Tift Regional Medical Center
Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

This notice describes this facility's practices and that of: all physicians and health care practitioners who have clinical privileges; any health care practitioner authorized to enter information into your medical record; all departments, units or clinics of this facility, whether located on the hospital campus or at other locations; any member of a volunteer group we allow to help you while you are in this facility; and all employees, staff and other facility personnel. All these persons, entities, sites and locations may share medical information with each other for treatment, payment or operations as described in this notice.

Your Rights:

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting the HIPAA Privacy Officer at (229)353-7553 or submitting a written complaint to kathy.alberson@tiftregional.com.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting: **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

Unless you tell us otherwise:

- We may share information with your family, close friends, or others involved in your care or payment for your care
- In the event of a disaster, we may share information to a disaster relief organization
- We may include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures:

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition

Run our organization
We can use and share your health information to run our facility, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- Sharing immunization records with educational institutions
- Evaluating workplace injuries or illnesses

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities:
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information you may contact our HIPAA Privacy Officer at (229) 353-7553 or email kathy.alberson@tiftregional.com or you may visit www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our facilities, and on our web site.

Other Terms
This facility and the physicians and other health care providers who have clinical privileges/functions at this facility work together in an organized health care arrangement to provide medical services to you when you are a patient of this facility. This facility and such physicians and other health care providers will share medical information that they collect from you at this facility as necessary to carry out treatment, payment, healthcare operations relating to the provision of care to patients at this facility.

Notice effective date: September 23, 2013.

You may Contact the HIPAA Privacy Officer, (229)353-7553, kathy.alberson@tiftregional.com.

TIFT REGIONAL MEDICAL CENTER

Consent to Medical Treatment and Hospital Admission

ACKNOWLEDGEMENT OF JOINT NOTICE OF PRIVACY PRACTICES

PRINTED NAME OF PATIENT

SIGNATURE PATIENT/REPRESENTATIVE

REPRESENTATIVE RELATIONSHIP TO PATIENT

(if applicable)

DATE

TIME

☐ Patient is unable to sign written consent for initial treatment but gives verbal consent

☐ Patient is unable to sign or give verbal consent.

WITNESS

DATE

TIME

Affinity Pediatrics
Individual/Family History Data

Child's Name: _____ Birth Date: _____

Address: _____ Phone: _____

_____

Parent/Guardian Name: _____ Relationship to Patient: _____

PERSONAL HISTORY

BIRTH HISTORY

Hospital _____

Home _____

Other _____

Delivery Type:

Vaginal _____ C Section _____

Length of Pregnancy _____

Condition at Birth:

Weight _____ Length _____

Jaundice: Y N Unknown

Birth Defects: Y N Unknown

Breathing Prob: Y N Unknown

Metabolic Screening: Y N Unknown

Result _____

Hgb. Electrophoresis: Y N

Results _____

Hearing: Pass Fail

Other, Specify: _____

Comments: _____

_____

HEALTH HISTORY

Allergies, Specify:

Drugs _____

Foods _____

Vaccines _____

Insects _____

Other _____

Anemia _____

Asthma _____

Ear Infection _____

Heart Trouble _____

Kidney/Bladder Infection _____

Manarche _____

Respiratory Disease _____

Rheumatic Fever _____

Scarlet Fever/Strep _____

Seizures _____

Vaccine Prevent Disease ___

Vision Color Test Date _____

Other, Specify _____

Comments: _____

HOSPITALIZATIONS/SURGERIES

_____

_____

_____

Accidents: _____

_____

_____

Current Health Problems:

(Specify Condition & Source of Treatment)

_____

_____

_____

_____

Current Medication & Dosages:

_____

_____

_____

_____

Primary Care Provider:

_____

Affinity Pediatrics
Individual/Family History Data

_____ _____ _____

FAMILY HISTORY

CODES: M—Mother F—Father S—Sibling C—Child MGM/MGF—Maternal Grandmother/Grandfather

PGM/PGF—Paternal Grandmother/Grandfather MA/MU—Maternal Aunt/Uncle PA/PU—Paternal Aunt/Uncle

Alcohol Abuse _____	Heart Condition _____	Sickle Cell Disorder _____
Allergies _____	Hypertension _____	Smoking _____
Birth Defects _____	Kidney Disease _____	Stroke _____
Blood Disorder/Anemia _____	Liver Disease _____	Tuberculosis _____
Cancer _____	Mental Illness _____	Vision Loss _____
Diabetes _____	Mental Retardation _____	Other _____
Drug Abuse _____	Multiple Births _____	_____
Hearing Loss _____	Neuromuscular _____	_____
(Childhood) _____	Seizures _____	_____

TUBERCULOSIS RISK ASSESSMENT QUESTIONAIRE:

Any YES answer indicates child is high risk and should receive a TB skin test (Mantoux).

1) Is the child a close contact person of a person with infectious tuberculosis? _____
2) Does the child have HIV infection or is he/she considered at risk for HIV infection? _____
3) Is the child foreign born (especially Asian, African, Latin American), a refugee or a migrant? _____
4) Is the child in contact with an incarcerated person who was incarcerated in the past five (5) years? _____
5) Is the child exposed to the following individuals: (HIV infected, illicit drug user, homeless, nursing home resident, institutionalized or incarcerated adult/adolescent, or a migrant farm worker? _____
6) Does the child have a medical condition or treatment of a medical condition which suppresses the immune system? _____
7) Does the child live in a community in which it has been established that a high risk exists for Tuberculosis? _____
8) Other? _____

UPDATE AND INDICATE ANY CHANGES AT EACH VISIT. USE THIS PAGE FOR ADDITIONAL INFORMATION AND NOTES

_____
_____
_____
_____

Tift Regional Physician Services

Abbeville Primary Care – Affinity Clinic – Affinity Pediatrics- Affinity Hopsital Medicine Transition Clinic
Allure Plastic and Reconstructive Surgery – Ashburn Primary Care - Arthritis and Osteoporosis – Employee Medical Home-
Cook Primary CareCook Family Practice- Irwin Primary Care – Nashville Primary Care - Ocilla Primary Care
Sylvester Family Practice - Tift Family Medicine and Wound Care Center - Tift Regional Anesthesia Pain Management

Medical Records Department
2225 Hwy 41 North Tifton, GA 31794
Phone (229) 391-4160 Fax (229) 391-4495

AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

Patient Name. _____ Medical Record Number:_____

Date of Birth: _____ Social Security # _____

1. I hereby authorize the use or disclosure of the above named individual's health information as described below. _____is authorized to make the disclosure of the following information as indicated: (check all that apply)

☐	problem list	☐	most recent discharge summary
☐	medication list	☐	most recent history and physical
☐	physician orders	☐	physician progress notes
☐	laboratory results	from date _____	to date _____
☐	x-ray / imaging reports	from date _____	to date _____
☐	x-ray films	from date _____	to date _____
☐	consultation reports	from (doctor's name) _____	
☐	entire record limited to	from date _____	to date _____
☐	other_____		

2. I understand these records may contain information concerning sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), drug abuse, alcoholism, sickle cell anemia, and behavior or mental health services.
3. This information may be disclosed to and used by the following individual or organization:

Name: AFFINITY PEDIATRICS Phone No: (229) 353-7335

Address: 39 KENT RD SUITE 5 TIFTON, GA 31794

4. For the following purpose: (check all that apply)

☐	Legal Issue	☐	Insurance Claim	☐	Personal Use
☐	Continuing Care	☐	Other (explain). _____		

5. I understand that this authorization, except for action already taken, may be revoked by me at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. Unless otherwise revoked, this authorization will expire one (1) year from today's date and must post date any date of service being requested.
6. I understand that TRMC/Tift Regional Physician Services will not condition treatment, payment, enrollment, or eligibility for benefits concerning my health care on whether I sign or refuse to sign this authorization.
7. I understand that authorizing the disclosure of this health information is voluntary and that disclosure of such information carries with it the potential for unauthorized re-disclosure.

_____ _____
Signature of Patient or Legal Representative Date Signed

_____ _____ _____
Print Name Relationship to Patient Signature of Witness