Good News Clinics Application Process

Good News Clinics provides free medical and dental care to Hall County residents without insurance or access to healthcare who meet federal poverty level guidelines. Please read the following to ensure you have everything you will need to process your application.

THE FOLLOWING DOCUMENTATION IS REQUIRED TO APPLY

1. Picture ID of yourself
2. Proof that you live in Hall County. This could be a recent utility, cable, phone or hospital bill, rental lease, mortgage, etc, in your name.
3. Proof of your combined household income. This could include:
    a. Current pay stubs for the last four weeks.
    b. Unemployment benefits statement from Ga. Dept. Of Labor.
    c. Work history statement from the Ga. Dept. of Labor
    d. Social Security, disability, pension income statements, workman's comp benefits.
    e. Child support and/or alimony statements.
    f. Self employment income (will need recent tax return).
    g. Rental income.
    h. If you have a spouse who lives with you who has any of these types of income, we will also need proof of that income as well.

    ***NOTE**: **If you have no income and someone other than a spouse is supporting you**, we must have the following documentation from this person:

    Notarized letter from this person stating that they are supporting you and their proof of address. **A copy of form is available from the receptionist. Have the person providing support complete form and have it notarized. If this person comes with you to apply, then letter does not have to be notarized – volunteer can witness signature at time of application.*

4. If receiving food stamps, we will need DFCS verification letter.
5. If claiming children over 18 years of age as part of your household, you must provide active school enrollment/ID documentation.
6. Current tax return is **required** for medication **Patient Assistance Programs (PAP).**

Good News Clinics is open Monday – Friday, 8:30 AM-5:00 PM and provides the following services:

- Medical Clinic - provides ongoing medical care for our patients, including medications as prescribed by our physicians/providers
- Dental Clinic – provides a prevention program, cleanings, fillings and extractions for our patients
- Health Access – specialty referral services for GNC patients
- Patients are seen by appointment

***Application times are as follows:**

*Medical and Dental applications are taken **Monday - Thursday on a sign-in basis at 8:30am on the Dental side.***

****If you are missing any of the above documentation we will not be able to process your application!**

Good News Clinics – Patient Registration & Renewal

(See reverse side for Spanish - Ver reverso para Español)

Personal Information

Today's Date_____

Last Name_____ First_____ Middle_____

Date of Birth_____ Social Security Number_____

Marital Status: _____ **Sex:** ☐Male ☐Female **Ethnicity**: ☐Spanish ☐Non-Spanish

Preferred Language: _____

Race: ☐White ☐Black ☐ Indian ☐Asian ☐Other (Specify):_____

Home Telephone_____ Cell Phone_____ Email: _____

Address_____

Emergency Contact_____ Relationship _____Telephone_____

Employed? ☐ Yes ☐ No **Employer's Name**_____

Employer's Address: _____

INCOME SOURCE: ☐Earned wages ☐Day Laborer ☐SSI Retirement ☐SSI Disability ☐Unemployment ☐Workman's Comp

☐Child Support ☐Rental Income ☐Other _____ **Total Monthly Income** $_____

Insurance(check one): ☐ Health ☐Vision ☐ Dental ☐Medicare ☐Medicaid ☐ Veterans ☐None

Family Members Information (Spouse and Dependents Under 18 years of age or 18-21 and in school):

Name _____ Relation _____ Date of Birth _____ Income $_____

Name _____ Relation _____ Date of Birth _____ Income $_____

Name _____ Relation _____ Date of Birth _____ Income $_____

Name _____ Relation _____ Date of Birth _____ Income $ _____

Name _____ Relation _____ Date of Birth _____ Income $_____

Name _____ Relation _____ Date of Birth _____ Income $_____

HOUSEHOLD SIZE: _____ **TOTAL INCOME:** $ _____

Patient Expenses:

Rent $ _____ Electricity $ _____ Gas $ _____ Water $ _____ Phone $ _____ Cable $ _____

Car Payment $_____ Car Insurance &_____Food $_____ Other $_____

Food stamps? ☐Yes ☐No Amount $_____ **TOTAL EXPENSES:** $_____

Last Physician Seen – Where/When?_____

Have you been to the ER or admitted in the past 4 weeks? ☐Yes ☐No

Reason: _____

PHQ-9 Patient Questionnaire

Patient Name: _____ Date: _____/_____/_____

Date of Birth: _____/_____/_____ Telephone: _____-_____-_____

Gender: Male / Female Preferred Language: Spanish / English

For the Staff: Patient Chart Number _____

Over the ***last 2 weeks***, how often have you been bothered by any of the following problems?

Questions	Not at all	Several Days	More than Half the days	Nearly Everyday
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling/staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed, or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
10. If you circled 1, 2, or 3 for ***any*** of the above questions, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Please circle one of the following choices that best describes your level of difficulty over the past two weeks.	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Good News Clinics is now offering counseling! Counseling is where you can come in and talk to a trained professional about the things that have gone on in your life. A counselor can provide assistance in helping you cope with or resolve personal, social, or psychological issues.

Would you like to receive counseling? Please circle: **Yes / No**

GOOD NEWS CLINICS ANNUAL CONSENT/AUTHORIZATIONS

Patient Name: _____DOB_____

Consent for Treatment:

- Permission is hereby given for any medical/surgical procedures, x-rays, drug or laboratory test, medication, or exam as may be deemed necessary by the Physician, Physician Assistant, or Nurse Practitioner.
- I understand I have the right to see a Physician if I so choose, and have the right to see a Physician prior to any prescription drug or device order being carried out by an Advanced Practitioner.
- In the case of an unemancipated minor, the consent below is being given on his/her behalf.

Consent to Release Medical Information to Others:

Tell us with whom we may discuss your protected health information:
(Name and relation-Example: Jane Doe, spouse; Jane Doe, child)
1)_____ 2) _____ 3) _____

- If you do not authorize information to be released to anyone please check this statement.

❑ **I do not authorize any information to be released to anyone other than myself.**

Authorized Messages:

❑ I hereby authorize messages to be left on a voicemail system or answering machine.

Please check one:

❑ I hereby authorize protected health information, such as lab results and medication information to be left on a voice mail system or answering machine.

❑ I hereby **DO NOT** authorize protected health information, such as lab results and medication information to be left on a voice mail system or answering machine.

Please indicate the contact number(s) Good News Clinics' staff can utilize to leave a message for you:

1)_____ 2) _____ 3) _____

- For Medical Records Release, see the separate Medical Records Release form.

Financial Responsibility:

I understand it is the responsibility of each patient to arrange for payment for the medical services received in relation to care at Good News Clinics. I hereby acknowledge my responsibility to pay for all non-covered services. I also authorize the release of any information necessary to coordinate payment and care outside of Good News Clinics.

I hereby authorize Good News Clinics or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by text messages, by telephone or by cell phone for reasons related to the services I received at Good News Clinics.

By initialing, I acknowledge that I received a copy of the Nondiscriminatory Act Notice.

Acknowledgement of Privacy Rights:

By signing below, I acknowledge that I am aware of the Good News Clinics' Notice of Privacy Practices and Individual Rights. We may use or share your medical information with personnel involved in your care at the Clinics. We may also disclose your medical information to entities outside the Clinics, for purposes of treatment, payment or healthcare operations related to my services with the Clinics.

I acknowledge that I have read the above, am giving my consent to the above, and am acknowledging I have been informed of my rights to privacy.

Signature: _____ Date: _____

Print Name: _____ Email address: _____

Good News Clinics – Privacy Statement, Rules & Procedures Acknowledgment

(See reverse side for Spanish - Ver reverso para Español)

Credit Report Authorization – Good News Clinics provides health and dental care to *residents of Hall County whose income is below 150% of the Federal Poverty Level* and will verify the information you provide in your application with an outside source. By signing below, I authorize the review of my credit report by the Northeast Georgia Health Systems and understand that GNC *cannot approve my care without this authorization.* Patient Initials _____

Privacy Notice Acknowledgement – By signing below, I acknowledge that I have received a copy of the Privacy Notice of Good News Clinics. Patient Initials _____

No Show Policy, Clinic Rules, and Procedures – By signing below, I acknowledge that I have receive a copy of the clinic rules and procedures. If you are unable to keep your appointment, please remember to cancel at least 24 hours before you scheduled appointment time. Patients arriving more than 15 minutes late for an appointment will be counted as a no show and must reschedule their appointment. Please see the policy listed below. Patient Initials _____

First Missed Appointment (new patients) – Should you miss your 1st medical appointment you are to call the clinic regarding the reason for your missed appointment. If you have a valid reason, your appointment can only be rescheduled once. If the second appointment is missed you will no longer be eligible for medical services.

Second Missed Appointment (follow-up) – You will receive a call and a letter by mail to inform you of the consequences of missing a subsequent appointment.

Third Missed Appointment – Someone will contact you to advise that you are no longer eligible for services and you will receive a letter informing you that GNC will no longer be your primary health provider. Medications will only be provided for 30 days while you find a new provider

_____ _____

Print Name of Patient or Legal Representative Patient Date of Birth

(Self) _____

Description of Legal Representative's Authority

_____ _____

Signature of Patient or Legal Representative Today's Date

Good News Clinics
Authorization For Release of Health Information

I hereby authorize _____, and its entities, its officers or agents to permit inspection, copying, and/or release of information in connection with the following:

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

Address: _____ **Telephone #:** _____

I further understand and acknowledge that in complying with my request for release, such disclosure will require Good News Clinics to disclose, as provided under applicable federal law, Protected Health Information, as defined in 45 C.F.R. § 160 et seq.

Information to be disclosed (CHECKING ALL APPLICABLE):

- ☐ **Complete Health Record**
- ☐ **Discharge Summary**
- ☐ **History and Physical Exam**
- ☐ **Consultation Reports**
- ☐ **Progress Notes**
- ☐ **Radiology Reports**
- ☐ **Abstract/Pertinent Information**
- ☐ **Emergency Department Record**
- ☐ **Laboratory Tests**
- ☐ **Other (Please Specify)** _____

I UNDERSTAND THIS MAY NOT INCLUDE INFORMATION RELATING TO THE FOLLOWING UNLESS EXPRESSLY AUTHORIZED BY CHECKING THE BOX(ES) BELOW:

- ☐ **Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)**
- ☐ **Psychiatric Care (Behavioral Health)[1]**
- ☐ **Treatment for Alcohol and/or Drug Abuse[2]**
- ☐ **Genetic Testing**
- ☐ **Sexually Transmitted Diseases (STDs)**

This information is to be disclosed to: Good News Clinics, 810 Pine Street
Gainesville, GA 30501 770-503-1369 (Ph) 770-503-9818 (Fax)

The purpose of the disclosure is _____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. A photocopy or FAX of this document is valid as the original. The expiration date of this release form is (one year from date of signing): DATE: _____

☐ **Signature of Patient or Legal Representative:** _____ **DATE:** _____

If Legal representative, what is the authority or relationship of the person? _____

☐ **Witness:** _____ **DATE:** _____

The patient information requested above may not be further disclosed to any party under any circumstances except with patient's express written consent or as otherwise permitted by law. The information may not be used except for the need specified above.

[1] Except psychotherapy notes as provided under federal and state laws.

[2] PROHIBITION OF REDISCLOSURE: This information has been disclosed from records whose confidentiality is protected by federal and state law. Federal Regulations (42 CFR Part 2) prohibit the receiver of these records from making any further disclosure of this information except with the specific written consent of the person who it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.

PATIENT MEDICAL CLINIC RESPONSIBILITES

1. I understand that The Good News Clinic is a non-profit organization funded solely by community donations, providing me free access to medical services. I also understand that I have the opportunity to assist the clinic through my personal donations at appointment times (donation boxes posted at sign-in windows and all exam rooms).

2. The Good News Clinic is for HALL COUNTY residents without insurance or access to healthcare who meet Federal Poverty Level guidelines. I confirm that none of the information regarding my place of residence or finances has been falsified on my application.

3. Should I get insurance, it is my responsibility to inform the Good News Clinic and seek medical care elsewhere. I understand that I must report any changes of income to determine continued eligibility at the clinic. Failure to report changes in income or insurance, Medicaid, or Medicare eligibility is ground for immediate dismissal from the clinic.

4. I understand that appointment times are valuable and I must make every effort to keep my appointments, as scheduled. Please notify us 24 hours prior to your appointment if you will not be able to make it; otherwise, it will be counted as a missed appointment. Should you miss your 1st appointment, it can only be rescheduled once if there is a valid reason for the No Show. Otherwise, you will no longer be eligible for medical services. Should you miss three scheduled appointments (NO SHOWS) and/or have excessive cancellations, you will be automatically dismissed as a patient from the Good News Clinic and will not be eligible to re-apply again.

5. I understand that clinic doctors and nurses take the responsibility of providing me with medical care to the best of their ability, very seriously. I understand that I may have to wait for another appointment, due to the limited physician schedule.

6. I understand that it is my responsibility to cooperate in my medical treatment to improve my health. This may include stopping smoking/alcohol, losing weight, exercising, taking medication as instructed, keeping scheduled appointments and other instructions as indicated by my doctor. If I make no effort in my own health actions, I may be discharged from the clinic.

7. I understand that most of the people who work in the clinic are volunteering and not being paid for their time. I also understand they are here because they share the vision of the Good News Clinic and choose to be here to help me. I understand I am expected to treat all staff with respect and dignity. Rudeness to any staff member is ground for immediate dismissal from clinic.

8. I understand that occasionally, due to emergencies, I may not be seen at my appointment time or may be seen by a different doctor. I also understand that if I am late to my appointment, it is possible that I may not be seen that day.

9. I understand that the clinic operates on an appointment schedule and that if I walk in without a scheduled appointment, I will not be able to be seen, unless there is a cancellation.

10. I understand that if I have lab testing done, I will be notified of the results at my next appointment. Should results be abnormal and require a change in therapy, I will be notified by the nurse.

11. I understand that if I am referred to the hospital for additional testing, I will be responsible for the charges associated with this visit. I also understand that I am able to apply for the Indigent Care Program at the hospital for assistance with my bill.

12. I understand that, for safety reasons, children without appointments are not allowed in exam rooms - please make babysitting arrangements prior to appointment.

13. I understand I am allowed to see Good News Clinic doctors and specialists referred through Health Access only. If I choose to see another doctor for my medical care, I must inform the clinic and have my care transferred to that medical provider. If the Good News Clinic discovers I am being seen by another physician, I will automatically be discharged from Good News Clinics. It is also absolutely against clinic policy to contact any of our Good News Clinic medical providers at their private practices. Anyone found doing so will be automatically dismissed from the clinic!!

SERVICES AVAILABLE

- MEDICAL – limited specialties.
- DENTAL – limited to fillings, cleanings and extractions.
- GYN ONLY - (No OB/birth control services available - referred to Health Dept).
- PHARMACY – Please call pharmacy for refills a few days before your medication runs out (refills will be ready for pick up after 1:00 pm the following day).
- COUNSELING services.

iese oversight activities include audits, investigations, and spections, as necessary for our licensure and for the vernment to monitor the health care system, government ograms, and compliance with civil rights laws.

idicial and administrative proceedings: If you are volved in a lawsuit or a dispute, we may disclose PHI about u in response to a court or administrative order. We may so disclose PHI about you in response to a subpoena, scovery request, or other lawful process by someone else volved in the dispute, but only if efforts have been made to ll you about the request or to obtain an order protecting the quest PHI.

addition, we are permitted to use or disclose PHI for ie following purposes:

esearch; We may disclose PHI about you to researchers hen their research has been approved by an institutional view board that has reviewed the research proposal and stablished protocols to ensure the privacy of your formation.

oroners, medical examiners, and funeral directors: We ay release PHI about you to a coroner or medical examiner. his may be necessary, for example, to identify a deceased erson or determine the cause of death. We may also isclose PHI to funeral directors consistent with applicable law carry out their duties.

)rgan or tissue procurement organizations: Consistent ith applicable law, we may disclose PHI about you to organ rocurement organizations or other entities engaged in the rocurement, banking, or transplantation of organs for the urpose of tissue donation and transplant.

lotification: We may use or disclose PHI about you to notify r assist in notifying a family member, personal epresentative, or another person responsible for your care, our location, and your general condition.

undraising: We may contact you as part of a fundraising ffort.

Notification: We may use or disclose PHI about you to notify or assist in notifying a family member, personal epresentative, or another person responsible for your care, your location, and your general condition.

Correctional institution: If you are or become an inmate of a correctional institution, we may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others.

To avert a serious threat to health or safety: We may use or disclose PHI 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.

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

National security and intelligence activities: We may release PHI 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 PHI 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.

Victims of abuse, neglect, or domestic violence: We may disclose PHI about you to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else or the law enforcement or public official that is to receive the report represents that it is necessary and will not be used against you.

Other Uses and Disclosures of PHI

The Agency will obtain your written authorization before using or disclosing PHI about you for purposes other than those provided for above or as otherwise permitted or required by law. You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing PHI about you, except to the extent that we have already taken action in reliance on the authorization.

For More Information or To Report a Problem

If you have questions or would like additional information about the agency's privacy practices, you may contact: *(CLINIC'S PRIVACY OFFICER'S INFORMATION)*. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer at the above address or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EFFECTIVE DATE
This Notice is effective as of July 1, 2006

(NAME OF CLINIC)

NOTICE OF PRIVACY PRACTICES

Appendix D

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.

The *(NAME OF CLINIC)* is required by law to take reasonable steps to protect the privacy of your Protected Health Information ("PHI) and to provide you with notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. PHI includes prescription records maintained by the agency. This Notice of Privacy ("Notice") describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to PHI about you.

The agency is required to follow the terms of this Notice. We will not use or disclose PHI about you without your written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

Your Health Information Rights

You have the following rights with respect to PHI about you:

Obtain a paper copy of the Notice upon request. You may request a copy of the Notice any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy. To obtain a paper copy, contact: *(PRIVACY OFFICER'S NAME AND ADDRESS)*.

Request a restriction on certain uses and disclosures of PHI.
You have the right to request additional restrictions on our use or disclosure of PHI about you by completing the Request for Restriction form and giving it to an agency associate for review. We are not required to agree to the restriction. If the restriction is possible, then the agency associate will process the request. The Request for Restriction form is available upon request also.

Inspect and obtain a copy of PHI. You have the right to access and copy PHI about you contained in a designated record set for as long as the agency maintains the PHI. The designated record set usually will include prescription and billing records. To inspect or copy PHI about you, you must complete the Request to Access Protected Health Information form and give it to an agency associate for review. If the request can be granted, then the agency associate will

provide you with a report detailing the PHI about you contained in our designated record set. The Request to Access Protected Health Information form is available upon request. We may charge you a fee for the costs of copying, mailing and supplies that are necessary to fulfill your request. We may deny your request to inspect and copy in certain limited circumstances, if you are denied access to PHI about you, you may request that the denial be reviewed.

Request an amendment of PHI. If you feel that PHI we maintain about you is incomplete or incorrect, you may request that we amend it. You may request an amendment for as long as we maintain the PHI. To request an amendment, you must complete the Request to Amend a Record form and give it to an agency associate for review. If the request can be granted, then the agency associate will amend the appropriate record(s). The Request to Amend a Record form is available upon request. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with the decision and we may give a rebuttal to your statement.

Receive an accounting of disclosures of PHI. You have the right to receive an accounting of the disclosures we have made of PHI about you after April 14, 2003. This accounting includes only those disclosures required to be accounted for under the federal privacy standards for health information (45 C.F.R. Part 164). Those standards do not require accountings for disclosures for treatment, payment or health care operations purposes, among others. The accounting will exclude certain disclosures, such as disclosures made directly to you, disclosures you authorize, disclosures to friends or family members involved in your care, disclosures for notification purposes, and routine disclosures made to regulatory or law enforcement agencies. The right to receive an accounting is subject to certain other exceptions, restrictions, and limitations. To request an accounting, you must submit a request in writing to: ***(PRIVACY'S OFFICER'S NAME AND ADDRESS)***. Your request must specify the time period, but may not be longer than six years. The first accounting you request within a 12 month period will be provided free of charge, but you may be charged for the cost of providing additional accountings. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time.

Request communications of PHI by alternative means or at alternative locations. You have the right to request communications by alternative means or at alternative locations. For instance, you may request that we contact you about medical matters only in writing or at a different residence or post office box. To request confidential communication of PHI about you, you must complete the Request for Confidential Communications form and give it to an agency associate for review. If the request can be granted, then the agency associate will make the appropriate changes. We will accommodate all reasonable requests; however in case of emergency situations, we may contact you by whatever means we deem necessary. The Request for Confidential Communications form is available upon request.

Examples of How We May Use and Disclose PHI

The following are descriptions and examples of ways we use and disclose PHI:

We will use PHI for treatment. Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. **Example:** Information obtained by the agency will be used to dispense medications and/or treatment to you. We will document in your record information related to the medications and/or treatments dispensed to you and other services provided to you.

WE will use PHI for payment. Payment includes but is not limited to actions to make coverage determinations and receive payment (including billing, claims management, subrogation, plan reimbursement, and utilization review and pre-authorizations). **Example:** We will contact your insurer to determine whether it will pay for your services and the amount of your co-payment. We will bill you or a third-party payor for the costs of services dispensed to you. The information on or accompanying the bill may include information that identifies you, as well as the medications you are taking.

We will use PHI for health care operations. Health care operations include but not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

Example: The agency may use information in your health record to monitor the performance of the agency providing treatment to you. This information will be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

We are likely to use or disclose PHI for the following purposes:

Business associates: There are some services provided by us through contacts with business associates. Examples include Claims Processors or Administrators, Pharmacy Benefit Managers, etc. When these services are contracted for, we may disclose PHI about you to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payor for services rendered. To protect PHI about you, we require the business associate to appropriately safeguard the PHI.

Communication with individuals involved in your care o payment for your care: Health professionals, using thei professional judgment, may disclose to a family membe other relative, close personal friend or any person you identify PHI relevant to that person's involvement in your care o payment related to your care.

Health-related communications: We may contact you t provide refill reminders or information about treatmer alternatives or other health-related benefits and services tha may be of interest to you.

Food and Drug Administration (FDA): We may disclose t the FDA, or persons under the jurisdiction of the FDA, PH relative to adverse events with respect to drugs, food supplements, products and product defects, or post-marketin surveillance information to enable product recalls, repairs, replacement.

Workers' compensation: We may disclose PHI about yo as authorized by and as necessary to comply with law relating to workers' compensation or similar program established by law.

Public health: As required by law, we may disclose PH about you to public health or legal authorities charged wi preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose PHI about you for la enforcement purposes as required by law or in response to valid subpoena or other legal process.

As required by law: We must disclose PHI about you wh required to do so by law.

Health oversight activities: We may disclose PHI about y to an oversight agency for activities authorized by law.