

Patient Registration Form

Last/Family Name	First/Given Name	MI	U#
Street Address	(C) _____ (H) _____		Phone Number
City, State, Zip	Email Address		
__ / __ / ____	__ - __ - ____		
Date of Birth (MM/DD/YYYY)	Social Security Number (SSN)		

Gender: Male Female TM TF Gender Non-Conforming

Hispanic Origin: Yes No Unknown Declined

Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander White Other Unknown Declined

Preferred Notification Method for Appointment Reminders: Cell Home Phone Email Text Do Not Call No Response

Preferred Language: _____ **Marital Status:** _____

Signature: _____ **Date:** _____

In case of medical emergency, please notify:

Name _____ Relationship: Parent Guardian Spouse Other

Phone (home) _____ (cell) _____

Do you have health insurance? Yes (please continue) No 

Subscriber Relationship: Self (skip the gray shaded area) Mother Father Spouse Other

Subscriber Last/Family Name (if not Self)	Subscriber First/Given Name	Date of Birth (MM/DD/YYYY)
Street Address	Phone Number	
City, State, Zip	Employer Name	
Insurance Company Name	Subscriber/Policy #	Group/Account #
Claims Address	City, State, Zip	Customer Service Phone Number

Do you have your insurance card? Yes No

CONDITIONS OF TREATMENT

NOTICE OF LIMITED LIABILITY

Medical care, treatment or services ("Medical Care") provided by employees and/or agents of the University of South Florida Board of Trustees ("USF Health") are subject to the provisions of § 768.28 Florida Statutes. Liability for the negligent acts and omissions of these USF Health employees and/or agents is limited by law to \$200,000 per claim or judgment by any one person and to \$300,000 for all claims or judgments arising out of the same incident or occurrence.

- I. Authorization for Medical Care.** I voluntarily consent to any Medical Care that may be considered necessary and/or advisable in the judgment of my Healthcare Provider. I understand that my Healthcare Provider is an employee or agent of USF Health. I also understand that my Healthcare Provider will be providing Medical Care to me in a healthcare teaching and research setting. Therefore, my Medical Care may be provided by residents and/or fellows under appropriate supervision and may be observed, and in some instances aided, by students under appropriate supervision. I understand that I have the right to refuse any Medical Care and I have the right to discuss all of my Medical Care with my Healthcare Provider.
- II. Authorization for Release of Information.** USF Health (through its employees, agents, affiliates or contracted copying services) may disclose my medical record and account information to:
- A. Any person or corporation which is or may be liable for all or any portion of my charges, including but not limited to insurance companies, health care service plans, and worker's compensation carriers to the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement.
 - B. Any referring physician to ensure continuity of my Medical Care.
 - C. Other Healthcare Providers within USF Health. USF Health maintains a single, combined medical record that includes all Medical Care provided to a patient by all Healthcare Providers across USF Health and each Healthcare Provider has access to this medical record.
- III. Health Information Exchanges.** I understand USF Health participates in one or more health information exchanges (HIEs) (currently known as "Care Everywhere"). Through Care Everywhere, USF Health is able to share information from my electronic medical record that may include but is not limited to my allergies, diagnoses, lab and imaging results, immunizations, medical history, medications, visit summaries, and it may also include sensitive information, such as HIV and sexually transmitted diseases, if applicable, with other health care providers. I agree that if I do not want my medical record shared with other health care providers who participant in the HIE, I must opt-out by filling out a USF Health, Care Everywhere Status Change form obtained from a USF Health front desk staff member or from USF Health Information Management at 813-974-4280 or at health.usf.edu/patient-forms.
- IV. Financial Agreement.**
- A. **Assignment of Insurance Benefits (if applicable).** I request my insurance carrier to pay to USF Health or its affiliates, all benefits due me related to my pending claim for Medical Care. I agree to pay all applicable deductible and coinsurance amounts due and other fees for services rendered for which my insurance plan/HMO is not liable for payment to the Provider and agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect such amounts.
 - B. **Medicare B Authorization (if applicable).** I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare & Medicaid Services or its intermediaries or carriers, or to the billing agent of this physician or supplier, any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

C. **Self-Paying Patient (if applicable).** I have been informed that the USF Health does not have a contract to participate with my insurance plan or HMO, and/or the requested Medical Care has not been authorized by my insurance plan/HMO, as applicable. I am requesting Medical Care as a fee-for-service, self-paying patient. I agree that I am responsible for all charges incurred as a result of this visit, including but not limited to all medical/surgical professional services, laboratory, radiological, and any other ancillary services. I agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect this account.

D. **Services rendered at USF Student Health Services (if applicable).** I understand that payment for services not covered by health fee or health insurance is my responsibility. **Students Only:** If I am unable to pay, I understand the charges will be placed on my OASIS account and I will be placed on administrative hold. This hold will immediately be removed upon payment of the outstanding balance at the Cashiers Office, Bayboro Hall 132 or online on OASIS.

V. **Prior Express Consent for Communications for Debt Collection and Payment Purposes.** I expressly agree and consent that, in order for USF Health or its employees, agents or affiliates to service my account (including debt collection and payment purposes) USF Health, or any of its employees, agents or affiliates, may contact me by telephone at any telephone number associated with my account, including any wireless/cellular telephone numbers, which could result in charges to me. USF Health, or any of its employees, agents or affiliates, may also contact me for debt collection and payment purposes by sending text messages or e-mails using any e-mail address or phone number I provide. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device.

VI. Acknowledgement of Receipt of Joint Notice of Privacy Practices and Notice of Organized Health Care Arrangement.

I acknowledge that I have been provided a copy of the USF Health Joint Notice of Privacy Practices and Notice of Organized Health Care Arrangement at health.usf.edu/patient-forms and have thereby been advised of how my health information may be used and/or disclosed, and how I may obtain access to and control this information.

VII. (Optional) Permission to Verbally Discuss my Medical Care. My Healthcare Providers may discuss my Medical Care with the following individuals:

Name and Relation

Phone #

Name and Relation

Phone #

By signature below, I acknowledge that I have read, understand, and agree to the foregoing as applicable to me and/or my minor child(ren), if provided Medical Care by or on behalf of USF Health. A signed copy shall be as valid as the original.

Patient Name (Print)

Signature (Patient or Representative)

Relationship to Patient (Please select one)

- Self
- Parent
- Legal Guardian

Date

Joint Notice of Privacy Practices And Notice of Organized Health Care Arrangement

THIS NOTICE DESCRIBES HOW HEALTH 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:

TGH Privacy Office
P.O. Box 1289
Tampa, FL 33601
Telephone: 813-844-4813

Organized Healthcare Arrangement

Florida Health Sciences Center, Inc. d/b/a Tampa General Hospital (TGH), the University of South Florida (USF), and all of the entities set forth in Exhibit A (hereafter referred to as “we” or “us”) have agreed to abide by the terms of this notice with respect to protected health information (PHI) as part of our participation in an organized healthcare arrangement (OHCA).

We will share PHI with each other as necessary to carry out treatment, payment, or health care operations relating to the OHCA, and as otherwise permitted by applicable law. We will do so through access to a shared electronic medical record. This notice applies to all of our service delivery sites and related support sites that use the shared electronic medical record.

NOTHING IN THIS NOTICE IS INTENDED TO SUGGEST THAT ANY OF US IS THE AGENT OF ANY OTHER OF US, OR THAT ANY OF US IS LIABLE FOR THE ACTS OR OMISSIONS OF ANY OTHER OF US.

Who Will Follow This Notice

As to TGH, this notice describes TGH’s practices and those of:

- Any health care professional authorized to enter information into or access information from your TGH medical record (e.g. physicians and nursing staff)
- All departments and units of TGH
- All departments and units of the free standing facilities affiliated with TGH (e.g., free standing clinics, diagnostic centers, other clinical sites, etc.)
- Any member of a volunteer group TGH allows to help you while you are a patient at one of TGH’s facilities
- All employees, staff and other hospital personnel

As to USF, this notice describes the practices of the following HIPAA covered health care components (Components):

- The USF Health Morsani College of Medicine and its constituent schools, departments and programs (including the USF School of Physical Therapy and Rehabilitation Sciences, the USF Health Byrd Alzheimer's Institute, and the USF Health Physician Assistant Program)
- The USF College of Pharmacy
- The USF Student Health Services
- The USF College of Behavior Sciences, Department of Communication Sciences and Speech Disorders
- The USF Medical Services Support Corporation
- University Medical Service Association, Inc.

and

- The USF administrative and operational units that support the Components
- All physicians, other healthcare providers, faculty, employees, trainees, students, volunteers and other workforce members and personnel of the Components

As to all of us except TGH and USF, this notice describes our practices, and the practices of all of our employees, staff and other personnel.

Our Pledge Regarding Health Information

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care, whether made by personnel or treating physicians, whether in paper, electronic or other forms of media. Your treating physicians outside of the OHCA may have different policies or notices regarding the use and disclosure of your health information created in the doctor's office or clinic. This notice will tell you about the ways in which we may use and disclose health information about you. We also will describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to health information about you
- Follow the terms of the notice that are currently in effect
- Notify you in the event of a breach of privacy regarding your private health information

How We May Use and Disclose Health Information About You

The following categories describe different ways that we use and disclose health information. In certain circumstances we may use and disclose PHI about you without your written consent. For each category of uses or disclosures we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, health care students, or other personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing

process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments also may share health information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose health information about you to people outside of the OHCA who may be involved in your medical care, such as family members, clergy, nursing homes, doctors or others we use to provide services that are part of your care.

For Payment: We may use and disclose health information about you so that the treatment and services you receive may be billed to, and payment may be collected from, you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at Tampa General Hospital so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you for health care operations. These uses and disclosures are necessary to run our offices and facilities and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, health care students, and other personnel for review and learning purposes. We may also combine the health information we have with health information from other providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of health information so others may use it to study health care and health care delivery.

Business Associates: We may use or disclose your PHI to an outside company that assists us in operating our offices and facilities. They perform various services for us. This includes, but is not limited to, auditing, accreditation, legal services and consulting services. These outside companies are called "business associates" and they contract with us to keep any PHI received from us confidential in the same way we do. These companies may create or receive PHI on our behalf.

Communication with Family Members and Friends: If you agree, we may disclose PHI about you to a family member, relative, or another person identified by you who is involved in your health care or payment for your health care. After your death, we may disclose PHI to a family member, relative, or other person who was involved in your health care or payment as long as that disclosure is consistent with your prior expressed preferences. You have a right to withdraw your permission or restrict these disclosures at any time. If you are unavailable, incapacitated or it is an emergency or disaster relief situation, we will use our professional judgment to determine whether disclosing limited PHI is in your best interest under the circumstances.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment for treatment or medical care.

Treatment Communications or Alternatives: We may use and disclose health information to contact you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-related Benefits and Services: We may use and disclose health information to contact you about health-related benefits or services that may be of interest to you.

Hospital Directory: With your prior approval TGH may include certain limited information about you in its hospital directory while you are a patient at the hospital. This information may include your name, location in the hospital, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if he/she does not ask for you by name. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing. You may prohibit the use or disclosure of this information by requesting "No Information" status at admission or anytime during your hospital stay.

Fund Raising: TGH or USF may use or disclose PHI, such as your name, address, phone number, the dates you received services, the department from which you received service, your treating physician, outcome information and health insurance status to contact you to raise money for their interests. They may share this information with the TGH Foundation, the USF Foundation, or their representatives to work on their behalf. If you do not want them to contact you with regard to their fundraising activities you may opt out. To opt out of these fundraising activities, or to opt in again, contact the Tampa General Foundation at (813) 844-3528 or tghfoundation@tgh.org or USF Health Care, Health Information Management, Attn: HIM Administration, 12901 North Bruce B. Downs Boulevard, MDC 33, Tampa, FL 33612, (813) 974-2201.

Community Education Programs: TGH from time to time participates in community educational programs, such as the White Coat Mini-Internship Program, and others. As part of these programs participants may accompany physicians and/or TGH staff as they attend to patients for educational purposes. Your PHI may be used or disclosed by TGH's personnel involved in your care for educational purposes in connection with such programs. You may opt out of such uses and disclosures by submitting the request in writing, to the TGH Privacy Office, P.O. Box 1289, Tampa, FL 33601, knowing that uses or disclosures made prior to the revocation cannot be taken back and are not subject to revocation. TGH may not condition treatment, payment, enrollment or eligibility for benefits on your opting out of such uses and disclosures.

Research: USF is an academic research institution, and TGH is an academic research hospital. Support of research is included in the missions of USF and TGH. Your health information may be used or disclosed for research purposes. Your medical record may be reviewed and data included in a research study. Your health information may be reviewed in preparation for research or used in a format that will not specifically identify you, or very limited information may be used and no additional authorization is required. A Privacy Board will determine whether your authorization is necessary for your health information to be included.

As Required By Law: We will disclose health information about you when required to do so by federal, state or local law.

To Avert Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or to the health and safety of another person or the public. Any disclosure, however, would only be to someone able to help prevent or lessen the threat.

Special Situations

Organ and Tissue Donations: If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplant or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

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

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

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

- To prevent or control disease; injury or disability
- To report births and deaths
- To report child abuse or neglect
- To report reactions to medications or problems with products
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- To notify your employer of a work-related illness or injury, if the health care was provided at the request of the employer and the employer is required to record the information

Abuse or Neglect: If you agree or when we are required or authorized by law, we may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, if we believe you have been a victim of abuse, neglect, or domestic violence, we may disclose your protected health information to a governmental entity authorized to receive such information.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

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

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness or missing person
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct

- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime

Coroners, Medical Examiners and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release health information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Shared Medical Record/Health Information Exchanges: We maintain PHI about our patients in shared electronic medical records that allow us to share PHI. We may also participate in various electronic health information exchanges that facilitate access to PHI by other health care providers who provide you care. For example, if you are admitted on an emergency basis to a hospital that participates in the health information exchange with us, the exchange will allow us to make your PHI available electronically to those who need it to treat you.

Other Uses and Disclosures of PHI

Most uses and disclosures of PHI for marketing purposes, including subsidized marketing information, uses and disclosures relating to highly confidential matters (such as abuse or neglect of a child, elderly person, or disabled adult, genetic testing, HIV/AIDS testing, diagnosis, or treatment, invitro fertilization, mental health, developmental disabilities, sexually transmitted diseases, or sexual assault), and disclosures that constitute the sale of PHI, require your written authorization. Psychotherapy notes (your mental health provider's written notes) will be disclosed only with your written permission and the consent of your mental health provider.

Your Rights Regarding Health information About You

You have the following rights regarding health information we maintain about you:

Right to Inspect and Receive a Copy: You have the right to inspect and receive a copy of health information that may be used to make decisions about your care. To inspect and obtain a copy of health information that may be used to make decisions about you, you must submit your request in writing to:

- For TGH: TGH Health Information Management Dept., Attn: Director, P.O. Box 1289, Tampa FL 33601, (813) 844-7533.

- For USF: USF Health Care, Health Information Management, Attn.: HIM Release of Information, 12901 North Bruce B. Downs Blvd., MDC 33, Tampa, FL 33612, (813) 974-9818.
- For entities other than TGH or USF, the office you visited.

For PHI in a designated record set that is maintained in an electronic format, you can request an electronic copy of such information. If you request a copy of the information, we may charge a fee for the costs associated with providing the requested information in paper or electronic format. We may deny your request to inspect and receive a copy in certain very limited circumstances. If you are denied access to health information related to these limited circumstances, you may request that the denial be reviewed as per the review policy of the denying entity.

Right to Request an Amendment or Addendum: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information, for as long as we maintain the information. To request an amendment, your request must be made in writing and submitted to:

- For TGH: TGH Health Information Management Dept., Attn: Director, P.O. Box 1289, Tampa FL 33601, (813) 844-7533.
- For USF: USF Health Care, Health Information Management, Attn.: HIM Release of Information, 12901 North Bruce B. Downs Blvd., MDC 33, Tampa, FL 33612, (813) 974-9818.
- For entities other than TGH or USF, the office you visited.

In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us
- Is not part of the health information kept by or for us
- Is not part of the information which you would be permitted to inspect and receive a copy
- Is accurate

The personnel who maintain the information will respond to your request within 60 days after you submit the written amendment request form. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to an Accounting of Disclosures: With some exceptions, you have the right to request information relating to certain disclosures of information we may have made about your health care for the six (6) year period prior to your request. To request this list or accounting of disclosures, you must submit your request in writing to:

- For TGH: TGH Health Information Management Dept., Attn: Director, P.O. Box 1289, Tampa FL 33601, (813) 844-7533.
- For USF: USF Health Care, Health Information Management, Attn.: HIM Administration, 12901 North Bruce B. Downs Blvd., MDC 33, Tampa, FL 33612, (813) 974-2201.

- For entities other than TGH or USF, the office you visited.

Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not disclose information about a surgery you had. We are not required to agree to your request except as described in the next section below. If we agree, we will comply with your request unless the information is needed to provide you emergency treatment. To comply with your request, it may be necessary to consider all information confidential. To request restrictions prior to or at the time of admission you must make your request in writing to:

- For TGH: TGH Admitting Dept., Manager, P.O. Box 1289, Tampa, FL 33601, (813) 844-7207.
- For USF: USF Health Care, Health Information Management, Attn.: HIM Administration, 12901 North Bruce B. Downs Blvd., MDC 33, Tampa, FL 33612, (813) 974-2201.
- For entities other than TGH or USF, the office you visited.

In your request, you must indicate (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to a relative.

Requested restriction to health plan: We will agree to restrict disclosure of PHI about an individual to a health plan if the purpose of the disclosure is to carry out payment or health care operations and the PHI pertains solely to a service for which the individual, or a person other than the health plan, has paid for in full. For example, if a patient pays for a service completely out of pocket and asks us not to tell his/her insurance company about it, we will abide by this request unless otherwise required by law. A request for this restriction should be made in writing, to:

- For TGH: TGH Admitting Dept., Manager, P.O. Box 1289, Tampa, FL 33601, (813) 844-7207.
- For USF: USF Health Care, Health Information Management, Attn.: HIM Administration, 12901 North Bruce B. Downs Blvd., MDC 33, Tampa, FL 33612, (813) 974-2201.
- For entities other than TGH or USF, the office you visited.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work. To request confidential communications, you must make your request in writing to:

- For TGH: TGH Admitting Dept., Manager, P.O. Box 1289, Tampa, FL 33601, (813) 844-7207.

Effective Date: July 13, 2017

- For USF: USF Health Care, Health Information Management, Attn.: HIM Administration, 12901 North Bruce B. Downs Blvd., MDC 33, Tampa, FL 33612, (813) 974-2201.
- For entities other than TGH or USF, the office you visited.

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to be Notified of a Breach: You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of unsecured protected health information.

The Right to Access to Your Own Health Information: Except for certain limited circumstances, you have the right to inspect and obtain a copy of your protected health information for as long as we maintain it. All requests for access must be made in writing. We may charge you a nominal fee for each page copied and postage if applicable. You also have the right to ask for a summary of this information. If you request a summary, we may charge you a nominal fee to create the summary. If you have any questions or requests, please contact:

- TGH: TGH Health Information Management Dept., Attn: Director, P.O. Box 1289, Tampa FL 33601, (813) 844-7533. Alternatively, if applicable, you may request secure online access to portions of your medical records through TGH's patient portal.
- USF: USF Health Care, Health Information Management, Attn.: HIM Administration, 12901 North Bruce B. Downs Blvd., MDC 33, Tampa, FL 33612, (813) 974-2201.
- For entities other than TGH or USF, the office you visited.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. To obtain a paper copy of this notice contact: TGH Privacy Office, Attn.: Director, P.O. Box 1289, Tampa, FL 33602, (813) 844-4813.

Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. If we make a material change to the terms of this notice we will make the revised notice available to you upon request (see section titled Right to a Paper Copy of this Notice). We will post a copy of the current notice in our offices and facilities, and on our websites. The notice will contain on the first page, in the bottom left-hand corner, the effective date. In addition, each time you present at our offices or facilities for treatment or health care services, we will offer you a copy of the current notice in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint, please contact:

- For TGH: TGH Admitting Dept., Manager, P.O. Box 1289, Tampa, FL 33601, (813) 844-7207.
- For USF: USF Health Professional Integrity Office, 12901 North Bruce B. Downs Blvd., MDC 74, Tampa, FL 33612, (813) 974-2222.
- For entities other than TGH or USF, the office you visited.

All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Health information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission, and we are required to retain our records of the care that we provide to you.

Nondiscrimination Statement

We comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-813-844-7000.

French Creole (Haitian Creole)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-813-844-7000.

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-813-844-7000.

Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-813-844-7000.

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-813-844-7000。

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-813-844-7000.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-813-844-7000.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-813-844-7000.

Arabic

813-844-7000 به رقم اتصالات المجان لك توافر اللغوية المساعدة خدمات فإبن اللغة، انكرت تحدثك أنت إذا بملاحظة

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-813-844-7000.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-813-844-7000.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-813-844-7000 번으로 전화해 주십시오.

Polish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-813-844-7000.

Gujarati

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-813-844-7000.

Thai

รีชน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-813-844-7000.

Exhibit A to Joint Notice of Privacy Practices And Notice of Organized Health Care Arrangement

- Al-Halawani, M.D., P.A., F.A.C.E;
- Ajoy Kotwal, M.D., P.A.;
- Center for Diabetes and Metabolic Disorders;
- Digestive Diseases Associates of Tampa Bay;
- Dr. Eugene Ward, M.D., P.A.;
- Dr. Venkata BiReddy, M.D., P.A.;
- Fernando A. Rodriguez, M.D., P.A.;
- Florida Department of Health, Children's Medical Services
- Florida Interventional Specialists;
- Health Association of Tampa Bay;
- Lucy C. Love, M.D., P.A.;
- Mary L. Stedman, M.D., P.A.;
- Medic Clinics Primary Care, L.L.C.;
- Omni Medical Center for Women;
- Palma Ceia Heart & Vascular, P.A.;
- Ronald S. Hulse, III, M.D.;
- Tampa General Medical Group, Inc.
- Tampa Neurology Associates;
- Tampa Bay Plastic Surgery;
- The Surgery Center at TGH Brandon HealthPlex, LLC; and
- Women's Healthcare.