Welcome! On behalf of Tallahassee Memorial HealthCare, thank you for choosing us. We look forward to meeting and learning more about you during your first appointment.

In anticipation of your visit, we have included the following:

- Welcome Letter
- Patient Registration
- Authorization and Agreement Form
- Patient Profile
- Verbal Communication Form
- TMH Authorization for Release of Protected Health Information Form (highlighted areas only)
- Medical Records release
- TMH Cancer Center Stress Tetrameter

Please bring the included (completed) forms along with your current medications, insurance card(s), and a valid photo ID with you for your appointment. Also, please be sure to arrive 45 minutes early to complete registration.

Our office will give a courtesy call for appointment reminders 48hrs in advance (please do not rely on this call in-case system is down). We do ask that if you need to cancel or reschedule appointment you give 24hr notice. If you No Show for appointment we will attempt to call you 3 times for reschedule. If we are unable to contact via phone, we will send a reminder letter & contact your referring provider.

You may receive bills from TMH Physician Partners, Tallahassee Memorial Hospital, or other organizations for services provided such as office visits, lab tests, x-rays, treatments, etc.

Please be prepared to discuss and pay any possible co-pays, deductibles, or co-insurance at each visit.

If you have any questions regarding any of the above information or your appointment, feel free to give us a call at (850) 431-5360. We look forward to seeing you soon!

Thank you,

TMH Physician Partners Cancer & Hematology Specialists
PATIENT INFORMATION
Patient Full Name: ___________________________________ Patient prefers to be called: ________________________
Date of Birth: ____________________ Social Security #: _____-____-______ Sex: □ Male □ Female
Mailing Address: ___________________________________ Apt/Unit#: __________________
City: __________________ State: ________ Zip Code: __________________
Home Phone: (_____)_______________ Work Phone: (_____)_______________ Cell Phone: (_____)_________________
Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated Email: _______________________________
Referring Physician: ___________________________ Primary Care Physician: ___________________________
Patient’s Employer Name: _________________________________________________________________
Employment: □ Full-time □ Part-time □ Not working □ Self Emp □ Retired □ Military □ Student: □ Full-time □ Part-time □ N/A
Emergency Contact Name: ___________________________ Relationship to Patient: ______________________
Emergency Contact Phone: (_____)__________________ Emergency Contact Other Phone: (_____)________________

FOR CHILDREN - guarantor information/responsible for payment:
Guarantor Name: ___________________________________ Guarantor Relationship: _______________________
Guarantor Date of Birth: _____________ Guarantor Address: ______________________ Apt/Unit#: _____________
City: __________________ State: ________ Zip Code: __________________

INSURANCE INFORMATION - PRIMARY PLAN - POLICY INFORMATION
Insurance Company: ___________________________________ Subscriber name: _____________________________
Cert/Policy #: ___________________________ Group Name: _______________________________________
Group#: ___________________________ Policy Telephone #: _________________________________
Relationship to the insured: □ Self □ Spouse □ Child □ Other
If you are not the policy holder, please complete the following:
Policy Holder Name: ___________________________ Address: ___________________________ City: _______ ST: ____ Zip: ______
Policy Holder Date of Birth: ___________________________ Policy Holder Sex: □ Male □ Female

INSURANCE INFORMATION - SECONDARY PLAN - POLICY INFORMATION
Insurance Company: ___________________________________ Subscriber name: _____________________________
Cert/Policy #: ___________________________ Group Name: _______________________________________
Group#: ___________________________ Policy Telephone #: _________________________________
Relationship to the insured: □ Self □ Spouse □ Child □ Other
If you are not the policy holder, please complete the following:
Policy Holder Name: ___________________________ Address: ___________________________ City: _______ ST: ____ Zip: ______
Policy Holder Date of Birth: ___________________________ Policy Holder Sex: □ Male □ Female

EDUCATION: We want to provide education regarding your health conditions and would like to know the following:
My Preferred teaching method is: □ I have no preference □ Written education materials □ Demonstration
Barriers to learning: □ Language barrier □ Poor eyesight □ Poor Hearing □ Other ___________________________
□ No barriers
Would you like someone with you during any education? (Name) ___________________________ (Relationship) ________________
Contact Preference: □ Phone □ Email □ Text ________________________________

Primary Language: □ English □ Spanish □ Other: ________________________________
Race: □ Asian □ African American □ American Indian □ Caucasian □ Other
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Other: ________________________________
1. Consent and Acknowledgements Relating to My Care and Treatment:
I hereby consent, for myself or, a minor child or another person for whom I have authority to sign to the rendering of medical care and treatment (including but not limited to medicinal drugs, diagnostic tests and procedures), that my attending physician(s) and/or other TMH Medical Staff members consider necessary and advisable to treat while a patient of a provider of Tallahassee Memorial HealthCare (TMH). I acknowledge that my medical care and treatment may be provided by physicians (including residents), physician assistants, nurses, medical and allied health students and other health care providers. In addition, I consent to the appropriate disposal by TMH of any specimens or other bodily materials removed during a technical procedure or for testing purposes.

2. Assignment of Benefits/Consent to Release My Information to TMH: I assign to TMH all my right, title and interest in benefits due from any and all insurance carriers, health care plans, health plan administrators, benefit programs, the Centers for Medicare and Medicaid Services (and their agents and review agencies) and/or other payment sources (“Payers”). I authorize my Payers to make payments directly to TMH of any benefits due for services provided by TMH. I acknowledge that TMH has the right to accept or refuse assignment of medical benefits. If my Payers will not allow direct payment to TMH or if TMH refuses to accept assignment of medical benefits, I agree to pay TMH all payments that I receive for services. I consent to my Payers providing TMH with all pertinent financial information concerning coverage and payments made under my health care plans.

3. Notice of Privacy Practices: I acknowledge that a copy of the TMH Notice of Privacy Practice has been provided to me, and that an electronic version of that document is available at www.tmh.org.

4. Patient’s Rights and Responsibilities: I acknowledge that the TMH Patient’s Rights and Responsibilities, has been provided to me, and that an electronic version of that document is available at www.tmh.org

5. Advance Directives. Information about your rights to make advance health care decisions (including but not limited to a Living Will, Healthcare Power of Attorney, and Designation of Healthcare Surrogate), as well as your healthcare providers’ policies regarding the same can be found on this document, and electronically at www.tmh.org

Do you have an Advance Directive?

Policy and Procedure on Advance Directives in The Outpatient Clinic Setting:
Patients will receive screening for advance directives during registration of their first visit to the TMH outpatient clinics. Patients are not required to have an advance directive.

Making Your Wishes Known
Advance directives outline predetermined actions you have indicated you desire for your healthcare if you are no longer able to make decisions for yourself due to incapacity or illness. These legally binding documents outline your wishes regarding life support, resuscitation and other interventions for both your healthcare team and your family members.

Living Will
A living will is a written, legal document that spells out medical treatment you would and would not want to be used to keep you alive if you have a terminal condition and cannot speak for yourself.

Healthcare Decision Maker
Your healthcare decision maker is another adult you appoint to make decisions on your behalf when you are unable to do so. It is usually recommended that you appoint someone who knows your wishes and is willing to carry them out, especially regarding your personal, religious, moral, and cultural beliefs. This can be done by signing a written designation of a healthcare surrogate that complies with Florida law. If you are incapacitated, your healthcare surrogate will have the authority to make all the medical decisions regarding your healthcare, including decisions about when to withhold or withdraw life-prolonging procedures.

Durable Power of Attorney
A durable power of attorney for healthcare is another legal document that can be used to name your healthcare decision maker. Once written, it should be signed dated, witnessed, notarized, and copied, and put into your medical record.

IN THE EVENT THE PATIENTS NEED EMERGENCY CARE IN THE OUTPATIENT CLINIC SETTING, WE WILL PROVIDE BASIC LIFE SUPPORT AND CALL 911 TO SUMMON EMERGENCY LIFE SERVICES, UNLESS A PHYSICIAN WHO IS FAMILIAR WITH THE PATIENT’S WISHES AND MEDICAL HISTORY ORDERS OTHERWISE.

This policy is in place because it may not be possible in an emergency situation in the outpatient clinic to determine your chance of survival or recovery. Once you have reached the Emergency Room or Hospital where a better determination of your condition can be made, your advance directive will be honored if you are not able to express your wishes. If you have an advance directive, please bring us a copy of your advance directive so we can electronically scan it into your medical record.

If you need additional information, you may contact an attorney or the Risk Management Department at TMH- 850-431-5364.
6. Consent for TMH to Release My Medical Information: I hereby authorize TMH to release my medical information to the following persons/entities (my “medical information” includes but is not limited to information relating to the following: medical, psychological, psychiatric, HIV/AIDS, communicable and sexually transmitted diseases, genetic testing and alcohol/drug abuse):

- My other health care providers for treatment or payment purposes, as well as my primary care provider (if I have provided TMH with the name of such provider);
- Payers for the purpose of processing health care claims; additionally, TMH may share my past, current and future health, treatment and patient records about services received from TMH and other providers for the purpose of managing or coordinating my care and improving the quality of that care;
- Person(s) I designate as my guarantor(s) for handling billing and payment of my account;
- Accrediting and quality organizations, regulatory agencies and/or other persons or entities for health care operations; and
- Persons, entities, agencies, and/or other health care providers as required by law, including but not limited to Section 395.1052, Fla. Stat.

If you wish to Opt-Out of the HIE please check □ Opt-Out.

8. Acknowledgment Regarding Billing:
I understand that I will receive one or more bills from TMH for the services provided. I understand that I will also receive one or more separate bills from the physicians who provide care while I am at TMH, including but not limited to surgeons, Anesthesiologists, Radiologists, Emergency Physicians, Pathologists and other specialists. Pathologists are responsible for analysis of specimens and assuring test results are clinically valid, reliable, and reported in a timely manner to my doctor. I agree to pay for those pathology services unless the pathologist has entered into an agreement with my insurance company to accept payment in full or unless otherwise provided by law.

9. Acknowledgment of Financial Responsibility: I acknowledge that I am responsible and obligated to pay for all charges for services provided, including but not limited to any amount not paid by my Payers, which includes but is not limited to Medicare, a health maintenance organization, an out-of-state workers’ compensation policy, or any other Payer. I consent to TMH obtaining consumer credit reports to determine my eligibility for financial assistance and/or payment options. I agree, whether I sign as the patient or as the parent, guardian, spouse, agent or guarantor of the patient, that I am obligated to pay TMH for the services rendered to the patient; if the account is referred to an attorney or collection agency for collection, I agree to pay the reasonable attorneys’ fees and costs of collection.

10. Notice to Medicare Patients: I understand that Medicare will not cover certain drugs. I understand that any tablet, capsule, suspension (including eye drops), ointment, patch or suppository will not be paid by Medicare in an outpatient setting even if my doctor ordered it and I received it. If I am unable to pay, please call the Central Business Office at 850-431-7289.

11. HMO ELIGIBILITY GUARANTEE: I hereby certify that if I enrolled in an HMO and/or Medicaid HMO that I am receiving health care services through the Primary Care Physician that I have chosen or has been assigned to me. I understand that if the above is not true or if I am not eligible under the terms of my medical and hospital subscriber health insurance agreement, I am liable for all charges for the services rendered. Also, if the above is not true, I agree to pay in full for all services received within thirty (30) days of receiving a statement/bill from TMH.

12. Consent to Contact Me: By providing a wireless and/or residential telephone number and/or an email address, I expressly consent to receiving live, autodialed and/or pre-recorded message calls, text messages and/or emails from TMH and/or its affiliates, agents, contractors or business associates (including but not limited to third party debt collectors) at any phone number or email address, whether cellular, residential or other, associated with my account for any purpose (including but not limited to debt collection or payment) relating to the services and goods provided by TMH or its affiliates that may be of interest to me. I understand if this information is provided to a third party, this information will no longer be protected by the person or entity that received the information in accordance with applicable law. TMH may not condition treatment, payment, enrollment or eligibility for benefits on your agreeing to this provision.

13. Consent to Photograph/Video: I consent to TMH physicians and staff taking photographs and/or video to be used in connection with my diagnosis, care and treatment, and such photos and videos are the property of TMH. I acknowledge that I may withdraw my consent at any time and that my medical care is not dependent on my agreement to have photographs and/or video taken.

Patient Name ____________________
Patient DOB ____________________
14. Prohibited Items: I acknowledge that pursuant to TMH policy, I am prohibited from bringing to TMH any weapon, explosive device, illegal substance or drug or any alcoholic beverages. I understand that if there is any violation of this policy, TMH will request that the items be removed. I understand that if I am non-compliant this may result in notification to TMH security and/or law enforcement.

15. Personal Valuables: I understand that TMH does not accept responsibility for any personal property (monetary or sentimental).

By signing below, I acknowledge and agree that I understand, accept and agree to be bound to the terms of this document. I understand that I have the right to revoke the authorizations in this document at any time by notifying TMH in writing, except to the extent that TMH has already taken action in reliance on them. These authorizations remain valid unless/until I revoke them in writing.

I CERTIFY AND STATE THAT I HAVE RECEIVED NO PROMISES, ASSURANCES, OR GUARANTEES FROM ANYONE AS TO THE RESULTS THAT MAY BE OBTAINED BY ANY MEDICAL TREATMENT OR SERVICES.

• If the patient is 18 years of age or older, the patient must sign and date this form.

• If the patient is 18 years of age or older and incapable of signing, a legally authorized person may sign and date the form; please indicate your legal authority and include documentation of that authority:
  - Legal Guardian
  - Health Care Surrogate/Power of Attorney
  - Spouse/Proxy

• If the patient is 17 years of age or younger, the patient’s parent or legal guardian must sign and date the form, unless an exception exists under state or federal law; please indicate your authority:
  - Parent
  - Legal Guardian

PRINT PATIENT NAME

PATIENT DATE OF BIRTH

PRINT LEGAL REPRESENTATIVE NAME

DATE

SIGNATURE PATIENT/LEGAL REPRESENTATIVE

RELATIONSHIP TO PATIENT
**PATIENT PROFILE**

**Date:** _________________________  **Sex:** ☐ Male  ☐ Female  **Date of Birth:** _____________________

Name (Last, First): ____________________________________________________________

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>If yes, when: <em><strong>/</strong><strong>/</strong></em></th>
<th>Where:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you had a colonoscopy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had a mammogram?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had a bone mineral density test (DEXA scan)?</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**IMMUNIZATIONS:**  Are your immunizations current?  ☐ YES  ☐ NO

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Date of last Tetanus: <em><strong>/</strong>__/</em>___</th>
<th>Date of Flu vaccine: <em><strong>/</strong>__/</em>___</th>
<th>Date of Pneumonia vaccine: <em><strong>/</strong>__/</em>___</th>
<th>Date of Shingles vaccine: <em><strong>/</strong>__/</em>___</th>
</tr>
</thead>
</table>

**Patient Health Questionnaire-2 (PHQ-2):**

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

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you experienced 10 lbs weight loss or gain in past 3 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have problems with mobility (use a wheelchair, cane, or walker)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*If YES describe the problem and/or the device used:

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you had a fall in the past year?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel unsteady?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you in a relationship where you are being threatened or hurt?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there any religious considerations that would keep you from receiving blood products?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Often True</th>
<th>Sometimes True</th>
<th>Never True</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within the past 12 months we worried whether our food would run out before we got money to buy more</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Within the past 12 months the food that we bought didn’t last and we didn’t have money to get more</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
PAST MEDICAL HISTORY:
Have you ever had any of the following? (Please Check)

- High Blood Pressure
- Heart Rhythm Disease
- Rheumatic Fever
- Emphysema or COPD
- Asthma
- Acid Reflux Disease
- Pancreatitis
- Low Thyroid
- Asbestos Exposure
- Thyroid
- Diabetes
- Glaucoma
- Osteoarthritis
- Rheumatoid Arthritis
- Stomach Ulcers
- Clotting Problems
- Diverticulitis
- Scleroderma
- Bone Fracture after 50
- OTHER:
- Hepatitis
- Lupus
- Cirrhosis
- Colitis
- Gallstones
- Glaucoma
- Seizures
- Tuberculosis
- Heart Failure
- Heart Rhythm Disease
- Coronary Artery Disease
- Sjogren's Syndrome
- Rheumatic Fever
- Stroke
- Steroid use >6months

Have you been diagnosed with cancer before?

<table>
<thead>
<tr>
<th>Type of Cancer</th>
<th>Where treated (Doctor, Hospital, City)</th>
<th>When (Dates)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Have you had Chemotherapy?  □ YES  □ NO  Why?________________________ When?________________________
Which drugs?________________________________________________________
Where did you receive it?______________________________________________

Have you had Radiation Therapy?  □ YES  □ NO  Why?________________________ When?________________________
Number of Treatments?________________________ Where did you receive it?________________________

List all past surgeries:_________________________________________________________________________________

FAMILY HISTORY OF CANCER:  Adopted? □ Yes □ No

<table>
<thead>
<tr>
<th>Relative</th>
<th>Type of cancer</th>
<th>Age when diagnosed</th>
<th>Alive?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

SOCIAL HISTORY:
Education: Check last year completed:
Grade School:  □ 1-5  □ 6-8  High School □ 9 □ 10 □ 11 □ 12  College: □ Bachelor □ Masters □ Doctorate

OCCUPATION: CHECK ONE OR MORE:
□ Employed/Self Employed  If employed, describe the work you do:___________________________________________
□ Student  □ Retired  □ Unemployed  □ Disabled

If retired, your occupation prior to retirement:____________________________________________________________

If disabled, describe disability and date work stopped:_____________________________________________________
### ALCOHOL & TOBACCO USE:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th># packs per day</th>
<th>How many years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you smoke cigarettes?</td>
<td>YES</td>
<td>NO</td>
<td># packs per day</td>
<td>How many years</td>
</tr>
<tr>
<td>Have you ever smoked for period of five (5) or more years?</td>
<td>YES</td>
<td>NO</td>
<td># packs per day</td>
<td>How many years</td>
</tr>
<tr>
<td>Are you interested in stopping?</td>
<td>YES</td>
<td>NO</td>
<td># packs per day</td>
<td>How many years</td>
</tr>
</tbody>
</table>
| Are you an ex-smoker? | YES | NO | If "yes" when did you quit? _______
| Regular alcohol/beer intake: | YES | NO | Per Day? _____ Per Month? _____ |
| Are you an ex-drinker? | YES | NO | If "yes" when did you quit? _______

### SOCIAL ISSUES: If "Yes", Please Explain

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you live alone?</td>
<td>YES</td>
<td>NO</td>
<td>Explanation</td>
</tr>
<tr>
<td>If not, who lives with you?</td>
<td>YES</td>
<td>NO</td>
<td>Explanation</td>
</tr>
<tr>
<td>Do you have transportation issues?</td>
<td>YES</td>
<td>NO</td>
<td>Explanation</td>
</tr>
<tr>
<td>Do you need assistance with your Activities of daily living?</td>
<td>YES</td>
<td>NO</td>
<td>Explanation</td>
</tr>
<tr>
<td>Do you have financial concerns?</td>
<td>YES</td>
<td>NO</td>
<td>Explanation</td>
</tr>
<tr>
<td>Concerned about your coping abilities, or your family’s ability to cope?</td>
<td>YES</td>
<td>NO</td>
<td>Explanation</td>
</tr>
<tr>
<td>Do you have any Marital concerns?</td>
<td>YES</td>
<td>NO</td>
<td>Explanation</td>
</tr>
<tr>
<td>Have you ever been the subject of violence in your home?</td>
<td>YES</td>
<td>NO</td>
<td>Explanation</td>
</tr>
</tbody>
</table>

### ALLERGIES: NO KNOWN ALLERGIES: ☐

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reaction</th>
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<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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### MEDICATIONS:

**Preferred Pharmacy ________________________________ **Location___________________________________

List any medications you are taking, including vitamins and all non-prescription drugs. Copy names and dosages of medication from the prescription label. Attach an additional sheet of paper if needed.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>How Often</th>
<th>Dosage (mgs/tablets)</th>
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<tbody>
<tr>
<td>1.</td>
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<td>15.</td>
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</table>
REVIEW OF SYSTEMS: In the past 3 months, have you experienced any of the following:

**CONSTITUTIONAL**
- Lack of appetite: [ ] Yes [ ] No
- Fever: [ ] Yes [ ] No
- Lethargy/fatigue: [ ] Yes [ ] No
- Night sweats/chills: [ ] Yes [ ] No
- Weight loss: [ ] Yes [ ] No
- How much? ___________________

**HEAD/EYES/EARS**
- Hair Loss: [ ] Yes [ ] No
- Pain in Eye: [ ] Yes [ ] No
- Eye injury: [ ] Yes [ ] No
- Double Vision: [ ] Yes [ ] No
- Blurry/Decreased Vision: [ ] Yes [ ] No
- Difficulty hearing: [ ] Yes [ ] No
- Earaches: [ ] Yes [ ] No
- Buzzing or ringing in ears: [ ] Yes [ ] No
- Sensation of spinning: [ ] Yes [ ] No

**NOSE, THROAT, NECK**
- Recurrent sore throats: [ ] Yes [ ] No
- Persistent Hoarseness: [ ] Yes [ ] No
- Frequent Nosebleeds: [ ] Yes [ ] No
- Mouth Ulcers: [ ] Yes [ ] No
- Oral bleeding: [ ] Yes [ ] No
- Dental problems: [ ] Yes [ ] No
- Sinus trouble: [ ] Yes [ ] No
- Swollen lymph nodes or glands: [ ] Yes [ ] No
- Where________________________
- Difficulty swallowing: [ ] Yes [ ] No
- Masses or lumps: [ ] Yes [ ] No
- Dry mouth: [ ] Yes [ ] No
- Altered taste: [ ] Yes [ ] No
- Neck pain: [ ] Yes [ ] No

**SKIN**
- Chronic skin condition: [ ] Yes [ ] No
- Lump or growth on skin: [ ] Yes [ ] No
- Change in color of skin: [ ] Yes [ ] No
- Skin Tumors or moles: [ ] Yes [ ] No
- Rash: [ ] Yes [ ] No

**BREASTS**
- Masses or lumps: [ ] Yes [ ] No
- Nipple Discharge: [ ] Yes [ ] No
- Nipple inversion: [ ] Yes [ ] No
- Pain: [ ] Yes [ ] No

**HEART**
- Chest pain: [ ] Yes [ ] No
- Ankle swelling: [ ] Yes [ ] No
- Sleeping with head elevated: [ ] Yes [ ] No
- Fainting: [ ] Yes [ ] No
- Calf cramps with walking: [ ] Yes [ ] No
- Pacemaker: [ ] Yes [ ] No

**LUNG**
- Cough: [ ] Yes [ ] No
- Shortness of Breath: [ ] Yes [ ] No
- Blood in sputum: [ ] Yes [ ] No
- Wheezing/asthma: [ ] Yes [ ] No
- Tuberculosis/or exposure: [ ] Yes [ ] No
- Infections/pneumonia: [ ] Yes [ ] No

**NEURO**
- Frequent or severe headaches: [ ] Yes [ ] No
- Dizziness or faintness: [ ] Yes [ ] No
- Nervousness/Anxiety: [ ] Yes [ ] No
- Numbness/tingling: [ ] Yes [ ] No
- Memory loss: [ ] Yes [ ] No
- Seizures: [ ] Yes [ ] No
- Disorientation: [ ] Yes [ ] No
- Weakness: [ ] Yes [ ] No
- Abnormal gait: [ ] Yes [ ] No

**GASTROINTESTINAL**
- Frequent heartburn/indigestion: [ ] Yes [ ] No
- Nausea or vomiting: [ ] Yes [ ] No
- Abdominal pain: [ ] Yes [ ] No
- Diarrhea or frequent stools: [ ] Yes [ ] No
- Blood in stool: [ ] Yes [ ] No
- Blood in vomit: [ ] Yes [ ] No
- Trouble swallowing: [ ] Yes [ ] No
- Yellow skin/jaundice: [ ] Yes [ ] No
- Constipation: [ ] Yes [ ] No
- Decreased appetite: [ ] Yes [ ] No
- Change in stools: [ ] Yes [ ] No
- Black, tarry stools: [ ] Yes [ ] No
- Hemorrhoids: [ ] Yes [ ] No

**BONES AND MUSCLES**
- Painful joints: [ ] Yes [ ] No
- Sore muscles: [ ] Yes [ ] No
- Bone pain: [ ] Yes [ ] No
- Muscle weakness: [ ] Yes [ ] No
- Decreased range of motion: [ ] Yes [ ] No
**ENDOCRINE**
- Hot flashes: [ ] Yes [ ] No
- Other endocrine diseases: [ ] Yes [ ] No

**HEMATOLOGIC/ LYMPH**
- Bruising: [ ] Yes [ ] No
- Enlarged lymph nodes: [ ] Yes [ ] No

**GENITOURINARY**
- Decreased size/force of urine stream: [ ] Yes [ ] No
- Increased frequency of urination: [ ] Yes [ ] No
- How often? __________
- Burning sensation during urination: [ ] Yes [ ] No
- Nighttime urination: [ ] Yes [ ] No
- How many times @ night __________
- Sensation that bladder cannot empty: [ ] Yes [ ] No
- Blood in urine: [ ] Yes [ ] No
- Erectile dysfunction (men only): [ ] Yes [ ] No

**PSYCHIATRIC**
- Delusions/Hallucinations: [ ] Yes [ ] No
- Mood swings: [ ] Yes [ ] No
- Depression: [ ] Yes [ ] No
- Schizophrenia: [ ] Yes [ ] No
- Body Dysmorphic Disorder: [ ] Yes [ ] No
- Post-Traumatic Stress Syndrome: [ ] Yes [ ] No
- Paranoia: [ ] Yes [ ] No
- Bi-Polar: [ ] Yes [ ] No
- Anorexia: [ ] Yes [ ] No
- Bulimia: [ ] Yes [ ] No
- OTHER: [ ] Yes [ ] No

**WOMEN ONLY**
- Age at first menstruation: ____________
- Date of last period: ____________
- Last Pap ____________
- Number of Pregnancies ____________
- Number of live births ____________
- Age of children _____________________________________________________________________________________
- Vaginal Discharge or bleeding: [ ] Yes [ ] No
- Irregular periods: [ ] Yes [ ] No
- Painful Intercourse: [ ] Yes [ ] No
- Ever use hormones? [ ] Yes [ ] No
- Gone through menopause? [ ] Yes [ ] No If “yes”, when? ____________
- Date & location of mammogram showing cancer: ____________________________________________________________
- Date & location of last normal mammogram: ________________________________________________________________

**PATIENT PHYSICIANS INFORMATION**
- Who referred you to our office? ________________________________________________________________________
- Primary Care Physician: ______________________________________________________________________________
- General Surgeon: _____________________________________________________________________________________
- Oncology Physician (Chemo Doctor) _____________________________________________________________________
- Radiation Oncology Physician (Radiation Doctor) ___________________________________________________________
- Pulmonary Physician (Lung Doctor) _____________________________________________________________________
- Neurology/Neurosurgery Physician (Brain Doctor) __________________________________________________________
- Dermatology Physician (Skin Doctor) ___________________________________________________________________
- Urology Physician (Bladder/Prostate Doctor) ________________________________________________________________
- Cardiology Physician (Heart Doctor) ____________________________________________________________________
- Gastroenterology Physician (Stomach Doctor) ________________________________________________________________
- List all upcoming Physician Appointments: ______________________________________________________________________
To protect a patient’s privacy and to ensure that our physicians and medical clinic staff members know whom they have permission verbally to communicate with regarding your protected health information contained in your medical and billing records please complete below. Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named below.

**Patient Name:**_________________________________________ **Date of Birth:**__________________________________

I authorize TMH, their physicians, nurses, and other health care personnel to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care and payment of my care.

**The information indicated above may be released to (family members/friends):**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.______</td>
<td>___________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>2.______</td>
<td>___________________________________________________________</td>
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</tr>
<tr>
<td>3.______</td>
<td>___________________________________________________________</td>
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</tbody>
</table>

________ (Initial) I specifically authorize the verbal release of all medical information, **INCLUDING** that related to mental health, alcohol and/or drug abuse treatment, and HIV (AIDS) testing, treatment or diagnosis.

________ (Initial) I specifically authorize the verbal release of all medical information, **EXCLUDING** that related to mental health, alcohol and/or drug abuse treatment, and HIV (AIDS) testing, treatment or diagnosis.

**Special Instructions or Restrictions on Disclosure: Other:**

May we leave a voicemail at the number(s): □ Yes □ No
May we leave a text message at the number(s): □ Yes □ No

*(I understand that texting is not a secure form of communication)*

This authorization is limited to the following timeframe from _______ to _______. If no date indicated, this form will remain in effect for an unlimited amount of time.

I understand that I have the right to revoke this authorization at any time, if I do so, it must be in writing and addressed to TMH. The revocation will not apply to any information already released as a result of this authorization. I also understand once the information is released, there is potential for re-disclosure by the recipient and no longer protected by applicable state and federal regulations. I understand this authorization is voluntary. I do not need to sign this form in order to receive treatment.

_________________________ ________________________________
**Patient/Legal Representative Signature** **Date**

_________________________ ________________________________
If authorization is by Legal Representative (Print Name) **Relationship to Patient**

Witness
Tallahassee Memorial Cancer Center

1775 One Healing Place, Tallahassee, Florida
Located near the corner of Miccosukee and Surgeons Drive

Phone 850-431-ICAN (4226)

We are pleased to announce that the following services are now being performed at our new Cancer Center facility:

**TMH PHYSICIAN PARTNERS**
- Radiation Oncology
- Cancer & Hematology
- Gynecologic Oncology
- Surgical Oncology

**TALLAHASSEE MEMORIAL HEALTHCARE – OUTPATIENT SERVICES**
- OP Infusion
- Navigation and Counseling Services
- Survivorship Programming
- Nutrition Assessments
- Music Therapy
- Animal Therapy
- Cancer Research and Registry
YOUR EXPERIENCE IS IMPORTANT TO US

We want to be the best, and you can help.

After your visit at TMH, you may receive a survey asking about your experience. Help us recognize outstanding caregivers, and/or provide feedback where we can improve. We thank you in advance for completing the survey.

You may receive a survey by phone, mail, email or text. Surveys are administered by Press Ganey Associates, Inc. All responses are confidential. Should you need an advocate or have a concern we can address while you are here, please contact Patient Experience Department at 431-5488.
Tallahassee Memorial Cancer Center  
Authorization For Release of Information

<table>
<thead>
<tr>
<th>Patient Information</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Date(s) of Service Requested:</td>
<td></td>
</tr>
<tr>
<td>______________________</td>
<td>______________</td>
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<tr>
<td>______________________</td>
<td>______________</td>
</tr>
<tr>
<td>Last 4 Numbers of SSN:</td>
<td></td>
</tr>
<tr>
<td>Day Phone:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td></td>
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<tr>
<td>State:</td>
<td></td>
</tr>
<tr>
<td>Zip Code:</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Releasing Party</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Who has the information you want released?</td>
<td></td>
</tr>
<tr>
<td>Tallahassee Memorial Hospital</td>
<td></td>
</tr>
<tr>
<td>Tallahassee Memorial Wound Care</td>
<td></td>
</tr>
<tr>
<td>Tallahassee Memorial Behavioral Health Center</td>
<td></td>
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<tr>
<td>Tallahassee Memorial Urgent Care</td>
<td></td>
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<tr>
<td>Tallahassee Memorial Rehabilitation Center</td>
<td></td>
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<tr>
<td>Tallahassee Memorial Cancer Center</td>
<td></td>
</tr>
<tr>
<td>Tallahassee Memorial Home Health Care</td>
<td></td>
</tr>
<tr>
<td>Tallahassee Memorial Clinic/ Physician Partners (specify location)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Receiving Party</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Where do you want the information sent?</td>
<td></td>
</tr>
<tr>
<td>Who may have the information?</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Day Phone:</td>
<td></td>
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<td>City:</td>
<td></td>
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<tr>
<td>State:</td>
<td></td>
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<tr>
<td>Zip Code:</td>
<td></td>
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<tr>
<td>Fax Number:</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Hospital (check all that apply):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Hospital Summary</td>
<td>□ Emergency Record</td>
</tr>
<tr>
<td>□ Discharge Summary</td>
<td>□ Cardiac Reports / EKG</td>
</tr>
<tr>
<td>□ History and Physical</td>
<td>□ Other</td>
</tr>
<tr>
<td>□ Consultation Reports</td>
<td>□ Other</td>
</tr>
<tr>
<td>□ Operative Reports</td>
<td>□ Other</td>
</tr>
<tr>
<td>□ Laboratory Reports</td>
<td>□ Other</td>
</tr>
<tr>
<td>□ Radiology Reports</td>
<td>□ Pathology Reports</td>
</tr>
<tr>
<td>□ Entire Record (not including psychotherapy notes)</td>
<td>□ Entire Record (not including psychotherapy notes)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Office/clinic (check all that apply):</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>□ Office Visits</td>
<td>□ Immunizations</td>
</tr>
<tr>
<td>□ Physical Exam</td>
<td>□ Radiology Reports</td>
</tr>
<tr>
<td>□ Laboratory Reports</td>
<td>□ Pathology Reports</td>
</tr>
<tr>
<td>□ Early Detection Screening</td>
<td>□ Treating Physician’s Office</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavioral Health/Substance Abuse (check all that apply):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Hospital Summary</td>
<td>□ Discharge Summary</td>
</tr>
<tr>
<td>□ Assessments</td>
<td>□ Progress Notes</td>
</tr>
<tr>
<td>□ Laboratory Reports</td>
<td>□ Medications</td>
</tr>
<tr>
<td>□ Clinical Reports</td>
<td>□ Other</td>
</tr>
</tbody>
</table>

| Format: | □ USB / CD | □ Paper | □ Other |  |
| Delivery Method: | □ Mail | □ Pick-up | □ Fax, where permitted |  |

PATIENT’S RIGHTS: I understand that: 1) I can cancel this permission at any time. I must cancel in writing to the Privacy Officer at the above address; 2) Any cancellation will apply only to information not yet released by facility or practice; 3) Once my health information is released, there is the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by applicable regulations; 4) Refusing to sign this form will not prevent my ability to get treatment; 5) TMH will not share or use my health information without my permission other than by ways listed in TMH’s Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at tmh.org; 6) A fee may be charged for providing the protected health information; 7) I have a right to receive a copy of this form upon my request.

I DO NOT WANT TO RELEASE (check all that apply):  
□ HIV / AIDS | □ GENETIC INFORMATION | □ SEXUALLY TRANSMITTED DISEASE (STD) | □ DRUG / ALCOHOL | □ MENTAL HEALTH

This permission expires one year after the date of my signature unless another date or event is written here: ______________________

Signature: ______________________ Print Name: ______________________ Date: ______________________

Witness Signature: ______________________ Print Name: ______________________ Date: ______________________

Note: If a minor consented for their outpatient treatment for pregnancy, STD or behavioral / mental health without parental consent, the minor must sign this authorization.

Note: If the patient lacks the legal capacity or is unable to sign, an authorized personal representative may sign this form.

Check the box below to indicate the relationship / authority (Written Proof may be requested):  
□ Healthcare Agent / POA | □ Guardian | □ Executor / Administrator / Attorney in Fact | □ Other
□ Parent | □ Adult Child | □ Affidavit Next of Kin | □ Spouse
## Screening Tools for Measuring Distress

### Patient's Date of Birth

<table>
<thead>
<tr>
<th>Problem</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trouble in hands/feet</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Sleep</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Skin/dry/thirty</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Social</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Pain</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Nose dry/congested</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Nausea</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Mouth sores</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Memory/concentration</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Indigestion</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Fatigue</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Feeling swollen</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Feeding</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Dying</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Dignity</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Changes in mood</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Breathlessness</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Starting depressed</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

### Other Problems/Comments

- Spiritual/Religious concerns
- Loss of interest in usual activities
- Work
- Money
- Family
- Friends
- Fear
- Depression
- Ability to have children
- Dealing with partner
- Dealing with children

First, please circle the number (0-10) that best describes how much distress you have been experiencing in the past week, including today. Be sure to check YES or NO for each problem. Second, please indicate if any of the following has been a problem.
NOTICE OF PRIVACY PRACTICES OF: Tallahassee Memorial Hospital and Tallahassee Memorial HealthCare, Inc.

Effective Date: April 14, 2003  Revised Date: June 1, 2017

This notice describes the privacy practices of all inpatient and outpatient departments and units of Tallahassee Memorial Hospital and all facilities operated by Tallahassee Memorial HealthCare, Inc. with the exception of Tallahassee Memorial Behavioral Health Center.

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.

A. PURPOSE OF THE NOTICE OF PRIVACY PRACTICES
A record is made of the care and services you receive each time you are a patient in our hospital or one of our affiliated facilities. This record documents such things as your physical examination, test results, diagnosis, treatment, plans for future care, and information related to billing. We need this record to provide you with quality care and to comply with certain legal requirements. This notice describes the type of information we gather about you while you are a patient, with whom that information may be shared and the safeguards we have in place to protect it. It applies to all records of your care generated by hospital personnel, agents of the hospital, or your doctor. Please note that your doctor may provide you with a notice regarding the use and disclosure of your health information in his particular office.

B. OUR LEGAL DUTY REGARDING YOUR MEDICAL INFORMATION
We are required by law to keep private any medical information that identifies you and provide you with a description of our privacy practices with respect to your medical information. We will follow applicable laws and the terms of the notice that are currently in effect.

C. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

1. Permitted and Required Uses and Disclosures of Your Health Information Which DO NOT Require Your Written Authorization or the Opportunity for You to Object or Agree
The following categories describe the different ways that we may use and disclose medical information and examples of each. Not every possible use or disclosure in a category will be listed.

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, training doctors, or other healthcare professionals 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. Different healthcare professionals also may share health information about you in order to coordinate the different things you may need, such as medications, lab work, meals, and x-rays. We may also disclose medical information about you to people outside the facility who may be involved in your medical care after you are discharged or that provide services that are part of your overall care.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your treatment so they will pay us or reimburse you. We may also use and disclose medical information about you to obtain prior approval or determine whether your insurance plan will cover the treatment. We may contact you for the purpose of billing/collection efforts. This may include leaving a message on your answering machine/voice mail.

For Health Care Operations: Members of our medical staff, clinical departments, and administrative units may use information in your medical record to review the care and outcomes in your case and similar cases. This is necessary to continually improve the quality of care for all patients we serve. For example, we may disclose information to doctors, nurses, technicians, training doctors, medical students, and other facility personnel for review and learning purposes. We may also use and disclose health information to assess your satisfaction with our services and for reviewing the competence of health care professionals.

Business Associates: Certain services are provided in our organization through contracts with business associates. We may disclose your health information to our business associates so that they can perform the job we’ve asked them to do. Some examples include CPA firms whose accounting services involve access to protected health information, healthcare clearinghouses that transmit claims on our behalf, independent medical transcriptionists who type medical reports, or a copy service we use to make copies of your health record. To protect your privacy, we require each business associate to sign an agreement that obligates the business associate to use appropriate safeguards to protect your health information.

Funeral Directors and Medical Examiners: Consistent with applicable law, we may use and disclose your health information to funeral directors and medical examiners in the event of your death.

Research: We may disclose information to researchers when an Institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research and granted a waiver of the authorization requirement.

Future Communications: We may communicate to you via newsletters, mailings or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities in which our facilities are participating.

As Required by Law: We will disclose medical information about you when required or directed to do so by federal, state or local law. This may include, but is not limited to requests from the following types of entities: 1) Food and Drug Administration; 2) Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability; 3) Governmental Authority which by law is authorized to obtain de-identified health information; 4) Protective Services for Victims of Abuse, Neglect or Domestic Violence; 5) Correctional Institutions; 6) Workers Compensation Agents; 7) Organ and Tissue Donation Organizations; 8) Military Command Authorities; 9) Health Oversight Agencies; 10) National Security and Intelligence Agencies; 11) Protective Services for the President and Others.

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care. This may include leaving a message on your answering machine/voice mail.

Fundraising Activities: We may use health information about you in an effort to raise money for Tallahassee Memorial HealthCare, Inc. and its operations. We may disclose certain information to the TMH Foundation so that the Foundation may raise money for the hospital. You have the right to request (opt-out) that we not contact you, for fund raising efforts. If you do not want to be contacted for fundraising efforts, you must notify us as directed by the fundraising communication (correspondence) or notify our Privacy Officer by phone or in writing at the number or address on the last page.

Affiliated Covered Entities: Protected health information will be made available to personnel at all facilities affiliated with and managed by Tallahassee Memorial HealthCare as necessary to carry out treatment, payment, and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the TMH Privacy Officer for further information on the specific sites which are affiliated with TMH.

Organized Health Care Arrangement: Our facilities and their medical staff members share an organized health care arrangement. Information will be shared as necessary to carry out treatment, payment, and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Data Aggregation: We may disclose protected health information to permit data aggregation with other health care providers for our health care operations such as quality assessment and improvement activities, population health analysis or clinical guideline development.

De-Identified Information: We may use or disclose protected health information to create de-identified information which is not individually identifiable health information.

2. Uses and Disclosures of Your Health Information Which DO Require That You Have the Opportunity to Object or Agree
We may disclose the following kinds of health information about you, if you are informed in advance of the use and disclosure, and you have had the opportunity to agree to or prohibit or restrict the use and disclosure of this information. We may inform you verbally or in writing of these types of uses and disclosures, and you may agree or object verbally or in writing to these
uses and disclosures.

**Directory:** We may include certain limited information about you in our facility directory while you are a patient here. This information may include your name and location, (whether an inpatient, outpatient, or Emergency Center patient.) It may also include your general condition (e.g. fair, stable, etc.) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you do not want to be included in the directory, please advise the Registration staff and request the “Opt Out Form”.

Individuals Involved in Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who is responsible for or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

**Health Information Exchange:** We may disclose protected health information to a health information exchange or other similar organization for treatment purposes and health care operations, such as quality assessment and improvement activities, population health analysis or clinical guideline development, and other purposes consistent with federal and state law. If you do not wish your protected health information to be shared with a health information exchange, please advise the Registration staff and request the “HIE Opt Out Form.”

3. Uses and Disclosures of Your Health Information Which Require Your Authorization

The following uses and disclosures will be made only with your written permission:
1) Most uses and disclosures of psychotherapy notes: 2) Disclosures that constitute the sale of your protected health information; 3) Uses and disclosures for marketing purposes.

**DO YOU WANTS REGARDS TO YOUR MEDICAL INFORMATION**

Your medical record is the physical property of the healthcare practitioner or facility that compiled it; however, you have the right to:

**Inspect and Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and obtain a copy your medical information, you must submit your request in writing to our Privacy Officer or our Director, Medical Records at the address at the end of this notice.

If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional selected by Tallahassee Memorial HealthCare will review your request and the denial. We will comply with the outcome of the review.

**Amend:** If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment and if this occurs, you will be informed of the reason for the denial.

**An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required. To request an accounting of disclosures, you must submit your request in writing to our Privacy Officer.

**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 health care 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 use or disclose information about a surgery you had. With the exception of “Out-of-Pocket Payments,” described below, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

**To request restrictions, you must make your request In writing to our Privacy Officer.** In your request, you must tell us (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. Restrictions may be terminated upon your oral or written agreement, your written request or upon you receiving a notice from us that we are terminating the agreement to a restriction.

To request restrictions regarding your presence and/or location in the facility, you must make this known when you register or check-in as a patient.

**Out-of-Pocket Payments:** If you prefer that we not bill your health plan for a specific item or service and you have timely paid out-of-pocket in full for that specific item or service, then you have the right to ask that your protected health information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request. Your request to limit disclosure in this way must be submitted in writing.

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 may ask that we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing to our Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.

Notification of a Breach: You have the right to be notified of any breach of your unsecured protected health information.

A Paper Copy of This Notice: You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.tmh.org. To obtain a paper copy of this notice, please request one when you register or check-in as a patient or contact our Privacy Officer.

E. OTHER USES OF MEDICAL INFORMATION WHICH REQUIRE YOUR WRITTEN AUTHORIZATION

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 permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing to our Privacy Officer, 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. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

F. CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and include the effective date. You have the right to obtain a copy of the revised notice upon request.

G. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the TMH Privacy Officer at the address below or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

H. TALLAHASSEE MEMORIAL HEALTHCARE PRIVACY OFFICER

You may contact the TMH Privacy Officer at 850-431-5339. Written requests or inquiries may be sent to:

Privacy Officer (OR) Director, Medical Records (for record copy request)
Tallahassee Memorial HealthCare, Inc.
1300 Miccosukee Road
Tallahassee, FL 32308

Secretary of the Department of Health and Human Services
Region IV-Office of Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, SW Atlanta, GA 30303-8980
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