI through the HIO.

Under Kansas law, you have the right to decide whether providers and health plans can access your health information through an HIO. You have two choices. First, you can permit authorized individuals to access your PHI maintained through an HIO for treatment, payment, or health care operations. If you choose this option, you do not have to do anything.

Second, you can restrict access to your PHI maintained through an HIO. To do so you must submit a request to opt out of HIE through the Kansas Health Information Exchange, Inc. (KHIE), which can be done by visiting http://www.kanhit.org. For more information on how to opt out, call the KHIE Support Center at (785) 296-0461. You can restrict KUMC from making your PHI available to the HIO by following instructions at the section above, "Right to Request Restrictions". Even if you restrict access through (or opt out of participating in) an HIO, providers and health plans may share your information through already available other legal means without your specific authorization.

Please understand your decision to restrict access to your electronic health information through an HIO may limit your health care providers' ability to provide the most effective care for you. By submitting a request for restrictions, you accept the risks associated with that decision.

END