TORRANCE MEMORIAL PHYSICIAN NETWORK

Patient Registration Form

For Office Use Only:
Visit Date: _____
Initials: _____

Patient Information

Patient's Last Name	First	Middle Initial	Date of Birth	Sex ☐ Male ☐ Female

Race* (see reverse for more detailed information*) ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Decline to answer	Ethnicity* (see reverse for more detailed information*) ☐ Hispanic ☐ Non-Hispanic ☐ Decline to answer

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Primary Language	Primary Care Physician

Patient's Street Address	Apt. No.	City	State	Zip

Email	Home Phone ☐ check if primary contact number ( )	Cell Phone ☐ check if primary contact number ( )

Day/Work Phone ☐ check if primary contact number ( )	Alternate Phone ( )	Mother's Maiden Name

Patient Employer Name	Employer Address	City	State	Zip

Employer Phone ( )	Patient Occupation	Employment Status: ☐ Not Employed ☐ Full Time ☐ Part Time ☐ Student ☐ Self-Employed ☐ Retired and Date_____

Full Name of Emergency Contact	Relationship	Home Phone ( )	Cell Phone ( )

Guarantor or person responsible for bill

Last Name	First	Middle Initial	Date of Birth	Relationship to Patient

Street Address	Apt. No.	SSN

City	State	Zip	Home Phone ( )	Work Phone ( )	Cell Phone ( )

Employer Name	Employer Address	City	State	Zip

Employer Phone ( )	Occupation	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired and Date:

Insurance Information

Primary Insurance Company	Subscriber's Full Name	Subscriber's Date of Birth

Subscriber's Employer Name	Relation to Insured	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired and Date:

Subscriber's Employer Address	City	State	Zip	Employer Phone No. ( )

Secondary Insurance Company	Relation to Insured	Subscriber's Full Name	Subscriber's Date of Birth

Acknowledgement: By signing below I signify that the information I have provided is accurate to the best of my knowledge. This signature also signifies my general consent for treatment to Torrance Health Association DBA Torrance Memorial Physician Network to provide any and all medical treatment to myself or my dependent.

Signature: _____ Date: _____

Notice of Privacy Practices: By signing below you acknowledge receipt of the *Notice of Privacy Practices*. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Signature: _____ Date: _____

Acknowledgements: By signing below you signify acknowledgement of the following:

- We request notification of cancellation or rescheduling of your appointment 48 hours prior to your scheduled visit
- You have received the *Disclosure Form for Sharing and Communication* in this packet and it explains our participation in an Accountable Care Organization (ACO) and Health Information Exchange (HIE) and additional ways we may utilize your information to better serve you .

Signature: _____ Date: _____

TORRANCE MEMORIAL PHYSICIAN NETWORK

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Visit Date: _____
Initials: _____

*RACE and ETHNICITY
Identify Race:
We are required by Federal health care programs to request this information as a part of the demographic data they collect. Individuals are asked to indicate one or more races that apply from among the following or you may decline to specify.

American Indian or Alaska Native **Asian** **Black or African American**	**Native Hawaiian or Other Pacific Islander** **White**
Race Categories As Defined by US Federal OMB:	
American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
Black or African American	A person having origins in any of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Identify Ethnicity:
We are required by Federal health care programs to request this information as a part of the demographic data they collect Individuals are asked to designate their ethnicity from the following or you may decline to specify:

Hispanic or Latino; or	**Not Hispanic or Latino**
Hispanic or Latino Defined	A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin regardless of race.
Unknown	Unknown/Not Reported

FOR OFFICE USE ONLY:

Primary Insurance Co.		Secondary Insurance Co.	
Circle: THIPA / HCP / PPO / MEDICARE		Circle: THIPA / HCP / PPO / MEDICARE	
Effective Date:		Effective Date:	
PCP	Group #	PCP	Group #
Annual Deductible $	Co-pay $	Annual Deductible $	Co-pay $
CPE	WW	CPE	WW
Reimbursement: 70/30% 80/20% 90/10% 100%		Reimbursement: 70/30% 80/20% 90/10% 100%	
Claims Address: _____ _____		Claims Address: _____ _____	

Patient did not sign Notice of Privacy Practices Acknowledgement reason: □ Refused □ Unable to sign (specify)_____

TORRANCE MEMORIAL
PHYSICIAN NETWORK

ASSIGNMENT OF BENEFITS FORM

I hereby assign and convey Torrance Health Association, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services. I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to *Torrance Health Association (THA), DBA Torrance Memorial Physician Network (TMPN)* for any equipment or services (i.e., provider visits, treatment, therapy, and/or medications) rendered or provided to me by the organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Centers for Medicare and Medicaid Services (CMS) my insurance carrier or other medical entity. A copy of this authorization will be sent to CMS, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand and agree:

- That I am financially responsible to the organization for all charges regardless of any applicable insurance or benefit.
- It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim.
- I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to THA/TMPN any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from THA or its attorneys in order to claim such medical benefits.

I understand that by signing this form I am accepting financial responsibility as explained above for all payments on the services I receive.

_____ _____ _____

Printed Name of Patient/Beneficiary Signature Date

MEDI-GAP/ MEDICARE SUPPLEMENTAL INSURANCE LIFETIME ASSIGNMENT OF BENEFITS:

I, the undersigned, have Medi-Gap Insurance coverage and assign directly to:

_____ (name of practice or provider), all medical benefit payments on my behalf. I hereby authorize release of medical information necessary to secure benefit payments. I authorize the use of the signature on all insurance submissions whether manual or electronic. This assignment is in effect until revoked by me in writing.

_____ _____ _____

Signature of Beneficiary Insurance ID Number Date

V: 062614

TORRANCE MEMORIAL PHYSICIAN NETWORK

DISCLOSURE FORM FOR SHARING AND COMMUNICATION

We may utilize a **Patient Portal** and/or an **Automated Appointment Reminder** and **Messaging** system to allow us to better serve you. (ex. appointment reminders via phone and text, online appointment requests, communicate with office via email, online access to your medical information)
By providing your cell phone number and email address we will automatically enroll you in this system(s) if they are available.

Disease and Immunization and California Immunization (CAIR) Registries are computer based tracking systems developed to assist medical providers and other approved agencies to track and review medical information for individuals, to assess needs and avoid redundant immunizations, and control disease outbreaks. By signing this agreement the patient or the parent/guardian acknowledge that their medical/immunization information is being shared with various Disease and Immunization (CAIR) Registries.

The State of California allows for patients to share immunization information with other CAIR providers. By initialing on the Patient Registration form you will allow all CAIR providers to access immunization information (ex: schools, emergency rooms). If you only want your Primary Care Provider to have access to your immunization information please notify the receptionist to provide you with the form to *Restrict Information to the CAIR Registry*.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

The *Notice of Privacy Practices* contains detailed information about how we may use and disclose your protected health information. We encourage you to read it in full. The following are two systems we are currently using to share your information.

Health Information Exchange (HIE)- we may make your individual health information available to a sponsored Health Information Exchange (HIE) and to a regional and/or National Health Information Exchange. You may notify the receptionist to provide you with a form to decline to participate.

Accountable Care Organizations (ACO) – we will be sharing your health information with our Accountable Care Organization (ACO).

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy on our website **www.tmphysiciannetwork.org.** If you have any questions about our *Notice of Privacy Practices* please contact our Privacy Officer at (310) 784-4953 or at tmpnprivacy.officer@tmmc.com.

Revised February 28, 2014

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION EFFECTIVE APRIL, 2003

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

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the:

TORRANCE MEMORIAL PHYSICIAN NETWORK
23326 Hawthorne Blvd. Suite 200
Torrance, CA 90505
TMPN Privacy Line 310-784-4953

WHO WILL FOLLOW THIS NOTICE:

This notice describes our office's practices and that of:

- Any health care professional authorized to enter information into your chart;
- All departments and affiliates of the **Torrance Memorial Physician Network**
- All employees, staff, and other personnel and students.

All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or office operation purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at **Torrance Memorial Physician Network**. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the office, whether made by our personnel or your personal doctor. Your other personal doctor's may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which **Torrance Memorial Physician Network** may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

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 with respect to medical information about you; and,
- follow the terms of this notice.

Revised February 28, 2014

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Disclosure at Your Request.

We may disclose information when requested by you. You must submit your request in writing utilizing the "Authorization for the Use or Disclosure of PHI" to **Torrance Memorial Physician Network**

For Treatment

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, medical assistants, technicians, students, or other office personnel who are involved in taking care of you. **For example**, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. We also may disclose medical information about you to people outside the office who may be involved in your medical care after you leave the office, such as family members, clergy or others (skilled nursing facilities, home health agencies, transport companies, community agencies, physicians or other practitioners/agencies) we use to provide services that are part of your care. This information is stored in the office computer system and is accessible via a secured network and/or interface transmission to authorized healthcare providers in order to make sure they have your information as quickly as possible to treat you.

For Payment.

We may use and disclose medical information about you so that the treatment and services you receive at the office may be billed to and payment may be collected from you, an insurance company or a third party. **For example**, we may need to give your health plan information about a procedure you received at the office so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also provide basic information about you and your health plan, insurance company or other source of payment to practitioners outside the office who are involved in your care, to assist them in obtaining payment for service they provide you.

For Health Care Operations.

We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care. **For example**, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical office information about many office patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective.
We may also disclose information to doctors, nurses, medical assistants, technicians, students, and other office or healthcare personnel for review, performance improvement and educational purposes. We may also combine the medical information we have with medical information from other offices to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are. We may share your Protected Health Information with third parties who perform services for us such as transcription or billing. In these cases, we have written agreements with the third parties that they will not use or disclose your information for any other purpose except as required by law.

Health Information Exchange (HIE):

Torrance Memorial Physician Network may make your individual health information available to a sponsored Health Information Exchange (HIE) and to a regional and/or National Health Information Exchange including, but not limited to, the National Health Information Network (NHIN). A HIE is the electronic transmission of healthcare-related information among facilities, health information organizations and government agencies which provides a mechanism for healthcare providers to share information electronically, with the common goal to improve healthcare delivery and the quality of care for our patients while protecting the privacy and security of Health Information. **For example**, we will be sharing your health information with our Accountable Care Organization (ACO). If you received treatment in our office; and your physician, who may be a participant in our ACO, would be able to access and review the treatment you received at the office during your physician office visit. Your physician will have access to the most current information about your care and treatment.

Accountable Care Organizations (ACO) are organizations formed by groups of doctors and health care providers that have agreed to work together to improve care coordination and providing care that is appropriate, safe and timely. An ACO must meet quality standards set by the Centers of Medicare Medicaid Services (CMS) relating to care coordination and patient safety, appropriate use of preventative health services, improved care for at-risk populations, and patient and caregiver experience of care.

Appointment Reminders.

We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the office. If you do not want us to contact you, you must complete a **"Request for Special Restriction on the Use or Disclosure of PHI"**

Treatment Alternatives.

We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Notification of Health System Programs and Classes.

We may use your medical information to tell you about health improvement related programs or services which are offered within the **Torrance Memorial Health System** and may be of interest to you. If you do not want to be contacted you must complete a **"Request for Special Restriction on the Use or Disclosure of PHI"**

Fundraising Activities.

The **HealthCare Foundation of the Torrance Memorial Medical Center** was established to raise funds to support the mission of the **Torrance Memorial Health System.** The foundation may use demographic information (such as your name, address, phone number and dates of treatment or services at Torrance Memorial Medical Center, Torrance Memorial Physician Network or Torrance Memorial Health System) to contact you about fundraising opportunities and events for Torrance Memorial Health System. If you do not want the Foundation to notify you of these opportunities, you must complete the form **"Opt Out of Fundraising".**

Individuals Involved in Your Care or Payment for Your Care.

We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. Unless you complete a **"Request for Special Restriction on the Use or Disclosure of PHI"**

Research.

Under certain circumstances, we may use and disclose medical information about you for research purposes. **For example**, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the office.

Business Associates:

We may use and disclose medical information about you to contracted services provided by business associates so they can perform a job we have asked them to do. To protect your medical information we require business associates to appropriately safeguard your information. **For example,** we may disclose your medical information to a transcription service to transcribe dictated reports from health professionals caring for you in the office, copy services for making copies of your health record or to a billing service to submit your claim to the insurance company for payment.

As Required By Law.

We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety.

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS:

Organ and Tissue Donation.

If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Community Education:

If you participate in a community education program, seminar or workshop, we may call you to discuss your appointment or payment options for the program, discuss your Protected Health Information during the training program, and mail you information about the programs we offer. If you do not want any of these to occur, please fill out either the **"Request for Restriction on the Manner of Confidential Communication"** or the " **"Request for Special Restriction on the Use or Disclosure of PHI"** and give it to the staff of the Community Education Service.

Outpatient Rehabilitation:

If you are part of a rehabilitation program, we may call you to discuss your appointment or treatment, we may mail you a notice of upcoming events, and we may have open discussions in the treatment area which could include some of your Protected Health Information (PHI). If you do not want any of these to occur, please fill out the **"Request for Special Restriction on the Use or Disclosure of PHI"** and give it to the staff of the rehabilitation service.

Military and Veterans.

If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation.

We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Reporting.

We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report the abuse or neglect of children, elders and dependent adults;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law; and
- to notify emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal laws.

Health Oversight Activities.

We may disclose medical information to a health oversight agency for activities authorized by law. **For example**, these oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes.

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you or your attorney about the request (which may include written notice to you). You may then obtain a motion to protect your information.

Law Enforcement.

We may release medical information if asked to do so by a law enforcement official:

- in response 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 person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at the office; and,
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors.

We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the office to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities.

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates.

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Multidisciplinary Personnel Teams

We may disclose health information to a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and child's parent, or elder abuse and neglect.

Special Categories of Information

In some circumstances, your health information may be subject to restrictions that may limit or preclude some uses or disclosures described in this notice. **For example,** there are special

restrictions on the use or disclosure of certain categories of information - e.g. tests for HIV or treatment for mental health conditions or alcohol and drug abuse. Government health benefit programs, such as Medi-Cal, may also limit the disclosure of beneficiary information for purposes unrelated to the program.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:

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

Right to Inspect and Copy.

You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but may not include some mental health information. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing utilizing the **"Authorization for the Use or Disclosure of PHI"**.

If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend.

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the office. To request an amendment, your request must be made in writing utilizing the **"Request to Amend PHI"**. In addition, you must provide a reason that supports your request.
We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us. **Exception**: if the person who created the information is unavailable to act on your request to amend it, we may consider your request if we can verify this information. **For example,** the doctor who originally created the information has died and you have no other way to obtain the amendment;
- is not part of the medical information kept by or for the office;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect.

Right to an Accounting of Disclosures.

You have the right to request an accounting of disclosure by completing the **"Request for an Accounting of Disclosures"**. This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment and health care operations, as those functions are described above.

In addition, we will notify you as required by law if your health information is unlawfully accessed or disclosed.

Right to Request Restrictions.

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. **For example,** you could ask that we not use or disclose information about a procedure you had. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request by utilizing the **"Request for Special Restriction on the Use or Disclosure of PHI"**. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. **For example**, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing by completing the **"Request for Restriction on the Manner of Confidential Communication"**. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at **Torrance Memorial Physician Network** for treatment or health care services as a patient, we will have a copy of the current notice in effect available to you.

Revised February 28, 2014

Right to a Paper Copy of This Notice.

You have the right to a paper copy of this notice. You may obtain a copy of this notice at our office, or on our website, www.tmphysiciannetwork.org.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with the office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact Torrance Memorial Physician Network at 310-784-4953. All complaints must be submitted in writing and may be mailed or hand delivered to the office. **You will not be penalized for filing a complaint**.

OTHER USES OF MEDICAL INFORMATION:

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.