Bartz-Altadonna Community Health Center REGISTRATION FORM

CLIENT NAME: _____ **UNIQUE ID#:**_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ ALTERNATE NUMBER: _____ OK TO LEAVE MESSAGE? _____home _____other

SOCIAL SECURITY#: _____ DATE OF BIRTH: _____ PLACE OF BIRTH: _____

MOTHER'S MAIDEN NAME: _____ PRIMARY LANGUAGE: _____GENDER: M F (please circle one)

HOUSING:
_____OWN _____RENT _____ # OF BEDROOMS _____AT RISK OF BEING HOMELESS _____ TRANSITION AGE YOUTH (16-24)

_____HOMELESS INDIVIDUAL _____CHRONIC HOMLESS (2 episodes in last 12 months) _____HOMELESS FAMILY

ETHNICITY: HISPANIC ☐ NON-HISPANIC ☐ **RACE:** WHITE☐ BLACK☐ AMER. INDIAN☐ ASIAN ☐NAT. HAWAIIAN/ PACIFIC ISLANDER☐ OTHER _____

CITIZENSHIP/RESIDENCE STATUS: _____ MARITAL STATUS: _____ SPOUSE'S NAME: _____

DEPENDENT CHILDREN: _____ NO _____YES #:_____

EMAIL ADRESS_____ **ARE YOU A VETERAN?** Y____ N_____

EMERGENCY NOTIFICATION: NAME _____ RELATIONSHIP: _____

ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ ALTERNATE PHONE: _____

METHOD OF PAYMENT:
_____ MEDICARE _____ MEDI-CAL _____ PRIVATE INSURANCE _____ HMO/HWLA _____ CASH _____ OTHER

MEDICAL #: _____ EFFECTIVE DATE: _____ MEDICARE #: _____ EFFECTIVE DATE: _____

MEDICARE (please circle) **PART A** YES NO **PART B** YES NO SHARE OF COST $: _____ INSUR.ANCE CO:_____

NAME OF INSURED: _____ INSURANCE CO. PHONE #: _____

EFFECTIVE DATE: _____ INSURED ID #: _____ GROUP # _____

EMPLOYMENT STATUS:
_____ FULL TIME _____PART TIME _____ UNEMPLOYED _____DISABLED _____ RETIRED _____ NONE

EMPLOYER: _____ PHONE: _____ POSITION: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

OTHER SOURCE OF INCOME:
_____ STATE DISABLITITY _____ AMT ($) _____ CALWORKS _____ AMT ($) _____UNEMPLOYMENT _____ AMT ($)

_____ SSI _____ AMT ($) _____ SSDI _____ AMT ($) _____ FOOD STAMPS _____ AMT ($) _____ GENERAL RELIEF _____ AMT ($)

GROSS MONTHLY INCOME: _____ OTHER INCOME: _____

TOTAL HOUSEHOLD INCOME: _____ PROOF OF INCOME ON FILE: _____YES _____ NO

HOW DID YOU HEAR ABOUT US? :_____**WHAT TYPE OF ASSISTANCE ARE YOU LOOKING FOR?**_____

_____ _____
Client Signature **Date**

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Agency Representative/Witness **Date**

OUTPATIENT HEALTH QUESTIONNAIRE

NAME _____ DATE OF BIRTH _____ HEIGHT _____ WEIGHT _____

CHIEF COMPLAINT _____ DURATION _____ DATE OF ONSET _____

ANY OTHER COMPLAINT _____ DURATION _____ DATE OF ONSET _____

PAST MEDICAL HISTORY (LIST ILLNESS)

_____ _____ _____

_____ _____ _____

OPERATIONS (LIST THE TYPE)

_____ _____ _____

_____ _____ _____

MEDICATIONS YOU ARE TAKING (LIST)

_____ _____ _____

_____ _____ _____

ALLERGIES (LIST) _____

_____

HAS ANY BLOOD RELATIVE EVER HAD THE FOLLOWING?

CANCER	YES NO	HIGH BLOOD PRESSURE	YES NO	ARTHRITIS	YES NO
T.B.	YES NO	STROKE	YES NO	ANEMIA	YES NO
DIABETES	YES NO	CONVULSIONS	YES NO	PSYCHIATRIC PROBLEM	YES NO
HEART TROUBLE	YES NO	BLEEDING TENDENCY	YES NO		

ANY DECEASED IN FAMILY (LIST CAUSE OF DEATH)

_____ _____ _____

HABITS

DO YOU SMOKE? NO YES HOW MUCH? _____ DO YOU TAKE ALCOHOL? NO YES HOW MUCH? _____

SYSTEM REVIEW: DO YOU HAVE ANY OF THE FOLLOWING?

GENERAL

RECENT WEIGHT CHANGE	NO	YES
HAVE YOU BEEN IN GOOD GENERAL HEALTH MOST OF YOUR LIFE?	NO	YES
DO YOU HAVE FEVER, CHILLS?	NO	YES

SKIN

SKIN DISEASE	NO	YES
JAUNDICE	NO	YES
HIVES, ECZEMA OR RASH	NO	YES
FREQUENT INFECTION OR BOILS	NO	YES
ABNORMAL PIGMENTATION	NO	YES

NEURO–PSYCHIATRIC

BLURRING OF VISION	NO	YES
HEADACHE	NO	YES
HEAD INJURY	NO	YES
CONVULSIONS	NO	YES
PARALYSIS	NO	YES
NUMBNESS	NO	YES
TINGLING	NO	YES
DIFFICULTY WITH URINE CONTROL	NO	YES
SPEECH TROUBLE	NO	YES
MEMORY LOSS	NO	YES
LOSS OF CONSCIOUSNESS	NO	YES

(TURN OVER)

Addressograph

760 650-M300-15 (5/90)

SYSTEM REVIEW (CONTINUED):

NECK

STIFFNESS	NO	YES
THYROID TROUBLE	NO	YES
ENLARGED GLANDS	NO	YES

RESPIRATORY

COLD (NOW?)	NO	YES
SPITTING UP BLOOD	NO	YES
CHRONIC OR FREQUENT COUGH	NO	YES
ASTHMA OR WHEEZING	NO	YES
DIFFICULTY BREATHING	NO	YES
ANY TROUBLE WITH LUNGS	NO	YES

CARDIOVASCULAR

DIZZY SPELLS	NO	YES
CHEST PAIN OR ANGINA PECTORIS	NO	YES
SHORTNESS OF BREATH WITH WALKING OR LYING DOWN	NO	YES
DIFFICULTY WALKING TWO BLOCKS	NO	YES
HEART TROUBLE OR HEART ATTACKS	NO	YES
HIGH BLOOD PRESSURE	NO	YES
SWELLING OF HANDS, FEET OR ANKLES	NO	YES
HEART MURMUR	NO	YES
PALPITATIONS	NO	YES

GASTROINTESTINAL

PEPTIC ULCER (GASTRIC OR DUODENAL)	NO	YES
VOMITING BLOOD OR FOOD	NO	YES
GALLBLADDER DISEASE	NO	YES
LIVER TROUBLE	NO	YES
HEPATITIS	NO	YES
PAINFUL BOWEL MOVEMENTS	NO	YES
BLEEDING WITH BOWEL MOVEMENTS	NO	YES
BLACK STOOLS	NO	YES
HEMORRHOIDS OR PILES	NO	YES
RECENT CHANGE IN BOWEL HABITS	NO	YES
FREQUENT DIARRHEA	NO	YES
HEARTBURN OR INDIGESTION	NO	YES
CRAMPING PAIN IN THE ABDOMEN	NO	YES
DOES FOOD STICK IN THROAT?	NO	YES
CONSTIPATION	NO	YES

GENITOURINARY

LOSS OF URINE	NO	YES
FREQUENT URINATION	NO	YES
NIGHT TIME URINATION	NO	YES
BURNING OR PAINFUL URINATION	NO	YES
BLOOD IN URINE	NO	YES
KIDNEY TROUPLE	NO	YES
KIDNEY STONES	NO	YES
BRIGHT'S DISEASE	NO	YES

LOCOMOTOR–MUSCULOSKELETAL

VARICOSE VEINS	NO	YES
WEAKNESS OF MUSCLES OR JOINTS	NO	YES
ANY DIFFICULTY IN WALKING	NO	YES
ANY PAIN IN CALVES OR BUTTOCKS ON WALKING, RELIEVED BY REST	NO	YES

ENDOCRINE

THYROID DISEASE	NO	YES
HORMONE THERAPY	NO	YES
ANY CHANGE IN HAT OR GLOVE SIZE	NO	YES
HAVE YOU BECOME COLDER THAN BEFORE OR SKIN BECOME DRYER?	NO	YES

HEAD-EYES-EARS-NOSE-THROAT

EYE DISEASE OR INJURY	NO	YES
DO YOU WEAR GLASSES?	NO	YES
DOUBLE VISION	NO	YES
HEADACHES	NO	YES
GLAUCOMA	NO	YES
ITCHING EYES OR NOSE	NO	YES
SNEEZING OR RUNNY NOSE	NO	YES
NOSEBLEEDS	NO	YES
CHRONIC SINUS TROUBLE	NO	YES
EAR DISEASE	NO	YES
IMPAIRED HEARING	NO	YES
DIZZINESS OR TRANSIENT EPISODES OF UNCONSCIOUSNESS	NO	YES

HEMATOLOGIC

ARE YOU SLOW TO HEAL AFTER CUTS?	NO	YES
BLOOD DISEASE	NO	YES
ANEMIA	NO	YES
PHLEBITIS	NO	YES
HAVE YOU HAD DIFFICULTY WITH BLEEDING EXCESSIVELY AFTER TOOTH EXTRACTION OR SURGERY?	NO	YES
HAVE YOU HAD ABNORMAL BRUISING OR BLEEDING?	NO	YES

GYNECOLOGICAL

AGE PERIODS STARTED _____

HOW LONG DO PERIODS LAST? _____

NO. OF PREGNANCIES _____ NO. OF MISCARRIAGES _____

DATE OF LAST CANCER SMEAR _____

RESULTS _____

ANY PAIN WITH YOUR PERIODS?	NO	YES

NUMBER OF CHILDREN _____ AGES _____

DATE OF FIRST DAY OF LAST PERIOD _____

_____
DATE

_____
SIGNATURE OF PATIENT (PARENT, IF MINOR)

Completion of this document authorizes the disclosure and/or use of individually identifiable information, as set forth below, consistent with California and Federal law concerning the privacy of such information.
Failure to provide all information requested may invalidate this Authorization.

PATIENT INFORMATION

Patient's Name: Last	First	Middle Initial	Birth Date	Social Security Number

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclose protected health information about the above patient as follows:

Authorized to use or disclose information: (Name of person or organization you are requesting information from)
Bartz-Altadonna Community Health Center

Address	City	State	Zip Code

Authorized to Receive information: (Name of person or organization who will receive the information)

Address	City	State	Zip Code
43322 Gingham Avenue, Suite 105	LANCASTER	CALIFORNIA	93535

DISCLOSE
☐ All Health information pertaining to any medical history, mental or physical condition and treatment received.
☐ Only the following records or types of health information. _____

Dates of Service: ☐ All ☐ Specific Dates: _____

Method of use or disclosure: ☐ mail ☐ pick up ☐ review /inspect ☐ fax to # _____
☐ other _____

PURPOSE The protected health information is being used or disclosed for the following purpose(s):
☐ Personal Use ☐ Continued Care ☐ Other _____

EXPIRATION: This authorization expires on (insert date or event): ☐ Date _____ ☐ Event _____

NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this authorization. I may revoke this authorization at any time.
My revocation must be in writing, signed by me or on my behalf, and delivered to the address listed above.
I have the right to receive a copy of this authorization.
Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
Information disclosed pursuant to this authorization could be re-disclosed by the re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
I may inspect or obtain a copy of the health information that I'm being asked to use or disclose.

SIGNATURE

Date	Signature (Patient, Parent, Legal Guardian or Authorized Representative)	If other than patient indicate relationship

Print Name	Address	Phone

Witness Signature	Print name and title	Date

BARTZ-ALTADONNA COMMUNITY HEALTH CENTER

CONDITIONS OF ADMISSION

CLIENT NAME (Please Print) _____

A. CONSENT TO MEDICAL AND SURGICAL PROCEDURES

I consent to the procedures and treatment that may be performed while a client of Bartz-Altadonna Community Health Center, including emergency treatment or services, such as laboratory procedures, x-ray examinations, local anesthesia, psychosocial counseling, or other services deemed necessary by Bartz-Altadonna Medical Providers. This consent for treatment and/or procedures to be performed shall stay in effect until I or my legal representative cancels such permission. Cancellation may verbal and/or in writing to Bartz-Altadonna employee.

DATE_____ **NAME**_____

SIGNATURE_____

If signed by other than client, indicate name and relationship to the client:

_____ _____

Name Relationship

_____ _____

Witness Date

Helping People Heal
BARTZ-ALTADONNA
Community Health Center

WHAT IS MY ACE SCORE?

Prior to your 18th birthday:

1. Did a parent or other adult in the household **often or very often**…
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   _____**Yes** _____**No** If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   _____**Yes** _____**No** If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   _____**Yes** _____**No** If yes enter 1 _____

4. Did you **often or very often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   _____**Yes** _____**No** If yes enter 1 _____

5. Did you **often or very often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   _____**Yes** _____**No** If yes enter 1 _____

6. Was a biological parent **ever** lost to you through divorce, abandonment, or other reason?
   _____**Yes** _____**No** If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   _____**Yes** _____**No** If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   _____**Yes** _____**No** If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   _____**Yes** _____**No** If yes enter 1 _____

10. Did a household member go to prison?
    _____**Yes** _____**No** If yes enter 1 _____

Now add up your "Yes" answers: This is your ACE Score _____

Bartz-Altadonna Community Health Center

Name of Patient: _____

Patient Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices and Client Rules, Rights, and Responsibilities

I confirm that I have received a copy of Provider's Notice of Privacy Practices and Client Rules, Rights and Responsibilities.

_____
Signature of Patient/Patient Representative Date_____

_____
Relationship to Patient

Documentation of Good Faith Efforts

To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices and Client rules, rights, and responsibilities.

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office on the date noted above and was provided with a copy of Covered Entity's Notice of Privacy Practices and Client Rules, Rights and Responsibilities. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notices. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign.
- ☐ Patient was unable to sign or initial because:

  _____

- ☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- ☐ Other reason (describe below):_____

  _____

_____ _____
Signature of Employee Completing Form Date

Bartz-Altadonna Community Health Center
CLIENT RULES, RIGHTS AND RESPONSIBILITIES

Bartz-Altadonna Community Health Center wants to make your experience at our facility a safe and comfortable one. In order to ensure the safety and welfare of all Bartz participants, we ask that all clients, staff, and volunteers comply with the following policies while on Bartz Premises.

A. CLIENT RULES: The safety of Bartz-Altadonna Community Health Center clients, staff, and volunteers is essential. The following rules must be adhered to whenever you visit Bartz:

1. Do not come to Bartz under the influence of alcohol or other non-prescribed substances. Intoxication and/or use of illicit drugs or alcohol will not be tolerated on or near the premises.
2. Do not come to Bartz with weapons on your person. Weapons of any kind will not be tolerated on or near the premises.
3. Do not verbally or physically abuse other clients, staff or volunteers. Physical violence or threats will not be tolerated on or near the premises.
4. People with infectious disease (such as TB) are required to notify their Bartz contact immediately prior to visiting.
5. Clients who violate these rules may face disciplinary action up to and including termination of services.

B. CLIENT RESPONSIBILITIES: To maximize the help Bartz is able to provide for you please accept the following client responsibilities:

1. Arrive on time for all appointments. If you are more than fifteen (15) minutes late, you may need to be rescheduled.
2. Keep your scheduled appointments. If you are unable to keep your scheduled appointment you must call to cancel or reschedule. If you miss more than three (3) scheduled appointments or the Bartz Contact is unable to reach you, your Case Manager may decide that it is unsound to continue your course of treatment without adequate follow up visits and discontinue your Bartz enrollment, with referral to another facility.
3. Participate in the development and implementation of your Individual Service Plan to the extent you are able.
4. To inform Bartz staff when you do not understand instructions or information received.
5. To communicate your needs to your Bartz Contact as quickly as possible, understanding that your Bartz Contact may not be able to satisfy “last-minute” requests.
6. To conduct yourself appropriately when interacting with persons involved in providing you services. Inappropriate behavior includes intoxication, threats, harassment, as well as physical and verbal abuse.
7. To keep your Bartz Contact informed about the quality, and appropriateness, and timeliness of services that you are receiving.
8. Call to cancel or reschedule appointments if you are unable to attend.
9. If we do not hear from you within a six (6) month period, your Bartz file may be considered inactive, necessitating reprocessing as a new client should you decide to return to Bartz.
10. Call 911 first for all emergency situations.

C. CLIENT RIGHTS:

1. To participate in the development and revision of the Individual Service Plan and be informed of all services to be provided, as well as, when and how it will be received.
2. To be given the name, agency address, agency telephone number and function of any person and affiliated agencies providing care or services to the client.
3. To decline any portion of the plan after being fully informed and understanding the consequences of not receiving such services.
4. To be involved in acuity-level reduction and case closure.
5. To recommend changes in policies and services.
6. To be informed both verbally and in writing of available grievance procedures.
7. To be informed of all agency rules and regulations related to the services provided.
8. To be treated with respect and dignity.
9. To have all information treated confidentially.
10. To be communicated to about services in a language and format that is understood by the client.
11. To withdraw client consent for services and/or seek services at another agency and to do so without pressure or intimidation.
12. To receive services without regard to age, race, creed, color, gender, sexual orientation, marital status, political affiliation, or disability.
13. While at Bartz, it is necessary to adhere to the rules of our affiliated hospitals and medical office buildings.
14. There is no smoking anywhere in or within 20 feet of The Bartz facility.
15. Clients are responsible for their own personal property. Bartz-Altadonna Community Health Center shall not be liable for loss or damage to personal property.

If you wish to appeal these rules and responsibilities, please contact the Director of Client Services of Bartz-Altadonna Community Health Center at (661)874-4050.

Bartz-Altadonna Community Health Center
Notice of Privacy Practices for Protected Health Information
Effective Date: 3/2012

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!

This office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

- A nurse obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Example of Use of Your Health Information for Payment Purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office/hospital. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office/hospital -- we are not required to grant the request, but we will comply with any request granted;
- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full—we must comply with this request;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office/hospital;
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office/hospital;

- Appeal a denial of access to your protected health information, except in certain circumstances;

- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office/hospital. We may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

  - Is not part of the health information kept by or for the office/hospital;

  - Is not part of the information that you would be permitted to inspect and copy; or,

  - Is accurate and complete.

  If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office/hospital;

- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office/hospital. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.

- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office/hospital, except to the extent information or action has already been taken.

- Elect to opt out of receiving further fundraising communications from the office/hospital.

If you want to exercise any of the above rights, please contact **Maria Sandoval, Director of Clinical Services 661-874-4050 x107** in person, by phone, or in writing, during regular, business hours. She will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The office/hospital is required to:

- Maintain the privacy of your health information as required by law;

- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;

- Abide by the terms of this Notice;

- Notify you if we cannot accommodate a requested restriction or request; and,

- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Maria Sandoval, Director of Clinical Services 661-874-4050 x107**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to **Maria Sandoval, Director of Clinical Services 661-874-4050 x107** You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services, Kathleen Sebelius, whose street address and phone number are:
The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free: 1-877-696-6775

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/hospital.

- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Research

- We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

- We may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA)

- We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

- If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect

- We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

- We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight

- Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

- We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

- We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Coroners, Medical Examiners, and Funeral Directors

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

Other Uses

- Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

Website

- If we maintain a website that provides information about our entity, this Notice will be on the website.