BAY MEDICAL CENTER

COASTAL OB/GYN

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.

Uses and Disclosures: We will use and disclose elements of your protected health information (PHI) in the following ways:

Without your signed authorization:

- Treatment: including, but not limited to, inpatient, outpatient or psychiatric care.
- To Bay Medical Center Medical Staff treating physicians.
- Payment: including, but not limited to, asking you about your health care plan(s), or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts, either ourselves or through a collection agency or attorney.
- Health care operations: including, but not limited to, financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.
- Disclosures when release is authorized by law: including, but not limited to, judicial settings and to health oversight regulatory agencies, law enforcement and correctional institutions.
- Uses or disclosures for specialized government functions: including but not limited to, the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign services.
- In emergency situations or to avert serious health/safety situations.
- If you are a member of the armed forces, we may release medical information about you and your dependents as requested by military command authorities.
- Disclosures of de-identified information.
- Disclosures relating to worker's compensation claims.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties.
- To organizations that handle organ and tissue donations.
- To public health organizations or federal organizations in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication.)
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.
- We may include certain limited information about you in the 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.
- You may be contacted by the hospital to remind you of any appointments, healthcare treatment alternatives and other health related benefits and services offered by the hospital.
- You may be contacted by the hospital for the purposes of raising funds to support the hospital's operations.

Personal Privacy Protection Directive

In accordance wit Bay Medical Center's Notice of Privacy Practices and to protect the confidentiality of my protected health information, I hereby direct that disclosure of my protected health information be restricted. Specifically, no documentation of any information related to my stay or treatment, including but not limited to, any documents or other materials prepared for peer review, risk management, or quality assurance purposes, is to be disclosed under any circumstances, redacted or otherwise, to anyone not affiliated with Bay Medical Center, for any purpose other than payment or legitimate health care operations, without my express written consent or the express written consent of my authorized representative.

Patient signature:_____ Date:_____

Effective Date: This notice is effective April 14, 2003.

I acknowledge receipt of this notice:

Sign: _____ Date: _____

Print name of patient: _____

If you are signing as the patient's representative:

Print your name: _____ Describe your authority_____

Other uses and Disclosures

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

Your rights: You have the following rights concerning your protected health information (PHI):

Restrictions: To request restricted access to all or part of your protected health information (PHI). To do this, contact the Bay Medical Center Medical Records Department. We are not required to grant your request and you do not have the right to restrict disclosures required by law. If we do agree, we must honor the restrictions you request.

Confidential communications: To receive correspondence of confidential information by alternate means or location such as phoning you at work rather than at home or mailing your health information to a different address. To do this, contact the Bay Medical Center Medical Records Department. We will take reasonable actions to accommodate your request.

Access: To inspect or receive copies of your protected health information (PHI). To do this, contact the Bay Medical Center Medical Records Department. In certain circumstances you may not have the right to access your records if Bay Medical Center reasonably believes (or has reason to believe) that such access would cause harm. Examples include but are not limited to, certain psychotherapy notes, information compiled in reasonable anticipation of or for use in civil, criminal or administrative actions or proceedings, or information obtained from someone other than a healthcare provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

Amendments/Corrections: To request changes be made to your protected health information (PHI). To do this, contact the Bay Medical Center Medical Records Department. We are not required to grant your request if we did not create the record or the record is accurate and complete. If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we agree to the request, we will make the correction within 60 days and will send the corrected information to persons we know who got the wrong information, and others you specify.

Accounting: To receive an accounting of the disclosures by us of your protected health information (PHI) in the six years (or shorter time) prior to your request. To do this, contact the Bay Medical Center Medical Records Department. By law, the list will not include disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. We are not required to give you a list of disclosures that occurred before April 14, 2003.

This notice: To get updates or reissue of this notice, at your request.

Complaints: To complain to us or the U.S. Department of Health & Human Services if you feel your privacy rights have been violated. To register a complaint with us, contact BMC Privacy & Security Officer: (850) 747-6670. The law forbids us from taking retaliatory action against you if you complain.

Our duties: We are required by law to maintain the privacy of your protected health information (PHI). We must abide by the terms of this notice or any update of this notice.

Privacy Contact: For more information about our privacy practices, please contact:

Karla Seaborn
BMC Privacy & Security Officer
Bay Medical Center
615 N. Bonita Avenue
Panama City, FL 32401
850-747-6670

MEDICAL HISTORY INFORMATION SHEET

Front and Back

Today's Date: / /			
Name:		Single	Widowed
DOB: / /		Married	Seperated
Birthplace:		Divorced	

Allergies (Please circle any that apply)		List any Medications You Take
Penicillin	Y N	
Sulfa	Y N	
Antibiotics	Y N	
Codeine	Y N	
Morphine	Y N	
Aspirin	Y N	
Insect bites/stings	Y N	
Any Foods	Y N	
Any Medications	Y N	
Other		

Hospitalizations: List all, for illness or surgery, beginning the most recent			
Date:	Reason:	Hospital:	Physician:

Diagnostic Testing - When Was Your Last			
Pap Smear	/ /	Mammogram	/ /
Menstrual History			
Age of First Period		Date of Last Period	
Length of last Period		Length Between Cycles:	

Circle Any Symptoms That Apply During Your Period			
Cramps	Heavy Flows	Clots	Pelvic Pain
			Head Aches

Circle Your Current Form Of Birth Control			
None	IUD	Spermicide	Birth Control Pills
Condoms	Implanon	Norplant	Tubal ligation
Diaphragm	Depo Provera	Withdrawal	Vasectomy

Pregnancy History(Please give total number for each)			
Pregnancies	Full Term	Premature	Elect. Abortions
Miscarriage	Ectopic	Mutiple Births	Living

List Each Delivery			
Month/Year	Delivery Type	Gestational Weeks	Sex / Birth Weight

MEDICAL HISTORY INFORMATION SHEET

Social History - Answer All Sections			
Weight Now:			Do you use seat belts: Y N
1 Year Ago:			**Tobacco**
Desired:			Cigarettes Packs/Day:
Alcoholic Beverages			Cigars: Pipe:
Never			Age started smoking:
Less than 6 drinks/week:			Age stopped smoking:
7-24 drinks/week:			Snuff
Over 24 drinks/week:			Chewing Tobacco
Treated for alcoholism?			**Diet**
Treated for drug dependency?			Any special diet:
Outcome of either treatment:			
			Exercise
			Type:

Family History	Health (Good/Poor)	Age/ Age At Death	Cause of death
Father			
Mother			
Brother / Sister			
Brother / Sister			
Spouse			
Son / Daughter			
Son / Daughter			
Date Of Your Last Physical / /		Physician	

Has any blood relative ever had:	Check If Yes	Relationship
Allergies		
Asthma		
Arthritis		
Birth Defects		
Cancer		
Depression/Emotional Prob.		
Diabetes		
Glaucoma		
Heart Trouble		
High Blood Pressure		
Kidney Trouble		
Mental Retardation		
Sickle Cell Anemia		
Stroke/ Epilepsy/ Seizures		
Sustance Abuse		
Suicide / Suicidal Thoughts		
Tuberculosis		