A MEMBER OF BAPTIST MEMORIAL MEDICAL GROUP
MEMPHIS LUNG

Robert W. Schriner, MD, FCCP, FAASM
Istvan D. Wollak, MD, FCCP
Joy C. Burbeck, MD
Jeff Wright, MD, PhD, FCCP
Muhammad M. Sheikh, MD
Anurag Mehrotra, MD
Jenna Scruggs, RN, MSN, FNP-C
Kenneth Azuka Okpor, MD, FCCP
Ajay Wagh, MD
Yadana Kyaw, MD
Ravis Curry, MD
Julia H. Barton, MD
Shannon Woods, RN, AGPCNP-BC
Amanda Nelson, RN, MSN, FNP-C
Michael D. Wilons, MD
C. Michael Smith, Jr, MD, FCCP
Todd M. Henderson, MD, FCCP
Rajeev Gupta, MD
Haitham El-Haddad, MD
Stephanie Lamar, RN, MSN, FNP-C
Amy Thomas, RN, MSN, FNP-C

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)

☐ **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)**
- ☐ **Any pertinent records for your visit including any hospitalizations or ER visits in the past six (6) months**
- ☐ **ALL outpatient testing records for any tests that you have had within the past two (2) years; includes CT scans of your chest, PET scans, Chest X-Rays, Lung Scans, Swallow Tests, Echocardiograms, Right Heart Caths, etc.** ***(For any imaging, we must have the images on a disc and we must also have a copy of the report.)***

***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 for your cooperation with this.

A MEMBER OF BAPTIST MEMORIAL MEDICAL GROUP
MEMPHIS LUNG

Late Arrival, Late Cancellation, and No Call/No Show Policy

Our goal at Memphis Lung Physicians Foundation is to provide exceptional individualized medical care. "Late Arrivals", "Late Cancellations", and "No Shows" create significant barriers for individuals who need access to medical care in a timely manner. As a courtesy, Memphis Lung Physicians Foundation issues reminder phone calls at least 48 hours in advance of our patient's appointments, furthering the expectation that patients arrive on time and/or cancel/reschedule their appointments in adequate time to allow for other patients to be seen. Communication regarding late arrivals and cancellations is of the utmost priority.

NOTICE: Effective September 1, 2019, the following policy will be enforced at all Memphis Lung Physicians Foundation facilities.

Late Arrival

If you arrive ***greater than 15 minutes after your scheduled check-in time without notifying our staff and receiving approval***, Memphis Lung Physicians Foundation reserves the right to reschedule your appointment for a different date and time.

Late Cancellation

We require that you notify the clinic of a cancellation 24 hours in advance of your scheduled appointment. ***Failure to cancel your appointment 24 hours in advance of your scheduled arrival time will result in a $25.00 Late Cancellation fee for each late cancellation.*** If it is determined that you habitually fail to provide adequate notice of your appointment cancellation, Memphis Lung Physicians Foundation will provide you with written notice.

No Call / No Show Appointments

If you fail to appear for a scheduled appointment, Memphis Lung Physicians Foundation follows the guidelines below:

1st and 2nd Missed Appointment: You will receive written notice regarding your No Call/No Show appointment and you will also incur a $25.00 "No Show Fee" for each occurrence.

3rd Missed Appointment: You will receive ***final*** written notice regarding your refusal to comply with the Memphis Lung Physicians Foundation No Show policy. As of your third No Show appointment, you will be referred back to your primary care provider and no additional appointments will be scheduled for you at Memphis Lung Physicians Foundation until a thorough review of your file has been completed by upper practice management and your provider(s).

It is expected that you satisfy any outstanding Late Cancellation or No Show fee balance incurred at Memphis Lung Physicians Foundation prior to check in at your next scheduled appointment. Please be mindful that these incurred fees are not reimbursable by your insurance company; all fees are billed directly to you, the patient.

By signing below, you acknowledge that you have received and read the guidelines above and that you agree to pay any incurred fees due to your inability to cancel a scheduled appointment within the required time period.

Printed Name	Signature	Date

Baptist Medical Group Inc. (BMG)
Authorization to Release PHI
Physician Practices

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

Address: _____

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

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

_____ _____

Witness Relationship and/or authority to act for the patient

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

1/2012, 4/2013, 9/13

Memphis Lung Physicians Foundation
Medication Sheet

Patient Name _____

Patient DOB _____

Name of Pharmacy _____

Pharmacy Phone # _____

Allergies (Include all allergies, such as drug, food, skin, etc.): _____

To ensure that your medication list is complete, please include all breathing medications, nebulized medications, inhalers, vitamins, herbs, and over-the-counter medications and/or supplements.

Medication Name	**Dosage/Strength/MG/McG**	**Frequency** (Times Per Day/Wk/Mo)

SCORE

Memphis Lung Physicians Foundation

Today's Date: _____

Patient Name: _____

Date of Birth: _____

The Epworth Sleepiness Scale

How likely are you to **doze off** or **fall asleep** in the following situations, in contrast to just "feeling tired"? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to estimate how they would affect you.

Use the following scale to choose ***the most appropriate number*** for each situation:

0 = would ***never*** doze
1 = ***slight*** change of dozing
2 = ***moderate*** chance of dozing
3 = ***high*** chance of dozing

Situation	Chance of Dozing (# from above)
1. Sitting and reading	
2. Watching TV	
3. Sitting, ***inactive***, in a public place (e.g. a theater or meeting)	
4. As a passenger in a car for an hour without a break	
5. Lying down to rest in the afternoon when circumstances permit	
6. Sitting and talking to someone	
7. Sitting quietly after a lunch ***without alcohol***	
8. In a car, while stopped for a few minutes in traffic	

Memphis Lung Physicians Foundation
Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.
Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) = ___ your total score Total score categories:

0–7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)

Memphis Lung Physicians Foundation

Stop-Bang Questionnaire

Name _____

Patient to complete:

1. Do you snore loudly? (Louder than talking - OR - loud enough to be heard through closed doors)	Yes (◯)	No (◯)
2. Do you often feel tired, fatigued, or sleepy during the daytime?	Yes (◯)	No (◯)
3. Has anyone observed you to stop breathing during your sleep?	Yes (◯)	No (◯)
4. Do you have or are you being treated for high blood pressure?	Yes (◯)	No (◯)

NURSE TO COMPLETE

Height _____in Weight_____lbs BMI _____ ? > 35

Age_____ yrs ? > 50

Neck Circumference _____ in ? M > 17 ; F > 16

Gender _____ ? M

Stop-Bang Score _____

SLEEP PATTERN:

How long have you had your sleep problem? _____ ◯ ◯ ◯ Weeks/Months/Years

On average, how long does it take you to fall asleep? _____ ◯ ◯ Minutes/Hours

What time do you usually go to bed? _____

What time do you usually get up? _____

On average, how often do you wake up during the night? _____ Times/night

On average, how long do you actually sleep at night? _____ ◯ ◯ Minutes/Hours

Do you take naps? Yes ◯ No ◯ How Long? _____ ◯ ◯ Minutes/Hours

Do you take any sleep medications? Yes ◯ No ◯ List: _____

New Patient Sleep Questionnaire

Patient Name: _____ **Birth Date:** _____

Referring Physician: _____ **Date:** _____

Reason for Visit: _____

GENERAL SLEEP

How long have you had your sleep problem?			
Do you snore?	Yes ○	No ○	Describe:
Do you stop breathing in your sleep?	Yes ○	No ○	Describe:
Do you wake up frequently overnight (more than 2 times)?	Yes ○	No ○	Describe:
Do you feel tired and non-refreshed when you wake up after your sleep period?	Yes ○	No ○	Describe:
Previously diagnosed with sleep apnea?	Yes ○	No ○	When/where:
Are you currently on CPAP/Bi-Level therapy?	Yes ○	No ○	Pressure setting:
Are you having trouble with CPAP/Bi-Level therapy?	Yes ○	No ○	Describe:
Are you under any stress, or feel depressed or anxious?	Yes ○	No ○	Describe:

Do you wake-up with any of the following?	Headache ☐	Dry mouth ☐	Sore throat ☐	Other:

SLEEP PATTERN

** Please answer these questions for an average day/night **

What time do you usually go to bed?			
How long does it take you to fall asleep?			
How often do you wake-up during the night?		How long does it take you to fall back to sleep? (minutes)	
What time do you wake-up in the morning?		What time do you get out of bed?	
What is the total time that you spend sleeping overnight?			
Do you take naps?	Yes ○	No ○	How many?
Do you keep the same sleep schedule on weekends/holidays/vacations?	Yes ○	No ○	Describe:
Have you ever done shift work?	Yes ○	No ○	Describe:
Describe your usual bedtime routine:			

SLEEP BEHAVIORS

Any factors that you can identify that contribute to your sleep difficulty? (i.e.: Pain, disturbances in the environment, etc.)

What position do you sleep in?(circle)	Back ◯	Side ◯	Stomach ◯	Toss and Turn ◯

Do you take any medications to help you sleep?	Yes ◯	No ◯	Describe:
How much caffeine do you drink per day? (cups)		What time is your last cup?	
Does your mind race when you lay down to fall asleep?	Yes ◯	No ◯	Describe:
Have you experienced drowsy driving or fallen asleep while operating a motor vehicle?	Yes ◯	No ◯	Describe:

Do you engage in any of the following activities that may keep you from falling asleep , such as: (Circle)

Clock watching?	YES ◯ NO ◯	Stick to a sleep schedule?	YES ◯ NO ◯
Watching TV?	YES ◯ NO ◯	Get enough morning daylight?	YES ◯ NO ◯
Computer usage?	YES ◯ NO ◯	Exercise regularly?	YES ◯ NO ◯
Phone usage?	YES ◯ NO ◯	Avoid daytime napping?	YES ◯ NO ◯
Reading?	YES ◯ NO ◯	Any post-lunch caffeine?	YES ◯ NO ◯
Listening to music?	YES ◯ NO ◯	Any nighttime nicotine?	YES ◯ NO ◯
Alcohol consumption?	YES ◯ NO ◯	Wind down before bedtime?	YES ◯ NO ◯
Stay in bed if unable to fall asleep within 30 minutes?	YES ◯ NO ◯	Keep room quiet, dark, comfortable?	YES ◯ NO ◯

Have you gained weight recently?	Yes ◯	No ◯	How much? Over how long?

Any factors that you can identify that contribute to your sleep difficulty? (i.e.: indigestion, pain, noise, etc.)

OTHER SLEEP SYMPTOMS

Restless Legs Symptoms: When sitting quietly for prolonged periods or when lying down to go to sleep do you suffer from:

A strong urge or desire to move the limbs, often associated with abnormal sensations?	YES ◯ NO ◯
Symptoms are worse or present only during rest and get partially or temporarily better with activity?	YES ◯ NO ◯
Nighttime worsening of symptoms?	YES ◯ NO ◯

Do you suffer from frequent nightmares?	Yes ◯	No ◯	How often?
Do you grind your teeth?	Yes ◯	No ◯	Describe:
Any history of sleep walking?	Yes ◯	No ◯	Describe:
Any history of sleep eating?	Yes ◯	No ◯	Describe:
Are you aware of any unusual behavior or activity such as muscle twitches, leg kicking, acting out dreams during sleep?	Yes ◯	No ◯	Describe:
When you first wake up, do you ever feel like your mind is awake, but your body is paralyzed?	Yes ◯	No ◯	Describe:
Do you have hallucinations or vivid dreams upon falling asleep or awakening from sleep?	Yes ◯	No ◯	Describe:
Do you experience muscle weakness with strong emotions?	Yes ◯	No ◯	Describe:
Have you ever fallen asleep at inappropriate times? (i.e. during a conversation)	Yes ◯	No ◯	Describe:
Do you have chronic nasal congestion? Or seasonal allergies?	Yes ◯	No ◯	Medications:
Any history of nasal trauma or been told that you have a deviated septum?	Yes ◯	No ◯	Describe:
Have you had a tonsillectomy?	Yes ◯	No ◯	Describe:

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
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Cardiovascular
- ☐ Chest Pressure/Pain
- ☐ Chest Pain on Exertion
- ☐ Irregular Heart Beats
- ☐ Lightheaded
- ☐ Swelling (Edema)
- ☐ Shortness of Breath When Lying Down
- ☐ Shortness of Breath When Walking

Constitutional
- ☐ Exercise Intolerance
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain (_____ lbs)
- ☐ Weight Loss (_____ lbs)
- ☐ Travel within 10 Days Where:

Eyes
- ☐ Dry Eyes
- ☐ Eye Irritation
- ☐ Vision Changes

Psychiatric
- ☐ Anxiety / Stress
- ☐ Depression
- ☐ Do Not Feel Safe in Relationship
- ☐ Mania
- ☐ Sleep Problems

Ears/Nose/Mouth/Throat
- ☐ Bleeding Gums
- ☐ Difficulty Hearing
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Ear Pain
- ☐ Frequent Infections
- ☐ Frequent Nosebleeds
- ☐ Hoarseness
- ☐ Mouth Breathing
- ☐ Mouth Ulcers
- ☐ Nose/Sinus Problems
- ☐ Ringing in Ears

Endocrine
- ☐ Increased Thirst / Urination
- ☐ Heat / Cold Intolerance

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black / Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Frequent Indigestion
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness

Genitourinary
- ☐ Pain with Urinating
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Incomplete Emptying
- ☐ Urinary Frequency
- ☐ Loss of Urinary Control

Hematologic / Lymphatic
- ☐ Easy Bruising / Bleeding
- ☐ Swollen Glands

Integumentary (Skin)
- ☐ Changes in Moles
- ☐ Dry Skin
- ☐ Eczema
- ☐ Growth / Lesions
- ☐ Itching
- ☐ Jaundice (Yellow skin or eyes)
- ☐ Rash

Respiratory
- ☐ Cough
- ☐ Coughing up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing
- ☐ Difficulty Breathing

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches / Migraines
- ☐ Memory Loss
- ☐ Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

Men Only
- ☐ Pain / Lump in Testicle(s)
- ☐ Penile Itching, Burning or Discharge
- ☐ Problems Stopping or Starting Urine Stream
- ☐ Waking up to Urinate at Night
- ☐ Sexual Problems / Concerns
- ☐ History of Sexually Transmitted Diseases

Women Only
- ☐ Bleeding Between Periods
- ☐ Heavy Periods
- ☐ Extreme Menstrual Pain
- ☐ Vaginal Itching, Burning, or Discharge
- ☐ Waking up to Urinate at Night
- ☐ Hot Flashes
- ☐ Breast Lump
- ☐ Breast Pain
- ☐ Nipple Discharge
- ☐ No Periods
- ☐ Painful Intercourse
- ☐ History of Sexually Transmitted Diseases

BAPTIST | SLEEP DISORDER CENTER DESOTO

Name: _____ **Date:** _____

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY. Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1	0	I do not feel sad .	12	0	I have not lost interest in other people.
	1	I feel sad.		1	I am less interested in other people than I used to be.
	2	I feel sad all of the time and I cannot snap out of it.		2	I have lost most of my interest in other people.
	3	I am so sad or unhappy that I can't stand it.		3	I have lost all of my interest in other people.
2	0	I am not particularly discouraged about the future.	13	0	I make decisions about as well as I ever could.
	1	I feel discouraged about the future.		1	I put off making decisions more than I used to.
	2	I feel I have nothing to look forward to.		2	I have greater difficulty in making decisions than before.
	3	I feel that the future is hopeless and that things cannot improve.		3	I can't make decisions at all anymore.
3	0	I do not feel like a failure.	14	0	I don't feel I look any worse than I used to.
	1	I feel I have failed more than the average person.		1	I am worried that I am looking old or unattractive.
	2	As I look back on my life, all I can see if a lot of failure.		2	I feel that there are permanent changes in my appearance that make me look unattractive.
	3	I feel I am a complete failure as a person.		3	I believe that I look ugly.
4	0	I get as much satisfaction out of things as I used to.	15	0	I can work about as well as before.
	1	I don't enjoy things the way I used to.		1	It takes an extra effort to get started at doing something.
	2	I don't get real satisfaction out of anything anymore.		2	I have to push myself very hard to do anything.
	3	I am dissatisfied or bored with everything.		3	I can't do any work at all.
5	0	I don't feel particularly guilty.	16	0	I can sleep as well as usual.
	1	I feel guilty a good part of the time.		1	I don't sleep as well as I used to.
	2	I feel quite guilty most of the time.		2	I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
	3	I feel guilty all of the time.		3	I wake up several hours earlier than I used to and cannot get back to sleep.
6	0	I don't feel I am being punished.	17	0	I don't get more tired than usual.
	1	I feel I may be punished.		1	I get tired more easily than I used to.
	2	I expect to be punished.		2	I get tired from doing almost anything.
	3	I feel I am being punished.		3	I am too tired to do anything.
7	0	I don't feel disappointed in myself.	18	0	My appetite is no worse than usual.
	1	I am disappointed in myself.		1	My appetite is not as good as it used to be.
	2	I am disgusted with myself.		2	My appetite is much worse now.
	3	I hate myself.		3	I have no appetite at all anymore.
8	0	I don't feel I am any worse than anybody else.	19	0	I haven't lost much weight, if any, lately.
	1	I am critical of myself for my weaknesses or mistakes.		1	I have lost more than 5 pounds.
	2	I blame myself all the time for my faults.		2	I have lost more than 10 pounds.
	3	I blame myself for everything bad that happens.		3	I have lost more than 15 pounds.
					I am purposely trying to lose weight by eating less. **Yes** _____ **No** _____
9	0	I don't have any thoughts of killing myself.	20	0	I am no more worried about my health than usual.
	1	I have thoughts of killing myself, but I would not carry them out.		1	I am worried about my physical problems, such as aches and pains; or upset stomach, or constipation.
	2	I would like to kill myself.		2	I am very worried about physical problems and it's hard to think of much else.
	3	I would kill myself if I had the chance.		3	I am so worried about my physical problems that I cannot think about anything else.
10	0	I don't cry any more than usual.	21	0	I have not noticed any recent change in my interest in sex.
	1	I cry more now than I used to.		1	I am less interested in sex than I used to be.
	2	I cry all the time now.		2	I am much less interested in sex now.
	3	I used to be able to cry, but now I can't cry even though I want to.		3	I have lost interest in sex completely.
11	0	I am no more irritated now that I ever am.			
	1	I get annoyed or irritated more easily than I used to.			
	2	I feel irritated all the time now			
	3	I don't get irritated at all by the things that used to irritate me.			

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.

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