CONFIDENTIAL PATIENT REGISTRATION INFORMATION Brookridge Internal Medicine Associates, P.A

PATIENT INFORMATION

Name_____ Date of Birth _____ Age_____
Address_____City_____State_____Zip_____
Phone#_____ Other Phone #_____ Cell # _____
Sex_____ SS # _____ Drivers License _____ Marital Status_____
Email address _____ Preferred contact method for reminders __mail __phone
Race__American Indian __Alaskan Native __Asian __Black __African American __Native Hawaiian __Other Pacific Islander __White
Ethnicity: ___Hispanic ___Not Hispanic
Spouse Name_____ Spouse SS#_____ Spouse DOB_____
Last Primary Care Physician_____ Phone _____

EMPLOYER INFORMATION

Employer_____ Phone_____
Address_____City_____State_____Zip_____
May we contact you at work? **Yes**_____ **No**_____

INSURANCE INFORMATION *(Must Be Filled Out In Order To Bill Insurance Company)*

Insurance Company Name_____ Phone_____
Address_____City_____State_____Zip_____
ID Number _____ Group # _____
Is Insurance with your employer _____Yes _____No
Subscriber Name_____ Date of Birth_____
Subscriber Address _____
Subscriber SS #_____ Phone_____
Employer_____Phone_____

Other Insurance Information: ***(Must Be Filled Out In Order To Bill Insurance Company)***
Insurance Company Name _____
Subscriber Name _____Subscriber SS#_____
ID Number _____Group # _____Subscriber DOB_____

EMERGENCY CONTACT

Name_____Relationship_____Phone_____
Address _____City _____State_____ Zip _____

Consent to Release

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice. The terms of our notice may change. If we change our notice, you may obtain a revised copy from the front desk. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Please be advised that you are ultimately responsible for the payment of services rendered to you. By signing below you authorize direct payment of medical benefits to Brookridge Internal Medicine Associates, P.A. for services rendered and that you are financially responsible for any balance not covered by your insurance and for payment in full due to non-payment of health insurance premiums. Also by signing below you authorize Brookridge Internal Medicine Associates, P.A. to release any medical or incidental information that may be necessary for either medical or processing applications for financial benefit.

X

SIGNATURE OF PATIENT/GUARDIAN **DATE**

Brookridge Internal Medicine Associates, P.A.

NAME_____ **DOB**_____

PATIENT HISTORY INFORMATION

MEDICAL HISTORY:

DO YOU HAVE A HISTORY OF:	YES	NO	EXPLAIN
Arthritis			
Blood Clots			
Cancer (Lung, Breast, Etc.)			
Diabetes			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Peptic Ulcer			
Prostate Disease			
Psychiatric Illness			
Rheuatic Fever			
Seizures			
Stroke			
Thyroid Disease			
TB (Tuberculosis)			
Lung Disease (Asthma, Emphysema)			
Other			

Please List all Surgeries

_____

_____

Current Medications (dosage and how taken)

_____

_____

Allergies_____

Do you currently smoke? YES_____NO_____

Did you smoke in the past? YES_____NO_____

If yes, number of years _____ number of packs per day_____

How much alcohol do you drink? _____

Do you/did you ever use recreational drugs? _____

FAMILY HISTORY	YES	NO	FAMILY MEMBER
Cancer			
Diabetes			
Hypertension			
Psychiatric Illness			

(Release Info - From Another Physician)

BROOKRIDGE INTERNAL MEDICINE ASSOCIATES, P.A.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. I authorize the use and disclosure of information from the medical record of:

Patient Name:_____ Medical Record #:_____

Address:_____

Phone#:_____ Date of Birth: ____/____/____ SSN:_____

2. I authorize the following individual organization to disclose the above named individuals health information:

_____Address:_____

Phone #:_____ Fax#:_____

This information may be disclosed TO and used by Brookridge Internal Medicine Associates, P.A., 300 N. Third St., Longview, TX 75601, Phone (903)-315-2907, Fax (903) 315-2927 for the purpose of medical care.

3. The type and amount of information to be disclosed is as follows: (*specify dates where appropriate):*

_ Immunizations
_ Most recent 3 years of Record
_ Entire Medical Record
_ X-ray films (specify type/date):
__Other
_ Laboratory Results, from date_____to date_____
_ X-Ray Reports, from date_____to date_____
_ Genetic testing, from date_____to date_____
_ HIV/AIDS information, from date_____to date_____

4. I understand that the medical information released by this authorization my include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also, include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

___**YES,** I consent to the release of this information ___**NO,** I do not consent to the release of this information

5. I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

6. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information. I can contact the privacy office at 903-315-2907.

_____ _____
Signature of Patient or Authorized Personal Representative Date

_____ _____
Personal Representative's Name (print) and Relationship Date

Brookridge
INTERNAL MEDICINE
Associates, P.A.

MEDICAL AUTHORIZATION TO SEE NURSE PRACTITIONER

I hereby accept medical treatment at Brookridge Internal Medicine Associates, P.A. by a Nurse Practitioner. It has been explained that they are not medical doctors but are licensed by the State of Texas. I understand that the Supervising Physician is Dr. Brenda Vozza and any problems with my medical care/treatment may be discussed with her. The medical treatment will be provided in accordance with the rules and regulations provided by the Texas State Board of Medical Examiners. Furthermore, treatment will be provided in accordance with the Protocols and Policies and Procedures as established by Dr. Brenda Vozza.

I am also aware that at any time I can request to see Dr. Vozza to carry out my medical treatment or answer questions about my medical care.

Patient's Name_____

Signature of Patient or Guardian_____

Date:_____ Witness: _____

Brookridge Internal Medicine Associates, PA

E-Prescribing PBM Consent Form

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribing program. These include:

* **Formulary and benefit transactions**-- Gives the prescriber information about which drugs are covered by the drug benefit plan.
* **Medication history transactions**-- Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Brookridge Internal Medicine Associates, PA can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefits for treatment purposes.

Pharmacy of Choice_____

Patient Name (printed)_____ Date of Birth ____/____/_____

Signature of Patient (or representative)_____

Date ____/____/_____ Relationship if other than patient_____

Consent Denied_____ Date ____/____/_____

Brookridge Internal Medicine Associates

PATIENT CONSENT TO PATIENT PORTAL COMMUNICATIONS

Brookridge Internal Medicine Associates, PA or BIM offers an electronic Patient Portal which allows you to electronically provide us with your health information for purposes such as registering for an appointment and allows us to electronically provide you with information such as test results and other medical reports. If you would like to use the Patient Portal, please review this form and acknowledge your consent by signing and returning this form to us. Use of the Patient Portal is strictly voluntary, and you are under no obligation to sign this form if you do not wish to use the Patient Portal.

DO NOT USE THE PATIENT PORTAL IF IT IS AN EMERGENCY OF YOU WISH TO COMMUNICATE SENSITIVE HEALTH INFORMATION (HIV/AIDS, MENTAL HEALTH, GENETIC INFORMATION). IF AN EMERGENCY, CALL 911.

1. OUR RESPONSIBILITY REGARDING THE PATIENT PORTAL

- We will only use or disclose your protected health information maintained in the Patient Portal as specified in our Notice of Privacy Practices and as set forth in this Consent.
- We will take measures that we believe to be reasonable and appropriate to protect the security of all Patient Portal communications. These measures include administrative, physical and technical safeguards of your electronic protected health information. However, we shall be under no obligations to encrypt communications from our office.
- We will retain copies of all Patient Portal communications from you and to you.
- We reserve the right to suspend or terminate the Patient Portal at any time for any reason. We will notify you if this occurs.
- Upon receipt of the Consent, we will contact you with instructions to register for use of the Patient Portal.

2. YOUR RESPONSIBILITY REGARDING PATIENT PORTAL COMMUNICATIONS

- If the reason you wish to contact us concerns a matter requiring immediate attention, or, if you are uncertain whether it may be an urgent matter, you must call our office at 903-655-1153 or 903-315-2907 instead of communicating with us by the Patient Portal.
- Understand that information you submit through the Patient Portal may not be read immediately during regular office hours when other patients are being seen or when our office is closed;, therefore, you must contact us via telephone or through our answering service regarding any issue that may require more immediate attention.
- Include how we may contact you in the text of our Patient Portal message.
- Keep you Patient Portal user name and password secure at all times and do not share your Patient Portal user name and password with anyone. You are responsible for the protection of your user name and password. Brookridge Internal Medicine Associates, PA shall not be liable for the protection of such information.
- Be as concise as possible in your Patient Portal messages. The Patient Portal may not be an appropriate method to communicate and received specialized medical or treatment advice. We may contact you by telephone, or we may request that you schedule an appointment for an office visit if we determine from a Patient Portal message that you require more personal contact or a detailed follow up.
- Provide us with and keep up-to-date, the email address to which you would like us to send notifications/ messages sent via the Patient Portal.
- Understand that your internet service and network providers may be able to access portal messages sent over your system, and that portal messages sent to us may be intercepted or viewed in transmission by person(s) unknown to you or us.
- Understand that because of technical failures inherent in electronic communications, it is your obligation to contact us by another method (via telephone, answering service, etc.) if we have not responded within three (3) business days to any electronic Patient Portal message you have sent to us.

My signature below acknowledges that I have read and understand the information contained in this Consent form and that I consent to electronic communications through the Patient Portal with personnel of BIM. I understand that such electronic portal communications may contain medical information about me and concern matters regarding my health care. I have reviewed and agree to fulfill my responsibilities as detailed in Section 2 above. I authorize BIM's personnel to respond to Patient Portal communications that BIM personnel reasonably believe to be from me. I understand that Patient Portal communications are subject to inherent risks of inadvertent and unintentional disclosure of my confidential health information and personally accept the risks of such disclosures in exchange for BIM's willingness to comply with my request to use the Patient Portal as a non-exclusive form of communications to and from BIM's practice. Further, in consideration for the promises detailed above in Section 1 of the Consent. I agree to hold harmless BIM, its physicians, officers, employees, agents, affiliates, and insurers from any and all claims, causes of action, losses, injuries, liabilities and expenses arising out of or relating to any electronic mail technical or administrative failure(s) and unauthorized disclosures.

This service is being offered to you at no charge but BIM reserves the right to change that policy at any time with prior notice to you. Likewise, BIM reserves the right to add or delete features of the Patient Portal at any time with prior notice to you. Refusal to sign this Consent will not affect our treatment of you nor in any way affect your eligibility for benefits of the services covered by your health plan. You may revoke this Consent and discontinue use of the Patient Portal by providing Brookridge Internal Medicine Associates, PA written notice.

SIGNATURE _____ DATE _____

PRINTED NAME _____ E-MAIL ADDRESS _____

BROOKRIDGE INTERNAL MEDICINE ASSOCIATES, P.A.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I acknowledge that Brookridge Internal Mediciane Asosociates, PA provided me with a written copy of The Notice of Privacy Practice.

I also asknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Signature of Patient Date

_____ _____

Signature of Personal Representative Signature (if applicable) Date

BROOKRIDGE INTERNAL MEDICINE ASSOCIATES, P.A.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Brookridge Internal Medicine Associates, PA to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). **(Brookridge Internal Medicine Associates, PA's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)**

I have the right to review the Notice of Privacy Practices prior to signing this consent. Brookridge Internal Medicine Associates, PA reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Brookridge Internal Medicine Associates, PA's Privacy Officer at 100 Zeid Blvd, Ste. A, Henderson Texas 75652.

With this consent, Brookridge Internal Medicine Associates, PA may call my home or other alternate location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Brookridge Internal Medcicine Associates, PA may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Brookridge Internal Medicine Associates, PA may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Brookridge Internal Medicine Associates, PA restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Brookridge Internal Medicine Associates, PA's use and disclosure of my PHI to carry out TPO

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Brookridge Internal Medicine Associates, PA may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Patient's name (printed)

I give consent for Brookridge Internal Medicine Associates, PA to give my Protected Health Information to:

_____

_____

NOTICE OF PRIVACY PRACTICES
BROOKRIDGE INTERNAL MEDICINE ASSOCIATES, PA

Effective Date: September 3, 2013

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.

If you have any questions about this Notice, please contact **Kay Segovia at 903-655-1153.**

Who will follow this Notice?

- Brenda Vozza, MD, FACP
- Amy Hicks, RN, FNP-C
- Marla English-Pickett, RN, A-GNP-C
- All staff of Brookridge Internal Medicine Associates, PA

We understand that medical information about you and your health is personal and are committed to protecting this information. When you receive care at Brookridge Internal Medicine Associates, PA, a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing records. This records serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payer can verify that services billed were actually provided;
- Source of information for public health officials, and
- Tools for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (herein referred to as "medical information". It also describes your rights and our obligations regarding the use and disclosure of medical information.

Our Responsibilities.

Brookridge Internal Medicine Associates, PA shall:

- Make every effort to maintain the privacy of your medical information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Brookridge Internal Medicine Associates, PA will notify you, and the Department of Health and Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

The Methods in Which We may use and disclose Medical Information about You.

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

For Treatment. We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to who you are referred for follow-up care.

For Payment. We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.

For Health Care Operations. We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run Brookridge Internal Medicine Associates, PA in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.

Appointment Reminders. We may use and disclose medical information in order to remind you of an appointment. For example, Brookridge Internal Medicine Associates, PA may provide a written or telephone reminder that your next appointment with Brookridge Internal Medicine Associates, PA is coming up.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for who one type of procedure is used to those for who another procedure is used for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

As Required by Law. We will disclose medical information about you when required to do so by federal or Texas laws or regulations.

To Avery a Serious Threat to Health or Safety. We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.

Sale of Practice. We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

Special Situations.

Organ and Tissue Donation. If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.

Military or Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

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.

Qualified Personnel. We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following activities:

- To prevent or control disease, injury or disability;
- 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; and
- To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. 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, eligibility or compliance, and to enforce health-related civil rights and criminal laws.

Lawsuits and Disputes. If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in a response to a court or administrative order.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order or subpoena, or
- If Brookridge Internal Medicine Associates, PA determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner when authorized by law (e.g., to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.

Inmates. If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.

Other Uses or Disclosures. Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

Your Rights Regarding Medical Information About YOU.

You have the following rights regarding medical information collected and maintained about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer for Brookridge Internal Medicine Associates, PA. If you request a copy of the information, Brookridge Internal Medicine Associates, PA may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records.

Brookridge Internal Medicine Associates, PA may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Brookridge Internal Medicine Associates, PA will review your request and denial. The person conducting the review will not be the person who denied your request. Brookridge Internal Medicine Associates, PA will comply with the outcome of the review.

Right to Amend. If you feel that medical information maintained about you is incorrect or incomplete, you may ask Brookridge Internal Medicine Associates, PA to amend the information. You have the right to request an amendment for as long as the information is kept by Brookridge Internal Medicine Associates, PA.

To request an amendment, your request must be made in writing and submitted to Brookridge Internal Medicine Associates, PA. In addition, you must provide a reason that supports our request.

Brookridge Internal Medicine Associates, PA 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, Brookridge Internal Medicine Associates, PA may deny your request if you ask us to amend information that:

- Was not created by Brookridge Internal Medicine Associates, PA, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by Brookridge Internal Medicine Associates, PA;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.

To request this list you must submit your request in writing to Kay Segovia, Office Manager. Your request must state a time period, which may not be longer that six (6) years. Your request should indicate in what form you what the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. Brookridge Internal Medicine Associates, PA will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information Brookridge Internal Medicine Associates, PA uses or discloses about you for treatment, payment or health care operations. you also have the right to request a limit on the medical information Brookridge Internal Medicine Associates, PA discloses about you to someone who is involved in your care or the payment for your care.

Brookridge Internal Medicine Associates, PA is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which Brookridge Internal Medicine Associates, PA has been pain out of pocket in full. Should Brookridge Internal Medicine Associates, PA agree to your request, Brookridge Internal Medicine Associates, PA will comply with your requests unless the information is needed to provide you emergency treatment.

To request restrictions you must make your request in writing to Brookridge Internal Medicine Associates, PA. In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit Brookridge Internal Medicine Associates, PA's use and/or disclosure; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that Brookridge Internal Medicine Associates, PA communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that Brookridge Internal Medicine Associates, PA contact you only at work or by email.

To request that Brookridge Internal Medicine Associates, PA communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. Brookridge Internal Medicine Associates, PA will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Changes to This Notice.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office. You may request that a copy be provided to you by contacting the Privacy Officer.

Complaints.

If you believe your privacy rights have been violated, you may file a complaint with Brookridge Internal Medicine Associates, PA or with the Office for Civil Rights, U. S. Department of Health and Human Services. To file a complaint with Brookridge Internal Medicine Associates, PA, contact the Privacy Officer at 903-655-1153. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

Secretary of Health & Human Services
Region VI, Office for Civil Rights
U. S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX. 75202

All complaints should be submitted in writing.

You will NOT be penalized for filing a complaint.