GRAND LAKE HEALTH SYSTEM

PATIENT INFORMATION

HOW DID YOU HEAR ABOUT US? _____

SOCIAL SECURITY # _____

FIRST NAME _____ MIDDLE _____

LAST NAME _____

SEX _____ DATE OF BIRTH ___/___/_____ RACE _____

PREFERRED LANG. ☐ ENG. OTHER _____ ETHNICITY _____

MARITAL STATUS ☐ MARRIED ☐ SINGLE

☐ DIVORCED ☐ WIDOWED ☐ LEGALLY SEPARATED

E-MAIL _____

HOME ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____

CELL PHONE _____

WORK PHONE _____

EMPLOYER/OCCUPATION _____

REFERRING PHYSICIAN _____

FAMILY DOCTOR _____

EMERGENCY CONTACT

NAME _____ HOME PHONE _____

RELATIONSHIP _____ WORK PHONE _____

IF MARRIED, SPOUSE INFORMATION

NAME _____ DATE OF BIRTH ___/___/_____ SSN _____

EMPLOYER _____ WORK PHONE _____

IF MINOR (UNDER THE AGE OF 18) WHO IS FINANCIALLY RESPONSIBLE? ☐ MOTHER ☐ FATHER

MOTHER'S NAME _____

ADDRESS _____

_____

SSN _____ DOB _____/_____/_____

EMPLOYER _____

WORK PHONE _____ CELL PHONE _____

FATHER'S NAME _____

ADDRESS _____

_____

SSN _____ DOB _____/_____/_____

EMPLOYER _____

WORK PHONE _____ CELL PHONE _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

☐ Medicaid ☐ Medicare ☐ None ☐ Other

INSURANCE COMPANY _____

INSURED'S NAME _____ RELATIONSHIP _____

DATE OF BIRTH ___/___/____ SSN _____ CO-PAY _____ POLICY NUMBER _____

SECONDARY INSURANCE INFORMATION

☐ Medicaid ☐ Medicare ☐ None ☐ Other

INSURANCE COMPANY _____

INSURED'S NAME _____ RELATIONSHIP _____

DATE OF BIRTH ___/___/____ SSN _____ CO-PAY _____ POLICY NUMBER _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESSS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICES AS DESCRIBED, REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES. I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT NECESSARY TO PROCESS INSURANCE CLAIMS.

The patient or representative, recognizing the need of medical care and/or evaluation, consents to services as ordered by the attending physician including local anesthesia, laboratory procedures, medical treatment, minor or emergency surgical treatment, radiology procedures, physical examination, or other services rendered under the general and specific instructions of the physician.

_____

SIGNATURE (Patient or Parent if Minor) DATE

GRAND LAKE
FOOT AND ANKLE CENTER™
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM

NEW PATIENT HISTORY

Patient Name: _____ Date of Birth: _____ Shoe Size:_____

YOUR ALLERGIES – please indicate reaction if there is a positive allergy:

☐ Dairy	☐ Tylenol	☐ Adhesive Tape	☐ Animal Dander
☐ Eggs	☐ Aspirin	☐ Cosmetics	☐ Dust
☐ Grains/Wheat	☐ Codeine	☐ Detergent	☐ Grass
☐ Nuts/Peanuts	☐ Sulfa Drugs	☐ Latex	☐ Insect bites/Stings
☐ Shellfish	☐ NSAIDS	☐ Metals	☐ Mites
☐ Strawberries	☐ Penicillin	☐ Molds/Mildew	☐ Pollen

Please list any other allergies you may have: _____

_____

YOUR MEDICAL HISTORY – Please check if you have any of these diagnoses:

☐ Alcohol Abuse	☐ Cancer type _____	☐ High Blood Pressure
☐ Anemia	☐ Depression	☐ High Cholesterol
☐ Arthritis	☐ Diabetes Type I or Type II	☐ Liver Disease
☐ Asthma	☐ Drug Abuse	☐ Lung Disease
☐ Bleeding Disorders	☐ Epilepsy	☐ Mental Disorder
☐ Migraines	☐ Stroke	☐ Thyroid Disorder

Other medical problems: _____

_____

FAMILY MEDICAL HISTORY – please indicate who has this in your family (Mother, Father, Brother, Sister, Paternal Grandparent, Maternal Grandparent, Children)

Arthritis _____
Asthma _____
Bleeding Disorder _____
Cancers _____
Diabetes _____
Heart Disease _____
High Cholesterol _____
High Blood Pressure _____
Kidney Disease _____
Liver Disease _____
Mental Illness _____
Seizures _____
Alcohol Abuse _____
Drug Abuse _____
Thyroid Disorder _____
Tuberculosis _____
Birth Defects _____
Bed Wetting (over age of 10) _____
Genetic Disorders _____
Other _____

SURGICAL HISTORY

Please list all of your surgeries and the date they were done.

_____

_____

_____

_____

_____

YOUR SOCIAL HISTORY

Occupation _____

Do you drink alcohol? ☐ YES ☐ NO

How much alcohol do you consume a week? _____

Do you smoke? ☐ YES ☐ NO

How much do you smoke? _____

Are you a former smoker? ☐ YES ☐ NO

How long did you smoke? _____

Do you use illicit drugs? ☐ YES ☐ NO

Is so, what type of drugs do you use? _____

How many times a week do you exercise? _____

TRAVEL

What countries have you traveled to in the last 6 months? _____

CONTRACEPTION HISTORY

Are you currently using contraceptives? ☐ YES ☐ NO

Are you currently pregnant? ☐ YES ☐ NO

Have you been exposed to any sexually transmitted infections? ☐ YES ☐ NO

If yes, please check:

☐ Chlamydia ☐ Gonorrhea ☐ HPV ☐ Syphilis ☐ Genital Herpes ☐ HIV

YOUR MEDICATIONS

Please List or attach a copy of all of your current medications with dosages.

MEDICATION	DOSAGE

ADVANCE DIRECTIVES

Do you have a living will? ☐ YES ☐ NO
Do you have a healthcare Power of Attorney? ☐ YES ☐ NO
Are you an Organ Donor? ☐ YES ☐ NO
Do you have a DNR or DNRCC? ☐ YES ☐ NO
If yes to any of the above, are the documents on file at JTDMH? _____

PROVIDERS

Please list information for any other physicians you currently see: (*ex: Dr. Smith - Urologist, Celina, OH*)

_____
_____
_____
_____
_____
_____

_____ _____ _____
Signature Date Time

GRAND LAKE
FOOT AND ANKLE CENTER™
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM
1013 E. Spring St., St. Marys, Ohio 45885
Ph: 419.394.8664 Fax: 419.394.1148

123 Hamilton St., Celina, Ohio 45822
Ph: 567.890.2655
WWW.GRANDLAKEHEALTH.ORG

Patient Name: _____

Consent for Notification

1. If we call you at home and you are not available, may we leave information such as positive/negative test results, appointments, billing matters and health care information with another person?

   _____YES _____NO

   If YES, please state name of person (s) and relationship:

   Name _____ Relationship _____

   Name _____ Relationship _____

   Name _____ Relationship _____

2. If you have an answering machine at home, may we leave a message regarding positive/negative test results, appointments, billing matters and health care information? Please note: If your answering machine does not identify yourself, we will not leave a detailed message.

   _____YES _____NO

3. If you have a cell phone may we leave a message regarding positive/negative test results, appointments, billing matters and health care information? Please note: If your cell phone voice mail does not identify yourself, we will not leave a detailed message.
   ** I am fully aware that a cellular telephone is not a secure line and private line.

   _____YES _____NO

If the above answers are NO, how is the best way to contact you? _____

_____

_____
Please PRINT Name

_____ _____ _____
Date of Birth Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient:_____

This Authorization is valid until you inform our office otherwise in writing.

GRAND LAKE
PHYSICIAN PRACTICES™
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM

Consent for Medical Treatment and Disclosure of Information

Patient Name: _____
Last First Middle

Patient's Date of Birth: _____

Authorization for Treatment: I hereby consent to the medical care recommended by my health care providers at Grand Lake Physician Practice. I authorize payment for all medical benefits for services performed at Grand Lake Physician Practice (GLPP).

Photographs, Videos: I understand that photographs, videotapes, digital or other images may be recorded to document my care, and I consent to this. I understand that GLPP will retain the ownership rights to these images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in policy. I also understand that several patient care areas have in-room surveillance to monitor patients for safety. Images that identify me will only be released and/or used outside the GLPP upon receipt of written authorization from me, or my legal representative.

Use and Disclosure of Information:
I consent to the use and disclosure of information from my medical record, including protected health information, by GLPP for treatment, payment, and health care operations as permitted by law. All uses and disclosures will abide by the terms identified in the GLHS Notice of Privacy Practices.

Prescription Drug Dispense History, Price and Benefit Information: I consent to my health care provider pulling my medication dispense history via a secure Surescripts database embedded in the electronic medical record. I understand that Surescripts utilizes patient information to retrieve medication dispense history data, which assists with timely and efficient patient centered care. I also consent to my health care provider to access and compare prescription price and benefit information. _____ Initials

Medicare and/or CHAMPUS/CHAMPVA Patients: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, its Intermediaries, or Carriers any information needed for this claim or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the practitioner or organization furnishing the services, or authorize such practitioner or organization to submit a claim to Medicare for payment.

PATIENT RIGHTS AND RESPONSIBILITIES

Notice of Privacy Practice: I hereby acknowledge that I have received Grand Lake Health System's notice of privacy practices, which sets forth the ways in which my personal health information may be used or disclosed, and outlines my rights with respect to such information. GLPP is required to provide each patient one copy of our notice of privacy practices as well as any subsequent revision to the notice.

FINANCIAL RESPONSIBILITY

Financial Responsibility:
Unless otherwise provided by law or a separate written agreement with GLPP indicating that another individual is to be held financially responsible for the GLPP account, the undersigned agrees, whether signing as the patient, legal guardian, or legal representative, and whether or not he or she is insured, that in consideration of the services to be rendered to the patient, that he or she is individually obligated to pay the full amount of the GLPP account on patient's discharge. The undersigned authorizes GLPP to make a credit investigation if necessary to determine credit risk. I understand that GLPP is acting solely as an agent for the patient in filing the insurance benefits assigned to it, however, GLPP does not guarantee payment of covered charges on the GLPP account. Credit to the GLPP account is shown only when GLPP has received payment.

Assignment of Benefits: I will hereby assign to Grand Lake Physician Practices any insurance or other third-party benefits available for health care services provided to me. I understand that Grand Lake Physician Practices has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the practice, I agree to forward the practice all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

I understand that I am responsible to determine, before a Well Child or Adult Exam, whether or not my insurance pays Well Exams or for any immunizations given. If it does not cover Well Exams or immunizations, I will be responsible for payment of these services.

In consideration of the services to be rendered to the patient, the undersigned agrees, whether signing as the patient, legal guardian, or legal representative that each is individually obligated to pay the full amount of the Grand Lake Physician Practice account, unless legal documentation or a separate written agreement with GLPP is provided, indicating that another individual is to be held financially responsible for the account. I understand that GLPP is acting solely as an agent for the patient in filing the insurance benefits assigned to it, however, GLPP can assume no responsibility for guaranteeing payment of covered charges for the account. Credit to the GLPP account is shown only when payment is received.

I expressly consent to receiving telephone calls from an automatic telephone dialing system, artificial and/or pre-recorded messages, emails, text messages, or other electronic communication from Grand Lake Health System, and/or their contractors, servicers, debt collection agencies, or agents for any reason by using any telephone number, email address, and/or mailing address associated with my account or obtained by such entities. I agree that my consent may only be revoked by sending a written notice to Grand Lake Health System or their agents. I agree to arbitrate any claims under the Telephone Consumer Protection Act, and I waive any right/ability to bring a class action against claims, against Grand Lake Health System, and/or their contractors, servicers, debt collection agencies, or agents.

Patient Signature	Date	Witness Signature	Date

If the patient is unable to consent or sign, or is a minor, complete the following:

☐ The patient is a minor, _____ years of age

☐ The patient is unable to consent or sign (describe): _____

Legal Representative Signature	Printed Signature	Relationship to patient	Date/Time

Witness Signature	Date/Time

EMANCIPATED MINOR ACKNOWLEDGEMENT – complete the following *(check all that apply)*

I am an emancipated minor, _____ years of age, and able to provide my own consent for treatment.

☐ I am married. ☐ I am enlisted in the armed forces. ☐ I am independent and self-supporting.

I do not live with my parents or depend on my parents for support or assistance. I understand that by signing the acknowledgement, I am attesting that I am emancipated for the purpose of consenting for treatment or the treatment of my child, as the case may be.

Patient Printed Name	Patient Signature	Date/Time

Witness Signature	Date/Time

Patient Portal Account Access Form

Thank you for your interest in the FollowMyHealth patient portal, made available by Grand Lake Health, to provide a convenient and secure way for patients to manage their personal health record from any computer or mobile device with internet access.

Instructions for Completing this Form

To sign up for access to your health information in FollowMyHealth, please complete this Access Form. You will receive an email with an invitation to join FollowMyHealth and step by step instructions to complete the process. A separate form will need completed for each patient requesting/granting access.

Your Information: (All sections required in order to receive an invitation – please print clearly.)

Patient Name: _____ Patient Birth Date ____ /____ /____ Sex: M □ F□

Patient Address: _____
(Street) (City) (State) (Zip Code)

Patient Phone:_____ Patient Email: _____

ACCESS TYPE
□ **Minor child Proxy (age 13 or younger) –** must have authorization signed by parent/legal guardian
□ **Minor child Proxy (age 14 to 17) –** must have authorization signed by patient (minor patient) • **for parent or legal guardian** **□ I grant full access** **□ I grant the standard limited access**
□ **Minor personal access (age 14 to 17) –** must have authorization signed by patient (minor patient) • **for patient's personal access**
□ **Adult Proxy (age 18+) –** must have authorization signed by patient • **for adult to grant another individual full access to their portal**
□ **Adult Personal Access (age 18+) –** Simply provide email address at time of check-in/registration – OR have authorization signed by patient.
To have access granted to the patient portal return this Patient Portal Account Access Form to one of the following: Grand Lake physician practice, medical records department at JTDMH or fax to 419-394-3692

INFORMATION FOR PROXY REQUESTING ACCESS (Proxy access is providing access to your patient information on the FollowMyHealth patient portal to someone other than yourself)

Proxy Name: _____ Proxy Birth Date ____ /____ /____

Proxy Address: _____
(Street) (City) (State) (Zip Code)

Proxy Phone:_____ Proxy Email: _____

Relationship to Patient: □ Mother □ Father □ Spouse □ Guardian □ POA □ Attorney □ Other

AUTHORIZATION: Permission is hereby granted to Grand Lake Health to release medical information via the Grand Lake Health FollowMyHealth® Patient Portal, to the individual as identified above.

Responsible Party Signature: _____ Date:_____

Relationship to patient: □ Self □:_____

FOR INTERNAL USE ONLY

□ Reviewed and verified form. _____ initials Patient MRN:_____

□ Access initiated in EHR_____ initials □ Form sent for scanning into EHR _____ initials

GRAND LAKE™ HEALTH SYSTEM
200 St. Clair Street
St. Marys, Ohio 45885
(419) 394-3335

NOTICE OF PRIVACY PRACTICES

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 terms of this Notice of Privacy Practices apply to Grand Lake Health System (GLHS) operating as a clinically integrated health care arrangement composed of the Joint Township District Memorial Hospital, Grand Lake Physician Practices, Home Health/Hospice, and Transitional Care Unit, the physicians, licensed professionals and other professionals seeing and treating patients at GLHS. The members of this clinically integrated health care arrangement work and practice at GLHS. All of the entities and persons listed will share personal health information of our patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to your personal health information and to notify you in the unlikely event of a breach or unauthorized disclosure of your personal health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all personal health information maintained by us. You may receive a copy of any revised notices at the Registration desk or a copy may be obtained by mailing a request to the Privacy Officer at GLHS, 200 St. Clair Street, St. Marys, OH 45885.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Your Authorization. Except as outlined below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization. There are certain uses and disclosure of your personal heath information for which we will always obtain a prior authorization and these include:

Marketing communications unless the communication is made directly to you in person, is simply a promotional gift of nominal value, is a prescription refill reminder, general health or wellness information, or a communication about health related products or services that we offer or that are directly related to your treatment.

Most sales of your health information unless for treatment or payment purposes or as required by law.

Psychotherapy notes unless otherwise permitted or required by law.

Uses and Disclosures for Treatment. We will make uses and disclosures of your personal health information as necessary for your treatment. For instance, doctors, nurses, and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, tests, etc. We may also release your personal health information to another health care facility or professional who is not affiliated with our organization but who is or will be providing treatment to you. For instance, if, after you leave the hospital, you are going to receive home health care, we may release your personal health information to that home health care agency so that a plan of care can be prepared for you.

Uses and Disclosures for Payment. We will make uses and disclosures of your personal health information as necessary for the payment purposes of those health professionals and facilities that have treated you or provided services to you. For instance, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations. We will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations which include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and care of our patients. We may also disclose your personal health information to another health care facility, health care professional, or health plan for such things as quality assurance and case management, but only if that facility, professional, or plan also has or had a patient relationship with you.

Our Facility Directory. We maintain a facility directory listing the name, room number, general condition and, if you wish, your religious affiliation. Unless you choose to have your information excluded from this directory, the information, excluding your religious affiliation, will be disclosed to anyone who requests it by asking for you by name. This information, including your religious affiliation, may also be provided to members of the clergy. You have the right during registration to have your information excluded from this directory and also to restrict what information is provided and/or to whom.

Family and Friends Involved In Your Care. With your approval, we may from time to time disclose your personal health information to family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with such individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide certain portions of your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Fundraising. We may contact you to donate to a fundraising effort for or on our behalf. You have the right to opt-out of receiving fundraising materials/communications and may do so by sending your name and address to JTD Hospital Foundation, 200 Saint Clair Street, Saint Marys, Ohio 45885 together with a statement that you do not wish to receive fundraising materials or communication from us.

Appointments and Services. We may contact you to provide appointment reminders or test results. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You may request such confidential communication in writing and may send your request to the Privacy/Security Officer at GLHS, 200 St. Clair Street, St. Marys, OH 45885.

Health Products and Services. We may from time to time use your personal health information to communicate with you about health products and services necessary for your treatment, to advise you of new products and services we offer, and to provide general health and wellness information.

Research. In limited circumstances, we may use and disclose your personal health information for research purposes. For example, a research organization may wish to compare outcomes of all patients that received a particular drug and will need to review a series of medical records. In all cases where your specific authorization has not been obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board or privacy board which oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

Disaster Relief. We may disclose limited personal health information to federal, state, or local government agencies engaged in disaster relief activities, as well as to private disaster relief or disaster assistance organizations (such as Red Cross) authorized by law or by their charters to assist in disaster relief efforts.

Health Information Exchange. We may disclose personal health information to a secure health information exchange (HIE). HIEs facilitate access to and retrieval of clinical data to provide timely and efficient patient centered care. You can opt out of the HIE by contacted the GLHS Privacy Officer.

Applications to Access Patient Data

GLHS provides the ability for patients to access their health information either through the patient portal or through a 3rd party application. The available information will be the same in both the portal and the app. If you have an application that you want to use to access your information, please contact the GLHS Privacy Officer to get further details. Any person seeking access through an app must be a current GLHS patient. GLHS reserves the right to deny access or disable any application that is deems does not meet GLHS' security guidelines.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization.

- We may release your personal health information for any purpose required by law;
- We may release your personal health information for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
- We may release your personal health information as required by law if we suspect child abuse or neglect; we may also release your personal health information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence;
- We may release immunization records to a student's school by only if parents or guardians (or the student if not a minor) agree either orally or in writing;
- We may release your personal health information to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
- We may release your personal health information to your employer when we have provided health care to you at the request of your employer to determine workplace-related illness or injury; in most cases you will receive notice that information is disclosed to your employer;
- We may release your personal health information if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
- We may release your personal health information if required to do so by subpoena or discovery request; in some cases you will have notice of such release;
- We may release your personal health information to law enforcement officials as required by law to report wounds and injuries and crimes;
- We may release your personal health information to coroners and/or funeral directors consistent with law;
- We may release your personal health information if necessary to arrange an organ or tissue donation from you or a transplant for you;
- We may release your personal health information for certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy;
- We may release your personal health information if in limited instances we suspect a serious threat to health or safety;
- We may release your personal health information if you are a member of the military as required by armed forces services; we may also release your personal health information if necessary for national security or intelligence activities; and
- We may release your personal health information to workers' compensation agencies if necessary for your workers' compensation benefit determination.

State Requirements. Ohio law requires that we obtain a consent from you in many instances before disclosing the performance or results of an HIV test or diagnoses of AIDS or an AIDS-related condition; before disclosing information about drug or alcohol treatment you have received in a drug or alcohol treatment program; before disclosing information about mental health services you may have received; and before disclosing certain information to the State Long-Term Care Ombudsman. For full information on when such consents may be necessary, you can contact the GLHS Privacy/Security Officer.

RIGHTS THAT YOU HAVE

Access to Your Personal Health Information. You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We may charge you per page if you request a copy of the information. We may also charge for postage if you request a mailed copy and will charge for preparing a summary of the requested information if you request such summary. You may obtain an Authorization for Access And Release of Patient Information form from the Health Information Management Department at Joint Township District Memorial Hospital (JTDMH), GLHS Home Health/Hospice, or a GLHS Physician Office.

You have the right to obtain an electronic copy of your health information that exists in an electronic format and you may direct that the copy be transmitted directly to an entity or person designated by you, provided that any such designation is clear, conspicuous, and specific with complete name and mailing address or other identifying information. We may charge you a fee for our labor and supplies in preparing your copy of the electronic health information.

Amendments to Your Personal Health Information. You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an Amendment Request form from the Health Information Management Department at JTDMH, GLHS Home Health/Hospice or a GLHS Physician Office

Accounting for Disclosures of Your Personal Health Information. You have the right to receive an accounting of certain disclosures made by us of your personal health information for six years prior to the date of your request. Requests must be made in writing and signed by you or your representative. Accounting Request forms are available from the Health Information Management Department at JTDMH, GLHS Home Health/Hospice, or a GLHS Physician Office. The first accounting in any 12-month period is free; a fee may be applied for any subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your Personal Health Information. You have the right to request restrictions on our uses and disclosures of your personal health information for treatment, payment, or health care operations. A Restriction Request form can be obtained from the Health Information Management Department at JTDMH, GLHS Home Health/Hospice, or a GLHS Physician Office. In most cases, we are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the Health Information Management Department at JTDMH, 200 St. Clair Street, St. Marys, OH 45885.

Breach Notification. In the unlikely event that there is a breach, or unauthorized release of your personal health information, you will receive notice and information on steps you may take to protect yourself from harm.

Complaints. If you believe your privacy rights have been violated, you can file a complaint with the Patient Representative or Privacy/Security Officer by calling or writing to their attention. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

Acknowledgment of Receipt of Notice. You may be asked to sign an acknowledgment statement that you received this Notice of Privacy Practices.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact the GLHS Privacy Officer by mail at 200 St. Clair Street, St. Marys, OH 45885 or by phone at (419) 394-3335.

As a patient you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means.

EFFECTIVE DATE

This Notice of Privacy Practices is effective April 1, 2019.