LANE COUNTY BEHAVIORAL HEALTH &
COMMUNITY HEALTH CENTERS OF LANE COUNTY

New Patient Registration Form: ADULTS **Please complete the entire form**

Patient Information

Last Name **First Name** **Middle Name** **Nickname** (Preferred Name)

Today's Date: _ _ / _ _ / _ _ _ _	**Date of Birth:** _ _ / _ _ / _ _ _ _	**Sex at Birth:** ☐ Male ☐ Female
Gender Identity: ☐ Female ☐ Male ☐ Transgender Male (FTM) ☐ Transgender Female (MTF) ☐ Other ☐ Choose not to disclose	**Sexual Orientation:** ☐ Straight ☐ Bisexual ☐ Lesbian or Gay ☐ Something else ☐ Choose not to disclose ☐ Don't Know	**Pronouns used:** ☐ He, Him, His ☐ She, Her, Hers ☐ They, Them, Theirs ☐ Ze, Hir ☐ Other ☐ Decline to Answer

Patient Address Information

Home Address	Mailing Address ☐ Same as Home
City State Zip	City State Zip

Patient Contact Information

Primary Phone (for appointment reminders*): ( ) Is this a cell phone? ☐ Yes ☐ No	Secondary Phone: ( ) Is this a cell phone? ☐ Yes ☐ No

*Reminders will always be sent via text for cell phones. ☐ I want voice only. ☐ I do not want to receive reminders.

Email Address:

Emergency Contact Information

Emergency Contact Name:	Relationship to Patient:	Emergency Contact Phone: ( )

For Pediatric Patients, ages 0-18: Parental Information

Parent's Name: ☐ Father ☐ Mother	Parent's Name: ☐ Father ☐ Mother
Primary Phone: ( )	Primary Phone: ( )

For Patient with Guardian: Guardianship Information (guardianship documentation required)

Legal Guardian's Name:	Legal Guardian's Primary Phone: ( )

Additional Patient Information

Primary Language Spoken: ☐ English ☐ Spanish ☐ Other_____

Do you need an Interpreter at appointments? ☐ No ☐ Yes, please specify language _____

Housing Situation – Check the box that best describes your household:	**Race –** Please check ALL that best describe your race:	**Ethnicity** – Check the box that best describes your ethnicity:
☐ Doubling up (couch surfing) ☐ Homeless shelter ☐ Not Homeless ☐ Not homeless, was in last 12 months ☐ Other, Examples include: Street, Camp, Bridge (Homeless/transient) Transitional housing (halfway house)	☐ White ☐ Black/ African American ☐ American Indian/ Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian/ Chamorro ☐ Samoan ☐ Other Pacific Islander	☐ No, not of Hispanic, Latino/a/x, or Spanish origin ☐ Yes, Mexican, Mexican American, Chicano/a ☐ Yes, Cuban ☐ Yes, another Hispanic, Latino/a/x or Spanish origin

Additional Patient Information Continued

Veteran Status: ☐ Veteran ☐ Not a Veteran

Farmworker Status:

Is your family's main source of income from a job as an agricultural laborer or farm worker?

- Includes planting, weeding, thinning, irrigation, and/or harvesting of crops and/or trees ☐ Yes ☐ No

If you are a farmworker, did you or your family move in the last two years in order to perform this work?

- Includes those who have stopped moving due to disability or age ☐ Yes ☐ No

Income and Household Data

Household Monthly Gross Income: $ _____	Family Size (# of people supported by household income): _____

Financial Responsibility Information

Responsible Party: Person responsible for this account (even if you have insurance)

SELF (circle if you are responsible for this account); if not, complete below:

Last Name	First Name	Relationship to patient	Sex at Birth ☐ Male ☐ Female
Address	City / State / Zip		Date of Birth

Insurance information: Please show current insurance cards at each appointment

☐ I have Oregon Health Plan ☐ I have private insurance ☐ I do not have health insurance

Primary Insurance Company Information		Secondary Insurance Company Information	
Primary Insurance Company	Effective Date	Secondary Insurance Company	Effective Date
Group Number	ID #/Policy #	Group Number	ID #/Policy #
Insured Party		Insured Party	
Relationship to patient		Relationship to patient	
Date of Birth	Phone #	Date of Birth	Phone #

Assignment of Benefits/Insurance Release

I hereby authorize Lane County Health & Human Services to bill my insurance company directly for all services provided for medical and/or mental health treatment. I understand I am financially responsible to Lane County Health & Human Services for charges not covered by my insurance benefits and that I am directly responsible for payment of all charges within the limits of Lane County Health & Human Services credit policy regardless of insurance coverage. I hereby authorize Lane County Health & Human Services to furnish to my Insurance Company(s) all information which said Insurance Company(s) may request and/or require concerning my illness(es) and/or injury(s) including all psychiatric, drug, alcohol abuse, acquired immunodeficiency syndrome, thus releasing Lane County Health & Human Services from any liability for furnishing such information.

_____ _____ _____

Patient Signature **Parent or Legal Guardian Signature** **Date**

Print Name/Relationship to Patient:_____

*In the event a legal representative other than parents of minor child signs this Authorization, documentation of legal authority must be attached (i.e. Health Care Power of Attorney or court appointed Health Care Representative.)

Continued on next page

Consent To Treat

I hereby authorize the providers of Lane County Health & Human Services to provide such health services, including medical, mental health, surgery, regular or emergency services, as determined to be in the best interest of myself, my child or legal charge, if I am a parent or legal guardian.

I understand that I have the right to be informed about specific services and procedures, including information about risks, benefits, and alternatives to each service proposed for my services. I understand that my participation in services is voluntary, I have the right to refuse any particular service, and I may withdraw from all services at any time. I understand that I have the right to ask questions about any service provided at any time. If I have concerns, I have the right to talk to a Program Supervisor and/or file a complaint or grievance which will be responded to promptly and respectfully.

I understand that there are several exceptions to the Individual/Provider privilege. For example, under Oregon Law, Lane County Health & Human Services must report:

a. child abuse
b. elder abuse
c. abuse of mentally ill persons or developmentally disabled persons
d. when required by a court order
e. harm or potential harm to self or others

This authorization shall continue and be in full force and effect until revoked in writing.

_____	_____	_____
Patient Signature	**Parent or Legal Guardian Signature**	**Date**

Print Name/Relationship to Patient:_____

*In the event a legal representative other than parents of minor child signs this Authorization, documentation of legal authority must be attached (i.e. Health Care Power of Attorney or court appointed Health Care Representative.)

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Lane County Behavioral Health
&
Community Health Centers of Lane County

Notice of Privacy Practices Acknowledgement of Receipt

The Notice of Privacy Practices tells you how Lane County HHS may use or disclose your information. Not all situations will be described. Lane County HHS is required to inform you of our privacy practices for the information we collect and keep about you.

I, _____ (client's name), have been offered a copy of Lane County Health & Human Services' Notice of Privacy Practices. I have had a chance to ask questions about how my information will be used.

Relationship:

- ❑ Patient
- ❑ Patient's Guardian (or parent of un-emancipated minor patient)
- ❑ Person authorized to make decisions on behalf of patient (e.g. by a medical power of attorney)

_____ Date:_____
Patient Signature

_____ Date:_____
Parent or Legal Guardian Signature

*In the event a legal representative other than parents of minor child signs this Authorization, documentation of legal authority must be attached (i.e. Health Care Power of Attorney or court appointed Health Care Representative.)

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LANE COUNTY BEHAVIORAL HEALTH &
COMMUNITY HEALTH CENTERS OF LANE COUNTY

MEDICAL HISTORY

Please describe your medical history. This will allow us to keep accurate information related to your healthcare.

Today's Date:_____ **Reason for Visit:** _____

Name: _____ **Healthcare Provider:** _____

Date of Birth:_____ **Sex Assigned at Birth:** _____

Gender Identify Now: _____

Pronouns Used (He, She, They, Other): _____

Employment:

Where do you work?	
Occupation:	
Years of employment:	

Marital Status/Family:

Marital Status:					
☐ Single	☐ Married	☐ Partnered	☐ Divorced	☐ Widowed	☐ Other:
Do you live alone? ☐ Yes ☐ No					

Pharmacy Information: Which pharmacy do you use?

Name	**Location**	**Phone and Fax**

Current Medications: Please list current medication.

Medication	**Dosage**	**Directions**

Medication	**Dosage**	**Directions**
☐ **Currently not taking medications**		

Allergies/Reactions: Please only list allergies to medications, latex, metals and chemicals. Do not include food and environmental allergies.

Allergy	**Reaction**

Allergy	**Reaction**
☐ **I have no allergies or reactions.**	

PLEASE CONTINUE TO THE NEXT PAGE

Medical History: Please check all that apply.

☐ AIDS/HIV	☐ CVA (Stroke)	☐ Hepatitis: _____	☐ Seizure
☐ Alcoholism	☐ Depression	☐ High blood pressure	☐ Sleep apnea
☐ Alzheimer's (Dementia)	☐ Diabetes	☐ High cholesterol	☐ Stomach ulcer
☐ Anemia/ low iron	☐ Drug addictions	☐ Kidney disease	☐ Thyroid disease
☐ Asthma	☐ Fibromyalgia	☐ Osteoporosis	☐ Tuberculosis (TB)
☐ Blood clots/DVT	☐ Gout	☐ Pacemaker	☐ Other: _____
☐ Cancer:_____	☐ Heartburn	☐ Poor circulation	☐ **None apply**
☐ COPD (Lung Disease)	☐ Heart disease	☐ Rheumatoid arthritis	

Family History: Please check all that apply.

Father	**Mother**	**Siblings**	**Children**
☐ Problems with anesthesia	☐ Problems with anesthesia	☐ Problems with anesthesia	☐ Problems with anesthesia
☐ Bleeding problems	☐ Bleeding problems	☐ Bleeding problems	☐ Bleeding problems
☐ Blood clots/DVT	☐ Blood clots/DVT	☐ Blood clots/DVT	☐ Blood clots/DVT
☐ Cancer:_____	☐ Cancer:_____	☐ Cancer:_____	☐ Cancer:_____
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Gout	☐ Gout	☐ Gout	☐ Gout
☐ Heart disease	☐ Heart disease	☐ Heart disease	☐ Heart disease
☐ High blood pressure	☐ High blood pressure	☐ High blood pressure	☐ High blood pressure
☐ Osteoarthritis	☐ Osteoarthritis	☐ Osteoarthritis	☐ Osteoarthritis
☐ Other:_____	☐ Other:_____	☐ Other:_____	☐ Other:_____
☐ **None apply**	☐ **None apply**	☐ **None apply**	☐ **None apply**

Surgical History: Please include all surgeries.

Surgery type	**Month/Date/Year**	**Surgery**	**Month/Date/Year**
	Mo / Day / Year		Mo / Day / Year
	Mo / Day / Year		Mo / Day / Year
	Mo / Day / Year		Mo / Day / Year
	Mo / Day / Year	☐ **No surgeries.**	

Social History:

☐ Never smoked		☐ Used to smoke
☐ Smoker, current status unknown	☐ Current occasional smoker	☐ Current every day smoker

Tobacco Use:			**Alcohol Use:**			**Recreational Drug Use:**		
☐ Yes	☐ No	☐ Former User	☐ Yes	☐ No	☐ Former Drinker	☐ Yes	☐ No	☐ Former User
Type:	☐ Chew	☐ Cigarettes				Type:		
	☐ Cigar	☐ E-Cigarettes						
Amount/Day:			Amount/Day:			Amount/Day:		
Years of use:			Years of use:			Years of use:		

Substance Use History: Please provide information about past and present substance abuse or substance dependence.

Have you ever experienced a problem with alcohol, drugs or prescription medications? ☐ Yes ☐ No
If yes, please provide details:

PLEASE CONTINUE TO THE NEXT PAGE

Immunization History: Please check all that apply. ☐ **None apply**

Vaccination	Yes	No	Date Given	Vaccination	Yes	No	Date Given
Flu Vaccine	☐	☐	Mo / Day / Year	Pneumovax	☐	☐	Mo / Day / Year
Hepatitis A	☐	☐	Mo / Day / Year	Tetanus	☐	☐	Mo / Day / Year
Hepatitis B	☐	☐	Mo / Day / Year	Other:_____	☐	☐	Mo / Day / Year

Diagnostic History: Please check all that apply. ☐ **None apply**

Test	Date/Year Completed	Results	
☐ Mammogram	Mo / Day / Year	☐ Normal	☐ Abnormal
☐ Bone Density	Mo / Day / Year	☐ Normal	☐ Abnormal
☐ Colonoscopy	Mo / Day / Year	☐ Normal	☐ Abnormal
☐ Other (Heart, lungs, etc.): _____	Mo / Day / Year	☐ Normal	☐ Abnormal

Women's Health: Please provide information about your female health history.

Age of first period:	Date of last menstrual period:	Age at menopause:
Are you currently pregnant? ☐ Yes ☐ No	Number of pregnancies:	Number of births:
Date of last Pap Smear: Mo / Day / Year		
Ever had an abnormal Pap Smear: ☐ Yes ☐ No	Result:	
Date of last mammogram: Mo / Day / Year	Mammogram results:	
Ever had a breast biopsy? ☐ Yes ☐ No	Biopsy results:	

Sexual History: Please provide information about your sexual health.

Have you had a sexually transmitted disease? ☐ Yes ☐ No	Diagnosis:
Current family planning option:	Birth control:

Exercise Frequency:

☐ Never	☐ Occasionally	☐ 2-4 times/week	☐ 5+ times/week	☐ Daily

Dietary Lifestyle: Please indicate any dietary restrictions or food allergies you have.

☐ Low fat diet restrictions	☐ Lactose restrictions	☐ Food allergies:
☐ Low carbohydrate intake	☐ Vegetarian diet	
How would you rate your diet? ☐ Good ☐ Poor		

Other Providers and Specialists: If you are currently seeing another provider for services, please provide their information below.

Name	Location	Specialty

PLEASE CONTINUE TO THE NEXT PAGE

Current Review of Systems: In the last 30 days, have you experienced any of the following:

Constitutional	Cardiovascular	Reproductive	Psychiatric	Hematologic/ Lymphatic
☐ Fatigue ☐ Weight gain ☐ Weight loss ☐ Other:_____	☐ Chest pain ☐ Edema ☐ Palpitations ☐ Irregular heart rhythm ☐ Other:_____	Male: ☐ Erectile dysfunction ☐ Penile discharge ☐ Other:_____ Female: ☐ Abnormal pap ☐ Painful sex ☐ Hot flashes ☐ Irregular periods ☐ Vaginal discharge ☐ Other:_____	☐ Anxiety ☐ Depression ☐ Trouble sleeping ☐ Other:_____	☐ Easy bleeding ☐ Easy bruising ☐ Swollen lymph nodes ☐ Other:_____
HEENT	**Gastrointestinal**	**Metabolic/Endocrine**	**Integumentary**	**Immunologic**
☐ Hearing loss ☐ Visual changes ☐ Other:_____	☐ Stomach pain ☐ Blood in stool ☐ Change in stool ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Other:_____	☐ Cold intolerance ☐ Heat intolerance ☐ Other:_____	☐ Hair loss ☐ Skin lesion ☐ Rash ☐ Breast discharge ☐ Breast lump ☐ Other:_____	☐ Seasonal allergy ☐ Environmental allergy ☐ Other:_____
Respiratory	**Genitourinary**	**Neurological**	**Musculoskeletal**	**Other Symptoms – Please List**
☐ Cough ☐ Shortness of breath ☐ Wheezing ☐ Other:_____	☐ Dribbling ☐ Burning on urination ☐ Blood in urine ☐ Slow stream ☐ Frequency ☐ Incontinence ☐ Retention ☐ Frequent urination at night ☐ Other:_____	☐ Dizziness ☐ Numbness legs/arms ☐ Weakness legs/arms ☐ Problems walking ☐ Headache ☐ Memory loss ☐ Other:_____	☐ Back pain ☐ Joint pain ☐ Joint swelling ☐ Neck pain ☐ Other:_____	☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____

Advance Directive:

An advance directive is a written document stating how you want medical decisions to be made if you lose ability to make them for yourself.
☐ I have an advance directive. (Please bring it to the office so a copy may be included in your medical record)
☐ I would like information about establishing an advance directive for my care in the event I cannot make my own medical decisions.
☐ I am not interested in an advance directive at this time.

COMMUNITY HEALTH CENTERS OF LANE COUNTY

Authorization to Use and Disclose Health Information
New Patient Registration Packet

Patient Information	
Patient Name (please print):	
Address:	**Birth Date:** month / day / year
City: **State:** **Zip:**	**Phone:**

I authorize and request my health records to be disclosed from the following providers or health care facility to Community Health Centers of Lane County for the purpose of continuity of care.

PLEASE FAX THE PATIENT'S RECORDS TO 541-682-9990

Records From – Provider or Health Care Facility	
Provider or Health Care Facility Name (Please Print):	
Address:	**Phone:**
City: **State:** **Zip:**	**Fax:**

Disclosure Information

By INITIALING the spaces below, I specifically authorize the disclosure of the following records, if such records exist:

_____ INITIAL HERE
Last 12 Months: *Office Chart Notes; Emergency & Urgent Care Records; Laboratory Reports*

_____ INITIAL HERE
All Records Pertaining To: *Pathology Reports; Diagnostic Imaging Reports; Immunization Records; Hospital Records & Hospital Consultation Reports*

IMPORTANT – PLEASE READ & COMPLETE: I authorize the information listed below to be used, disclosed or received by placing my initials in the space next to the information (Must be initialed to be included with released documents):

_____ INITIAL HERE *HIV/AIDS Related Records*	_____ INITIAL HERE *Genetic Testing Information*
_____ INITIAL HERE *Mental Health Information*	_____ INITIAL HERE *Alcohol & Drug Treatment Info*

Authorization

My signature indicates that I authorized the disclosure of the above information and understand the following:

- I understand that I may choose not to sign this authorization and that my choice not to sign will not be a basis to affect my ability to obtain treatment or my eligibility for health care benefits.
- I understand I can cancel my permission to use and disclose my information at any time in writing. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent **will expire one year from the date of signing**, or shall remain in effect for the period reasonably needed to complete the request.
- I understand this change will not affect information that has already been shared.
- I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer be protected under federal law. I understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

Patient's Signature: _____ Date _____

Parent or Legal Guardian Signature: _____ Date _____

Print Name/Relationship to Patient: _____

*In the event a legal representative other than parents of minor child signs this Authorization, documentation of legal authority must be attached (i.e. Health Care Power of Attorney or court appointed Health Care Representative.)

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Permission to Verbally Discuss Protected Health Information with Family Members and Friends

Completion of this form is optional.

Patient's Name	**Date of Birth**

By signing this form, I grant permission to Community Health Centers of Lane County to VERBALLY share the information I have checked with the family members or friends that I have listed below as being directly involved in my health care, care coordination or coordination of payment of my health care.
This form does not authorize releasing copies of my medical records to the persons named below.

Please select each option you permit us to discuss with your designated family member or friends.

- ☐ **Appointment information** (schedule, cancel, reschedule, or confirm appointment dates / times)
- ☐ **Medication information**, including my symptoms, diagnoses, medication(s), treatment plan and coordination of prescription refills
- ☐ **Test results** examples include lab, imaging and other diagnostic results
- ☐ **Billing and Payment Information**

Other (describe):_____

Community Health Centers of Lane County has my permission to discuss the above information with the following family members or friends. This information is directly relevant to their involvement in my health care (or payment for that care):

1. Name_____ Relationship to Patient_____
   Phone #_____
2. Name _____ Relationship to Patient _____
   Phone #_____

I understand that in certain situations Community Health Centers of Lane County may speak to other individuals who are involved in my health care or payment of that care, if permitted by law that may not be identified on this form.
I understand that I have the right to revoke my permission at any time except where Community Health Centers of Lane County has already made disclosures in reliance upon this form. **I understand this permission remains in effect until revoked.**

Signature of Patient/Authorized Legal Representative _____ **Date** _____
If other than patient state relationship and authority to sign _____
Documentation required to confirm legal representation of patient

To revoke (stop) all permissions to verbally discuss any further information related to your healthcare with the individual(s) listed above, please fill out this section below. A new permission form is required if you wish to modify your list of allowed people above.

By signing below I wish to revoke (stop) my permission to discuss protected health information. I understand that I can request to fill out a new permission form with modified information.

Signature of Patient/Authorized Legal Representative _____ **Date** _____

Permission to Verbally Discuss Protected Health Information with Family Members and Friends

We have established a process that allows you to tell us who we may talk with about your healthcare. This includes appointments and scheduling information, test results, treatment information and billing information.

How can I give others permission to get verbal information about me?
Complete the Permission to Verbally Discuss Protected Health Information form **on the reverse of this page** to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss.

Does this mean that you will not speak to anyone I haven't specifically named on the form?
No. If permitted by law, the Community Health Centers of Lane County may speak to other individuals involved in your care (or payment for that care).

How is the information on the form used?
Anytime your designated person calls or makes a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

What are some examples of when this might be useful?

- If a patient wants to share information with a spouse or significant other
- If an elderly parent wants an adult child to help understand medical treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping a patient with health issues
- If a college student wants information shared with a parent
- If an adult child calls to find out his/her parent's appointment time

What if I change my mind?
You can change or revoke (stop) this process at any time by completing a form available at our clinic locations.

What happens if I don't complete this form?
We will continue to protect your private information as required by law.

Can the person I designate also get copies of my medical records?
No, they can only receive verbal information. To get copies of medical records, complete a separate Authorization form available by contacting your primary clinic or calling our clinic for further information at 541-682-3550.

LANE COUNTY HEALTH & HUMAN SERVICES
BEHAVIORAL HEALTH AND
COMMUNITY HEALTH CENTERS OF LANE COUNTY
NOTICE OF PRIVACY PRACTICES

Effective Date: February 24, 2023

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.

Lane County Health & Human Services (HHS) provides many types of services, such as public health, mental health, and drug and alcohol services. HHS staff must collect information about you to provide these services. HHS knows that information we collect about you and your health is private. HHS is required to protect this information by Federal and State law. We call this information "protected health information (PHI)."

The Notice of Privacy Practices will tell you how HHS may use or disclose information about you. Not all situations will be described. HHS is required to give you a notice of our privacy practices about the information we collect and keep about you. HHS is required to follow the terms of the notice currently in effect.

HHS May Use and Disclose Information Without Your Authorization

• **For Treatment.** HHS may use or disclose information with health care providers who are involved in your health care. For example, information may be shared to create and carry out a plan for your treatment. **There are exceptions to this for some A&D, Mental Health, and HIV services**. Some of your information may be exchanged electronically via a Health Information Exchange (HIE). If you do not want your information included in the HIE you may opt-out of this by contacting Lane County Behavioral Health or the Community Health Centers of Lane County
• **For Payment.** HHS may use or disclose information to get payment or to pay for the health care services you receive. For example, HHS may provide PHI to bill your health plan for health care provided to you.
• **For Health Care Operations.** HHS may use or disclose information in order to manage its programs and activities. For example, HHS may use PHI to review the quality of services you receive.
• **For Health Oversight Activities.** HHS may use or disclose information during inspections or investigations of our services.
• **As Required by Law and For Law Enforcement.** HHS will use and disclose information when required or permitted by federal or state law or by a court order.
• **For Abuse Reports and Investigations.** HHS is required by law to receive and investigate reports of abuse.
• **To Avoid Harm.** HHS may disclose PHI to law enforcement in order to avoid a serious threat to the health and safety of a person or the public.

Uses and Disclosures in Special Situations

We may use or disclose your PHI in the situations described below unless you notify us in writing that you would like us not to. See the information below under "Your PHI Privacy Rights" for information about how to request limitations.

• **Appointments and Other Health Information.** HHS may send you reminders for medical care or checkups. HHS may send you information about other treatment or health services that may be of interest to you.
• **For Public Health Activities.** HHS is the public health agency that keeps and updates vital records, such as births and deaths, and tracks some diseases.
• **For Government Programs.** HHS may use and disclose information for public benefits under other government programs. For example, HHS may disclose information for the determination of Supplemental Security Income (SSI) benefits.
• **For Research.** HHS uses information for studies and to develop reports. These reports do not identify specific people.
• **Individuals Involved in Your Care.** Unless you object, HHS may disclose to a member of your family, relative or a friend or any other person you identify. If you are unable to agree to such a disclosure, such as with a medical emergency, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement.

Other Uses and Disclosures Require Your Written Authorization

For other situations, HHS will ask for your written authorization before using or disclosing information. You may cancel this authorization at any time in writing. HHS cannot take back any uses or disclosures already made with your authorization.

• **Other Laws Protect PHI.** Many HHS programs have other laws for the use and disclosure of information about you. For example, you must give your written authorization for HHS to use and disclose your HIV or alcohol and drug treatment records.

Your PHI Privacy Rights

When information is maintained by HHS as a public health agency, the public health records are governed by other State and Federal laws and are not subject to the rights described below.

• **Right to See and Get Copies of Your Records.** In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.
• **Right to Request a Correction or Update of Your Records.** You may ask HHS to change or add missing information to your records if you think there is a mistake. You must make the request in writing, and provide a reason for your request.
• **Right to Get a List of Disclosures.** You have the right to ask HHS for a list of disclosures made after April 14, 2003. You must make the request in writing. This list will not include the times that information was disclosed for treatment, payment, or health care operations. The list will not include information provided directly to you or your family, or information that was sent with your authorization.
• **Right to Request Limits on Uses or Disclosures of PHI.** You have the right to ask that HHS limit how your information is used or disclosed. You must make the request in writing and tell HHS what information you want to limit and to whom you want the limits to apply. HHS is not required to agree to the restriction. You can request that the restrictions be terminated in writing or verbally.
• **Right to Choose How We Communicate with You.** You have the right to ask that HHS share information with you in a certain way or in a certain place. For example, you may ask HHS to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the basis for your request.
• **Right to File a Complaint.** You have the right to file a complaint if you do not agree with how HHS has used or disclosed information about you.
• **Right to Get a Paper Copy of this Notice.** You have the right to ask for a paper copy of this notice at any time.
• **Right to be Notified of a Breach.** You have the right to be notified if we (or a business associate) discover a breach of your unsecured health information.

How to contact HHS to Review, Correct, or Limit Your Protected Health Information (PHI)

You may contact your local HHS office or the HHS Privacy Officer at the address listed at the end of this notice to:

- Ask to look at or copy your records
- Ask to limit how information about you is used or disclosed
- Ask to cancel an authorization
- Ask to correct or change your records
- Ask for a list of the times HHS disclosed information about you

HHS may deny your request to look at, copy or change your records. If HHS denies your request, HHS will send you a letter that tells you why your request is being denied and how you can ask for a review of the denial. You will also receive information about how to file a complaint with HHS or with the U.S. Department of Health and Human Services, Office for Civil Rights.

How to File a Complaint or Report a Problem

You may contact any of the people listed below if you want to file a complaint or to report a problem with how HHS has used or disclosed information about you. HHS cannot retaliate against you for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe to be unlawful.

Lane County Health & Human Services, **Lisa Nichols, HIPAA Privacy Officer**
151 W. 7th Ave. #520
Eugene, OR 97401
Phone: 541-682-1225 Email: HHSHIPAAConcerns@lanecountyor.gov

US Department of Health & Human Services, Office for Civil Rights
Medical Privacy, Complaint Division
U.S. Department of Health and Human Services
200 Independence Avenue, SW, HHH Building, Room 509H
Washington, D.C. 20201
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For More Information

If you have any questions about this notice or need more information, please contact the program contact person below:

Lane County Health & Human Services, **Lisa Nichols, HIPAA Privacy Officer**
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Eugene, OR 97401
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