



MEMPHIS LUNG PHYSICIANS FOUNDATION

A Member of Baptist Medical Group

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APPOINTMENT DATE: _____

CHECK-IN TIME: _____

- LOCATION:** **6025 Walnut Grove Rd, Suite 508, Memphis, TN 38120**
 PH: 901-767-5864 FAX: 901-767-6591
(Located in the office building next to Baptist East hospital – Medical Plaza 1)
- 6025 Walnut Grove Rd, Suite 400, Memphis, TN 38120**
 PH: 901-767-5864 FAX: 901-767-6591
(Located in the office building next to Baptist East hospital – Medical Plaza 1)
- 1500 W. Poplar Ave, Suite 309, Collierville, TN 38017**
 PH: 901-850-1170 FAX: 901-850-1169
(Inside the Baptist Collierville hospital, take elevators located at the main entrance)
- 1520 Union Ave, Memphis, TN 38104**
 PH: 901-767-5864 FAX: 901-767-6591
(Located in the BMG Primary Care office, through the right side when you enter)
- 401 Southcrest Cir, Suite 212, Southaven, MS 38671**
 PH: 662-349-0488 FAX: 662-349-5974
(Go straight in sliding glass doors, take elevator to 2, go Left)

PLEASE ARRIVE AT THE CHECK-IN TIME LISTED ABOVE, BUT DO NOT ARRIVE MORE THAN 30 MINUTES PRIOR.

Below is a checklist of items that you need to bring to your upcoming appointment. *Please be sure to bring each item, as this will save time for you when you arrive.*

- Insurance cards and photo ID.
- Records from your referring physician (if they have not been faxed to us).
- Paperwork from this packet (PLEASE FILL OUT BEFORE APPOINTMENT).
- If you are currently on CPAP, please bring machine and mask, power cord and tubing.
- IF YOU HAVE HAD A PREVIOUS SLEEP STUDY, WE MUST HAVE A COPY OF THAT SLEEP STUDY BEFORE YOU CAN SEE THE PHYSICIAN. IF WE DO NOT HAVE THIS, THE PHYSICIAN CANNOT SEE YOU.

You MUST bring this paperwork filled out entirely in order to be seen.

IMPORTANT NOTICE

When entering the Memphis Lung Physicians Foundation offices, please refrain from wearing perfumes, colognes, fragrance lotions, fragrance creams, essential oils, etc. that have a strong smell.

These fragrances can and will trigger asthma attacks and/or COPD exacerbations for some patients and employees.

Thank you so much for your cooperation with this.

MEMPHIS LUNG PHYSICIANS FOUNDATION

Baptist Clinic Name: Memphis Lung Physicians Foundation Phone # _____ Fax# _____

Address: _____

➔ PATIENT'S NAME: _____ BIRTH DATE: _____ Chart #: _____

➔ ADDRESS: _____ Phone #: _____ Last 4 digits of SS #: _____

I authorize MLPF to leave a message at the phone number(s) I have provided. YES _____ NO _____

I authorize Baptist or the following person or organization (specify if applicable) _____ to:

➔ disclose my health information to: _____

(Name and Address) - Specify: Attorney, Insurance, Self, etc

➔ obtain/request copies of my health information from: _____

(Name and Address) - Specify: Hospital, Doctor, etc

Purpose of use, disclosure, and or request: Continuation of Care/Treatment Attorney At the request of the patient

Payment Other, specify: _____

I authorize use and/or disclosure of information covering treatment from: _____ to: _____

(enter specific dates)

Information to be used and/or disclosed:

History and Physical Progress Note Lab Radiology/Imaging All records Itemized bill

Other (Specify): _____

I understand that the disclosure of my personal health information may include information regarding diagnosis and/or treatment for any of the following: alcohol abuse, drug abuse, psychiatric or mental illness, and/or sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) or (AIDS virus).

This release will include information I have previously restricted from my health plan unless I initial here.

This authorization will expire one year from the date of your signature unless you specify a different expiration date, event, or condition.

Please specify: _____

I understand that I have a right to revoke this authorization at any time, except to the extent that release of information has already occurred in reliance on my prior authorization.

I understand that in order to revoke an authorization, a written document stating the intent of the patient is to be either delivered in person or by certified mail to the Director of Health Information Management at the Baptist facility indicated above. The revocation document is to contain the signature of the patient or patient's legal representative.

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. Refusal to sign this form will not affect my receipt of treatment. However, if this authorization is for release of records to a third party for payment, enrollment or eligibility of benefits purposes, such as workers' compensation, private health insurance, application for insurance, etc., my refusal to sign may effect payment, enrollment or eligibility for benefits. This, in turn, may effect payment for services I receive and I may become responsible for all charges incurred. I understand that it is my responsibility to inquire with the party requesting my health records regarding the effect of my refusal to sign this form.

I understand that any disclosure carries with it the potential for re-disclosure by the recipient of the information and such re-disclosure may not be protected by federal confidentiality laws.

When Baptist **seeks** an authorization for its own use or disclosure of protected health information (e.g., marketing, research, etc.), a **copy** of the authorization is provided to the patient.

Date

Witness

PATIENT SIGNATURE (or person authorized to consent for minor or patient who is unable to sign)

Relationship and/or authority to act for the patient

Photo ID was provided: Yes No If no, specify form of patient identification: _____



NOTICE TO OUR PATIENTS

During the course of your treatment at BMG, your healthcare provider may recommend you to have procedures performed. Specifically, if you are referred to have radiology or certain other imaging services, such as an MRI, CT or PET scan, we want to provide you with information to ensure you are informed of your rights as our patient.

- I. You have the right to receive your healthcare services at the provider of your choice.
II. You have the option to use BMG or an alternate healthcare service provider.
III. You will not be treated differently by your BMG healthcare provider if you choose not to use BMG services.

Below is a list of some alternate healthcare service providers:

The Flinn Clinic
1300 Wolf Park Dr.
Germantown, TN 38138

Imaging Center
320 S Gloster St
Tupelo, MS 38804

Diagnostic Imaging PC
6401 Poplar Ave
Memphis, TN 38119

Radiology Clinic
411 Main St S
Amory, MS 38821

Park Avenue Diagnostic
5190 Park Avenue
Memphis, TN 38119

Premier Imaging
1207 MS-182
Starkville, MS 39759

Outpatient Diagnostic Center of Memphis
5130 Stage Rd
Memphis, TN 38134

Alliance Health Care Services
581 Medical Drive
Clarksdale, MS 38614

Diagnostic Imaging Specialists
7420 Guthrie Dr. N # 105
Southaven, MS 38671

Imaging Center
2526 N. 5th Street
Columbus, MS 39705

Please inform your healthcare provider, if you desire to have your procedures performed at a facility other than BMG.

I acknowledge that as a patient of Baptist Medical Group, I have been informed of my rights.

Patient Name (Please Print or Type)

Date of Service

Patient Signature

Date



AUTHORIZATION TO LEAVE MESSAGES

Patient Last Name _____ First Name _____ Middle Initial _____ Suffix _____ (Jr/Sr/II etc.)
 Address _____ City _____ State _____ Zip _____
 Date of Birth ____/____/____

Which of the following communications means are appropriate/acceptable for BMG to communicate with you: (please check all that apply)

- Home phone # _____ Okay to leave a message? Yes No
- Cell phone # _____ Okay to leave a message? Yes No
- Work phone # _____ Okay to leave a message? Yes No

Which method of communication is preferred? No contact Mail Phone Email Mychart

With whom may we share information about your health? Please list below.

Note: In order for BMG to disclose your Private Health Information, the representative listed must be able to provide (2) two of the (3) identifiers listed below:

- 1. Last 4 digits patient's social security number
- 2. Patient's date of birth
- 3. Patient's zip code

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Name	Relationship to You	Telephone Number	May Discuss Diagnosis/Treatment	May Discuss Billing Info
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have a legal document that states who will make decisions if you are unable? Yes No

If yes, Name _____ Relationship to Patient _____

Check one: Healthcare Proxy/Agent General Power of Attorney Healthcare Power of Attorney

If you would like information about appointing a healthcare proxy/agent, please let us know.

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to discuss and use the patient's healthcare information.

Patient/Legal Representative Signature: _____ Date: _____

OFFICE USE ONLY – Document should be Scanned under Ambulatory Auth and Consent Doc type

**Memphis Lung Physicians Foundation
Medication Sheet**

Patient Name _____

Chart/MRN# _____

Date of Visit _____

Name of Pharmacy _____

Pharmacy Phone # _____

Allergies (Please put N/A if not applicable): _____

PLEASE INCLUDE ALL BREATHING INHALERS & NEBULIZED MEDICATIONS

	<u>Medication Name</u>	<u>Dosage/Strength/MG/McG</u>	<u>Frequency (Times Per Day)</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____

Are you currently taking any birth control? (Choose One) YES _____ NO _____

Signature

Date

If you need additional space, please use lines below.

	<u>Medication Name</u>	<u>Dosage/Strength/MG/McG</u>	<u>Frequency (Times Per Day)</u>
13.	_____	_____	_____
14.	_____	_____	_____
15.	_____	_____	_____
16.	_____	_____	_____
17.	_____	_____	_____
18.	_____	_____	_____
19.	_____	_____	_____
20.	_____	_____	_____
21.	_____	_____	_____
22.	_____	_____	_____
23.	_____	_____	_____
24.	_____	_____	_____

Signature

Date

Memphis Lung Physicians Foundation
6025 Walnut Grove Rd, Suite 508
Memphis, TN 38120

Review of Systems

Patient Name: _____ DOB: _____ Age: _____ Gender: M / F

*Please check any symptoms you are experiencing that are **related to your complaint today:**

Allergic/Immunologic	Ears/Nose/Mouth/Throat	Genitourinary	Men Only
Frequent Sneezing	Bleeding Gums	Pain with Urinating	Pain / Lump in Testicle(s)
Hives	Difficulty Hearing	Blood in Urine	Penile Itching, Burning or Discharge
Itching	Dizziness	Difficulty Urinating	Problems Stopping or Starting Urine Stream
Runny Nose	Dry Mouth	Incomplete Emptying	Waking up to Urinate at Night
Sinus Pressure	Ear Pain	Urinary Frequency	
Cardiovascular	Frequent Infections	Loss of Urinary Control	
Chest Pressure/Pain	Frequent Nosebleeds	Hematologic / Lymphatic	
Chest Pain on Exertion	Hoarseness	Easy Bruising / Bleeding	Sexual Problems / Concerns
Irregular Heart Beats	Mouth Breathing	Swollen Glands	History of Sexually Transmitted Diseases
Lightheaded	Mouth Ulcers	Integumentary (Skin)	
Swelling (Edema)	Nose/Sinus Problems	Changes in Moles	Women Only
Shortness of Breath When Lying Down	Ringing in Ears	Dry Skin	Bleeding Between Periods
	Endocrine	Eczema	Heavy Periods
Shortness of Breath When Walking	Increased Thirst / Urination	Growth / Lesions	Extreme Menstrual Pain
Constitutional	Heat / Cold Intolerance	Itching	Vaginal Itching, Burning, or Discharge
Exercise Intolerance	Gastrointestinal	Jaundice (Yellow skin or eyes)	Waking up to Urinate at Night
Fatigue	Abdominal Pain	Rash	Hot Flashes
Fever	Black / Tarry Stool	Respiratory	Breast Lump
Weight Gain (_____ lbs)	Blood in Stool	Cough	Breast Pain
Weight Loss (_____ lbs)	Change in Appetite	Coughing up Blood	Nipple Discharge
Travel within 10 Days Where:	Frequent Indigestion	Shortness of Breath	No Periods
	Hemorrhoids	Sleep Apnea	Painful Intercourse
Eyes	Trouble Swallowing	Snoring	History of Sexually Transmitted Diseases
Dry Eyes	Vomiting	Wheezing	
Eye Irritation	Constipation	Difficulty Breathing	
Vision Changes	Diarrhea	Neurological	
Psychiatric	Nausea	Dizziness	
Anxiety / Stress	Musculoskeletal	Fainting	
Depression	Back Pain	Headaches / Migraines	
Do Not Feel Safe in Relationship	Joint Pain	Memory Loss	
Mania	Muscle Aches	Numbness	
Sleep Problems	Muscle Weakness	Restless Legs	
		Seizures	
		Weakness	

Memphis Lung Physicians Foundation
MEMBER OF BAPTIST MEDICAL GROUP

PRIVACY NOTICE (HIPAA) ACKNOWLEDGEMENT

The signature below acknowledges a copy of this notice was RECEIVED (not necessarily read.)

Date ↑

Patient/Legal Representative Signature ↑

NOTICE OF PRIVACY PRACTICES

Effective Date October 1, 2018

THIS NOTICE OF PRIVACY PRACTICES 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 of Privacy Practices, please contact 1-877-BMH-TIPS and choose Option 3 during regular business hours. If necessary, your question may be directed to the Privacy and Security Officer, or their designee, at the hospital, clinic, doctor's office, or other health care entity to which your question refers. You may also contact the Corporate Privacy and Security Department at Baptist Memorial Health Care Corporation, 350 N. Humphreys Blvd., Memphis, TN 38120.

WHO WILL FOLLOW THIS NOTICE: This notice describes our privacy practices and that of:

- ⊕ The physician members of the hospital's medical staff and credentialed, non-physician health care professionals who may provide care in the hospital
- ⊕ All departments and units of the hospital
- ⊕ Any volunteers who perform volunteer work in the hospital, clinic, doctor's office, or other health care entity All employees, staff and other personnel at the hospital, clinic, doctor's office, or other health care entity

BMH is an abbreviation for

- Baptist Memorial Hospital
- BMH-Booneville
- BMH-Calhoun
- Baptist Nursing Home – Calhoun, Inc
- BMH-Collierville
- BMH-Carroll County
- BMH-Crittenden
- BMH-Desoto
- BMH-Golden Triangle
- BMH-Memphis
- BMH-North Mississippi
- BMH-Tipton
- BMH-Union City
- BMH-Union County
- BMH-for Women
- Spence and Becky Wilson Baptist Children's Hospital
- Baptist Memorial Restorative Care Hospital
- NEA Baptist Memorial Hospital
- Baptist Minor Medical Centers, Inc.
- Kemmons Wilson Family Center for Good Grief
- Baptist Home Medical Equipment Medical Alternatives
- Baptist BestHealth, Inc.
- All Offices/Foundations affiliated with Baptist Medical Group
- Baptist Medical Group Outpatient Care Center
- Memphis Lung Physicians Foundation
- Family Physicians Group Foundation
- Gastrointestinal (GI) Specialists Foundation
- The Stern Cardiovascular Foundation
- Baptist Cancer Center Physicians Foundation
- NEA Baptist Clinic Charitable Foundation
- NEA Baptist Clinic Foundation
- Fowler Family Center for Cancer Care
- Baptist Clinical Research Institute
- Baptist Cancer Research Center
- Baptist Memorial Health Services
- Universal Parenting Place

- Walnut Grove Plaza Pharmacy
- Golden Triangle Outpatient Pharmacy
- Brain and Spine Network: Baptist + Semmes-Murphey, LLC Baptist Memorial Health Care Corporation
- Baptist Memorial Hospital Mississippi
- Baptist Medical Center
- Baptist Memorial Hospital - Attala Baptist Memorial Hospital - Leake Baptist Memorial Hospital - Yazoo
- All Offices/ Clinics affiliated with Medical Foundation of Central Mississippi (Baptist Medical Groups Clinics) Baptist Adult Day Centers

All these entities, sites and locations follow the terms of this Notice of Privacy Practices. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or health care operations purposes described in this Notice of Privacy Practices.

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 this health care entity to provide you with quality care and to comply with certain legal requirements. This Notice of Privacy Practices applies to all of the records of your care generated by this entity, whether made by entity personnel or your personal doctor. Unless your personal doctor is a member of a physician group listed at the beginning of this Notice of Privacy Practices, your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's own office or clinic.

This Notice of Privacy Practices will tell you about the ways in which we 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 keep private medical information that identifies you; give you this notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the Notice of Privacy Practices currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. For better understanding, we have provided some examples in each category. 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.

General Uses and Disclosures That May Be Made Without Authorization or Without an Opportunity to Object. Under the Privacy Rules, we are permitted to use and disclose your health information for the following purposes, without obtaining your permission or authorization:

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, technicians, medical students, students in other health care fields, or other 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. Different departments of the health care entity also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We may disclose medical information about you to people outside the entity who may be involved in your medical care after you leave the entity, such as family members assisting you or other health care providers, such as nursing homes, home health care agencies, or medical equipment providers. We also may use your medical information to contact you to check that you are progressing in your recovery. In addition, if you receive treatment from an entity that participates in a Health Information Exchange, we will share your health information with the Health Information Exchange. Other healthcare providers who are not affiliated with the above listed entities may access your health information through these health information exchanges as part of your treatment. Contact the Corporate Privacy and Security Officer at Baptist Memorial Health Care Corporation, 350 N. Humphreys Blvd., Memphis, TN 38120 for questions or concerns.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at this entity 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 surgery you received so your health plan will pay us or reimburse you for the surgery. 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 share your information with other health care providers who treat you, such as an ambulance service or a physician who serves as a consultant during your treatment.

Note on the Right to Request a Restriction. You have the right to request that we do not file a visit with your insurance company. However, there are certain limits on that right: 1) You must pay out-of-pocket for the full cost of the visit. If we cannot unbundle the visit from other services, you will need to pay in full for the entire bundle of services, 2) You will have to pay each provider who would otherwise have the right to bill insurance for the services they provided to you, 3) If the final amount of charges cannot be calculated during the time of your visit, you will be asked to pay an estimated amount at the time of the visit and any difference between the final and estimated amount when the final amount is known. If you fail to pay the difference between the final and estimated amount, then we have the right to file the claim with your insurance company. To restrict a disclosure of protected health information to a health plan for item(s) or service(s) paid out-of-pocket, you must make that request at the time of the visit to the hospital, clinic, doctor's office, or other health care entity providing the services listed on page one of this Notice of Privacy Practices.

For Health Care Operations. We may use and disclose medical information about you for this entity's operations and the collective operations of the entities covered by this Notice of Privacy Practices. These uses and disclosures are necessary to run the entity 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 information about our patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, students in other health care fields, and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other health care providers 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 also use and disclose your medical information when providing customer service, responding to complaints and appeals, providing case management, care coordination, employee health services, conducting medical review of claims and other quality assessment and improvement activities, conducting internal training programs for supervisory purposes, teaching health professionals, and activities associated with licensing and issuance of credentials for our staff.

Group Health Plan Disclosures. We may disclose your PHI to a sponsor of a group health plan, such as an employer or other entity that is providing a health care program to you. We can disclose your PHI to that entity if they have contracted with us to administer your health care program on their behalf.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law, including with the Department of Health and Human Services.

Health Information Exchange. Many facilities participate in one or more health information exchanges. A health information exchange facilitates sharing of information among health care organizations such as hospitals, clinics, health plans and state or federal- mandated reporting organizations. This facility may also participate in a health information exchange that allows for the sharing of information between hospitals, doctors, and health plans.

Accountable Care Organization. We participate in the Connected Care of West Tennessee Accountable Care Organization ("ACO"). ACOs are organizations formed by groups of doctors and health care providers that have agreed to work together to improve care coordination and provide care that is appropriate, safe and timely. An ACO must meet quality standards set by the Centers of Medicare Medicaid Services (CMS). We share information with the ACO to carry out the health care operations, which may include, for example, information regarding a physician's compliance with ACO protocols in the physician's treatment of you. If you do not want Medicare to share information about the health care you received with the ACO, you need to call 1-800-633-4227. We can't communicate with Medicare on your behalf.

Photographs. We may photograph patients, including newborn babies, for security and identification purposes. In certain circumstances, we may take photographs to document wounds, changes in wound healing, or for other treatment related purposes.

Patient Satisfaction Surveys. We may use a limited amount of information about you to conduct patient satisfaction surveys by telephone and written communications, including email. If you do not want to receive a patient satisfaction survey, you need to let us know by calling 1-877-BMH-TIPS and choosing Option 3.

Patient Reunions. Baptist currently sponsors reunions each year for various patient groups, such as Transplant and Neonatal Intensive Care Unit graduates, to celebrate their successes. If you are a graduate of these programs, or similar programs, we may use your information to contact you and invite you to the reunions.

Health Awareness Materials. We may use your demographic information to send general health information to you to create awareness in the community of important health topics.

Health Fairs/Screenings. We may use your information to contact you with the results of any screenings that are not available on the day of the health fair/screening. We may keep a copy of your screenings to verify that you received screenings at a health fair.

Personal Representatives. If you have an advance directive, such as a Durable Power of Attorney for Health Care, or if a court has appointed a guardian for you, we will share information regarding your treatment with your personal representative unless we believe that the sharing of information would jeopardize your health or safety.

Appointment Reminders. We may use and disclose your information to contact you as a reminder that you have an appointment for medical care. This practice includes contacting you by mail, telephone, email, text message, or through the MyChart patient portal.

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. This includes reviewing your medical information to see if you meet the criteria to be eligible to participate in clinical trials.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Fund Raising Activities. We may use your demographic information and other limited information, including dates of service and department of service, to contact you in an effort to raise money for any of the entities covered by this Notice of Privacy Practices and their operations. We may disclose information to a foundation related to the entity so that the foundation may contact you in raising money for the entity. If you do not want the foundation to contact you for fund raising efforts, you must notify Baptist Memorial Health Care Foundation by calling 1-800-895-4483.

Email. If you provide us with an email address, we may use that email address to contact you for any general communications, such as appointment reminders, patient reunion invitations, patient satisfaction surveys, health awareness materials, etc.

Research. Under certain circumstances, we may use and disclose your medical information for research purposes. All research projects, as required by federal regulation, are subject to an approval process, using an Institutional Review Board (IRB). Before we disclose medical information contained in medical records to a researcher, the project will have been approved by the IRB. In addition, we may also contact you about eligibility to participate in a clinical trial.

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.

Business Associates. We may disclose your protected health information to third party "business associates" that perform various activities (e.g. billing, insurance, release of information services) for or on our behalf. Our business associates may use, disclose, create, receive, transmit or maintain protected health information during the course of providing services to us. Business Associates are also required to protect your protected health information under HIPAA.

SPECIAL SITUATIONS

We are allowed or required by law to share your information in other ways. We have to meet certain conditions set forth in the law before we can share your information for these purposes.

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.

Access by Parents. Some state laws concerning minors permit or require disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the law of the state where the treatment is provided and will make disclosures following such laws.

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.

Medical Surveillance of the Workplace. If you are an employee who is being evaluated at the request of your employer for medical surveillance of the workplace or in relation to a work-related illness or injury, we may share information obtained from such evaluation with your employer.

Public Health Risks. 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 suspected child or adult abuse or neglect; 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.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, 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 and other laws and regulations or to participate in registries such as cancer registries. We may also disclose medical information to lawyers or consultants who are providing services to a health care entity listed on this Notice of Privacy Practices or a related entity regarding a legal or regulatory matter.

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 we receive written assurances that the party seeking your medical information has made efforts to tell you about the request or to obtain an order protecting the information requested. We may use your medical information to defend a legal action against a health care entity listed on this Notice of Privacy Practices or a related legal entity.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official as follows: 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 location of the health care entity; 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 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.

Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

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.

Uses and Disclosures Which Require the Opportunity to Agree or Object. Under the Privacy Rules, we are permitted to use and disclose your health information without your authorization when you are informed in advance of the use and disclosure and have the opportunity to agree, object, or limit the use or disclosure. Unless you advise us of your objection to these uses, we will assume that the use of your personal health information, as described in this section of the Notice of Privacy Practices, is acceptable to you.

Hospital Directory. We may include certain limited information about you in the hospital directory while you are a patient at the hospital so your family and friends can visit you in the hospital and generally know how you are doing. This information includes your name, location in the hospital, and your general condition (e.g., good, satisfactory, critical, etc.). The directory information may be released to people who ask for you by name; unless you specifically request that we do not include you in the hospital directory. Additionally, your religious affiliation,

if you provide it to us at registration, may be given to a minister of your faith even if they do not ask for you by name. This allows you to receive visits from a clergy of your faith. If you do not provide us with your religious affiliation during registration, your name will not be given to any visiting clergy. If you do not want us to list this information in our directory and provide it to clergy or others, you must tell us that you object.

Notification. We may use or disclose protected health information to notify, identify, or locate a family member, personal representative or another person responsible for your care, to inform them of your health status or condition, or death (unless doing so is inconsistent with any prior expressed preference that is known to us). We may disclose your protected health information to a public or private entity authorized by law to assist in disaster relief efforts. In the event of a disaster, we may disclose medical information about you to an entity assisting in a disaster relief effort (such as the Red Cross) so that your family can be notified about your condition, status and location. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with family and others.

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 with your medical care or payment for services, unless you inform us that you object to such disclosure. (However, you may not use such an objection to avoid payment for services by a responsible party.) We may use or disclose information about you to locate and notify your family, personal representative or other person responsible for your care that you are in the hospital, clinic, or doctor's office and your general condition.

Immunizations. We may provide proof of immunization to a school that is required by state or other law to have such proof with agreement to the disclosure by a parent or guardian of, or person acting in loco parentis for an unemancipated minor.

Uses and Disclosures Which Require Written Patient Authorization. The following types of uses and disclosures require written authorization from the patient:

Psychotherapy notes. Most uses and disclosures of your psychotherapy notes will require your written authorization, except for uses or disclosures for carrying out treatment, payment, or health care operations, as required by law, health oversight activities, or to avert a serious threat to health or safety.

Marketing. We must obtain your authorization prior to using or disclosing your protected health information to make a communication about a product or service that encourages recipients of the communication to purchase or use the product or service, excluding face to face communications and promotional gifts of nominal value. However, we may send you communications that relate to your treatment, case management or care coordination.

Sale of Protected Health Information. Any disclosure of your personal information which constitutes a sale under regulatory definitions because we would receive something of financial value in exchange for providing your personal information.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this Notice of Privacy Practices or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, 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 authorization, and that we are required to retain our records of the care that we provided to you.

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 obtain a copy of medical information used to make decisions about your care. Usually, this generally includes medical and billing records. To inspect or request a copy of medical information used to make decisions about you, you must submit your request in writing to the Health Information Management Department at the hospital, clinic, doctor's office, or other health care entity from whom you (or another person or entity designated by you) are seeking a copy of your medical information. We will provide a copy or summary of your health information, usually within ten (10) days of your request for clinics or physician offices and thirty (30) days for hospitals, or other health care entities. If you request a copy of the information, we may charge a reasonable, cost-based fee. If the hospital, clinic, doctor's office, or other health care entity from whom you

are requesting a copy of your records maintains records electronically, you (or another person or entity designated by you) will have the option to receive an electronic copy of your records. Alternatively, you may request an abstract of your record via the Baptist electronic patient portal, MyChart.

Note on Limitation of the Right to Access. We may deny your request to inspect and obtain a copy in certain, limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

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 hospital, clinic, doctor's office, or other health care entity whose records you are seeking to amend. To request an amendment, your request must be made in writing and submitted to the hospital, clinic, doctor's office, or other health care entity whose records you are seeking to amend. 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: 1) was not created by us, 2) unless the person or entity that created the information is no longer available to make the amendment; 3) is not part of the medical information kept by this health care provider; 4) is not part of the information which you would be permitted to inspect and copy; or 5) is accurate and complete. We will send you our decision, in writing, within sixty (60) days from receipt of your request.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for reasons other than treatment, payment or health care operations. For example, an accounting of disclosures would include disclosures that we are required by law to make, such as reporting communicable diseases to the county health department.

To request this accounting of disclosures, you must submit your request in writing to the Corporate Privacy & Security Officer, Baptist Memorial Health Care Corporation, 350 N. Humphreys Blvd., Memphis, TN 38120. Your request must state a time period, which may not be longer than six (6) years prior to the date of your request. The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any cost is incurred.

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 protected health information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. 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 or if disclosure is required by law. To request restrictions, you must make your request in writing to Corporate Privacy and Security Officer, Baptist Memorial Health Care Corporation, 350 N. Humphreys Blvd., Memphis, TN 38120. 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. We will notify you if we do not agree to a requested restriction.