



## **Welcome to Centers For Foot and Ankle Care!**

**Our Mission:** The podiatrists at Centers For Foot and Ankle Care are dedicated to providing you the highest quality foot care. Our practice includes doctors, medical assistants and receptionists who share a commitment to providing the best possible care for you or members of your family.

**Complete Foot and Ankle Care:** Centers For Foot and Ankle Care specialize in the treatment of any foot or ankle related pain, sports injuries, diseases or other problems. The most common conditions we see include heel and arch pain; diabetic foot care; ingrown and fungal nails; fractures and sprains; corns and calluses; bunions; hammertoes; endoscopic surgery for heel spurs and pinched nerves; reconstructive foot and ankle surgery; and ankle arthroscopy. In addition, we provide pediatric medical and pediatric surgical care.

**Scheduling Appointments:** When you need an appointment, we ask that you call our office directly. Our receptionist will take your basic information and will ask you the reason for your visit. This is important information so that we can schedule enough time for your appointment with the doctor. Our office hours are generally 9 a.m. to 5 p.m., Monday through Friday with occasional Saturdays and extended hours at certain locations.

**Registration:** Each time you arrive for your appointment, you will be asked to present your insurance card and verify your address and phone number. While this may seem like an inconvenience, we've found that often the insurance companies make slight changes to the coverage that are important for us to know. Please be prepared to present this information to the receptionist upon checking in for your appointment. Our goal is to have you in the exam room and prepared to see the doctor at your scheduled appointment time. If there are changes in your address, phone number or insurance information, please plan to arrive 10 minutes prior to your scheduled appointment to complete the needed paperwork.

**Referrals:** If your health plan requires referrals, please be sure that your primary care physician has completed this process before your visit. If this process has not been completed and approved by your insurance company, you may be subject to the entire cost for the visit.

**Copay Policy:** Centers For Foot and Ankle Care, along with your insurance company, requires that any insurance copayments you may have be made at the time of service. We will collect these copayments after your appointment. If your copayment is not paid at the time of service, CFAC reserves the right to assess a \$20.00 fee to the patient's account. For your convenience, we accept cash payments, personal checks, Visa and MasterCard.

**Returned Check Reprocessing Charge:** Centers For Foot and Ankle Care will assess a \$20.00 Returned Check Reprocessing Fee for each check returned unpaid by our bank.

**After Hours Protocol:** In the event that you need care after hours or on weekends, Centers For Foot and Ankle Care has staff available. Please phone the office and listen for information on having the on-call physician or other staff paged.

**Treatment of Minors Policy:** Patients under the age of 18 must have a parent/legal guardian present to complete initial paperwork and treatment consent. All minors must have written parental consent with each subsequent office visit, even if they are accompanied by an older sibling, babysitter or grandparent. Without parental consent, the child's appointment will have to be rescheduled. A parent/legal guardian must be present when routine care/injections are administered.

**Medication Refill Policy:** If you are on regular medications, you may need refills. When our physicians see you in the office, they will write your prescription with a certain number of refills to hold you over until your next visit. Follow-up appointments to monitor your progress on these medications are very important. That is why in some cases, we may not accommodate your request to phone your refill into your pharmacy. Be sure to call our office well in advance of the time your refill is needed.

When you come to our office for your visit, be sure to bring an up-to-date list of all medications you are currently taking.

**Missed Appointment Policy:** We realize that circumstances may cause you to arrive late or miss an appointment. CFAC asks that you call the office at least 24 hours in advance in cases where you know that you are unable to keep your appointment. If you know you will be late, please call us at least 30 minutes in advance.

If you arrive 15 minutes late or more without advance notice, you may be asked to reschedule. If you miss an appointment without giving us advance notice, CFAC reserves the right to charge \$20 for the missed appointment time. A pattern of missed appointments may result in your dismissal from Centers For Foot and Ankle Care

**Billing Office:** If you have questions or concerns about your bill or need to set up payment arrangements, please feel free to contact our billing office directly at **513-533-6010 or 1-888-237-4264** (outside of Cincinnati).

**Release/Transfer of Medical Records:**

CFAC requires an administrative fee for the retrieval, duplication and transfer of a patient's medical chart. This fee covers the cost of the duplication and any applicable postage to forward those medical records. Prior authorization from the patient is required before any copies are released. CFAC's fee policy for the transfer of records in accordance with Ohio Revised Code 3701.741 (as follows):

- An initial fee of \$15.00 labor location/materials/assembling/reassembling charge
- All Pages - .20 cents per page
- Maximum charge per patient \$30.00
- ***Only the last two years of the record will be copied.***

After receiving your authorization for release/transfer of records you will receive a letter totaling the cost for transfer. Upon receipt of your payment, CFAC will forward a copy of the last two years of your medical record to the physician/facility you have designated.



## First Time Arrival Checklist

### Items to bring:

- Registration Form completed
- Medical History Form completed
- PAD Screening Form completed if one of the following applies:
  - Over 65, (50 with diabetes)
  - Smoke
  - History of known heart disease
- Personal Representative Authorization Form completed (optional – see form for details)
- All insurance cards
- Up-to-date list of all medications

### After arrival:

We are required to have you sign an acknowledgement that you have received the Notice of Privacy Practices that was included with this packet.

# REGISTRATION FORM



## Patient Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Nickname \_\_\_\_\_  
Street Address \_\_\_\_\_ Initial here if changed \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Sex  M  F SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email address \_\_\_\_\_ Student?  Yes  No  
Family Primary Care Doctor \_\_\_\_\_

## Responsible Party Information Same as patient

(If different from patient)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_  Address Same as Patient  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Initials \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

## Primary Insurance Information

Insurance Carrier Name \_\_\_\_\_ Effective Date \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_  
Name of Employer Providing Insurance \_\_\_\_\_  
Patient Relationship to Insured  Self  Spouse  Child  Other Insured's Sex  M  F

## Secondary Insurance Information

Insurance Carrier Name \_\_\_\_\_ Effective Date \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_  
Name of Employer Providing Insurance \_\_\_\_\_  
Patient Relationship to Insured  Self  Spouse  Child  Other Insured's Sex  M  F

## How did you hear about our practice?

Family  Friend  Newspaper  Radio  TV  Phone book  CFAC Website  Internet  Signage  
 Insurance directory  Other physician  Hospital  Previous patient  Other Name \_\_\_\_\_

**The undersigned patient or individual acting on behalf of the patient agrees that the above facts are correct.**

Signature \_\_\_\_\_ Date \_\_\_\_\_



## Consent to Treat/Acknowledgement of Financial Responsibility

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. Authority is granted to Centers for Foot and Ankle Care to render needed treatment and/or tests to the patient.
2. I authorize Centers for Foot and Ankle Care to release any information required for payment of insurance claims.
3. I authorize my insurance or Medicare benefits to be paid directly to the treating physician, realizing I am responsible to pay non-covered and unauthorized services.
4. I understand that I am responsible for all charges incurred through Centers for Foot and Ankle Care. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.
5. I have been given Centers for Foot and Ankle Care's handout on missed appointments and understand my responsibilities regarding being late or absent.
6. Parent or legal guardian consent must be provided for treatment of a child (under the age of 18) for every visit. If you are unable to accompany your child to each visit, you may designate specific person(s) (adults over age 18) below as giving consent to treat for your child on your behalf.

Name \_\_\_\_\_ Relation to child \_\_\_\_\_

7. In the event of an emergency, I designate the following person as my emergency contact:

Name \_\_\_\_\_ Home phone \_\_\_\_\_

Address \_\_\_\_\_ Other phone \_\_\_\_\_

City/State/ Zip \_\_\_\_\_

8. Expirations or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

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**Signature of Patient or Legal Guardian**

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**(Date)**

# MEDICAL HISTORY

Date \_\_\_\_\_ Family Physician \_\_\_\_\_

Name \_\_\_\_\_ Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_

Please describe your foot concern \_\_\_\_\_

Have you had previous foot injuries, care, or surgery? (If yes, describe) \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

Have you been diagnosed with the following conditions? (Indicate yes or no by circling Y or N)

|     |  |     |                         |     |                       |
|-----|--|-----|-------------------------|-----|-----------------------|
| Y N | Diabetes (high blood sugar)  | Y N | Liver Disease           | Y N | Venereal Disease      |
| Y N | Hypertension (high blood pressure)                                       | Y N | Thyroid (hypo or hyper) | Y N | AIDS                  |
| Y N | Heart Disease (heart attack, murmur, arrhythmias, mitral valve prolapse) | Y N | Hearing/Vision Problem  | Y N | Cancer _____          |
| Y N | Abnormal Bleeding/Healing/Sickle Cell                                    | Y N | Rheumatic Fever         | Y N | Arthritis             |
| Y N | Stroke   | Y N | Stroke                  | Y N | Gout                  |
| Y N | Phlebitis/Blood Clot in Vein   | Y N | Anemia                  | Y N | Convulsions, Epilepsy |
| Y N | Asthma   | Y N | Poor Circulation        | Y N | Polio, CP, MS         |
| Y N | Bronchitis   | Y N | Tuberculosis, Pneumonia | Y N | Other: _____          |
| Y N | Emphysema  | Y N | Kidney Disease/Stones   |     | _____                 |
| Y N | Hepatitis, Jaundice  | Y N | Ulcers                  |     | _____                 |

List any medications you are taking:

1. \_\_\_\_\_ 4. \_\_\_\_\_ 7. \_\_\_\_\_  
2. \_\_\_\_\_ 5. \_\_\_\_\_ 8. \_\_\_\_\_  
3. \_\_\_\_\_ 6. \_\_\_\_\_ 9. \_\_\_\_\_

Have you had any allergies or reactions to the following? (List, or indicate by circling Y or N)

|                  |             |     |                      |
|------------------|-------------|-----|----------------------|
| Medication _____ | Food _____  | Y N | Novocaine, Lidocaine |
| Medication _____ | Other _____ | Y N | Iodine Dyes          |
| Medication _____ | Y N Latex   | Y N | Adhesive Tape        |

When was your last tetanus booster shot? \_\_\_\_\_

Women: are you pregnant or nursing? Y N

Please check any of the following which you use or have used:

Y N Alcohol # of drinks/day \_\_\_\_\_  
Y N Tobacco # of packs/day \_\_\_\_\_ Years smoked \_\_\_\_\_  
Y N Non-Prescription Drugs (List) \_\_\_\_\_

List any previous surgery or hospitalization \_\_\_\_\_

## Consent For Treatment

The above information is correct to the best of my knowledge and I consent to such diagnostic procedures (including x-rays) and medical care and treatment as deemed necessary by the doctor(s).

\_\_\_\_\_  
Signature of Patient or Consenter

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

Name \_\_\_\_\_

### FAMILY HISTORY

(Immediate family only - Please indicate yes or no by circling Y or N and which relative.)

|   |   |                     | Mother | Father | Sister | Brother | Other | Type  |
|---|---|---------------------|--------|--------|--------|---------|-------|-------|
| Y | N | High Blood Pressure | _____  | _____  | _____  | _____   | _____ |       |
| Y | N | Diabetes            | _____  | _____  | _____  | _____   | _____ |       |
| Y | N | Heart Disease       | _____  | _____  | _____  | _____   | _____ |       |
| Y | N | Stroke              | _____  | _____  | _____  | _____   | _____ |       |
| Y | N | High Cholesterol    | _____  | _____  | _____  | _____   | _____ |       |
| Y | N | Cancer              | _____  | _____  | _____  | _____   | _____ | _____ |
| Y | N | Glaucoma            | _____  | _____  | _____  | _____   | _____ |       |
|   |   | Other: _____        | _____  | _____  | _____  | _____   | _____ |       |

If any parents or siblings are deceased, please give ages and cause of death: \_\_\_\_\_

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### SYSTEM REVIEW

(Please indicate yes or no by circling Y or N, if you have had any of the following problems on a regular basis.)

- |   |   |                                |   |   |  |
|---|---|--------------------------------|---|---|--|
| Y | N | Frequent or severe headaches   | Y | N | Heart murmur                                   |
| Y | N | Blurred vision                 | Y | N | Anxiety or feelings of being blue/hopelessness |
| Y | N | Eye Infection (Conjunctivitis) | Y | N | Shortness of breath                            |
| Y | N | Wear glasses or contacts       | Y | N | Cough  |
| Y | N | Ringing in ears                | Y | N | Night sweats                                   |
| Y | N | Hearing loss                   | Y | N | Urinary frequency                              |
| Y | N | Hay fever                      | Y | N | Burning on urination                           |
| Y | N | Nose bleeds                    | Y | N | Kidney stones                                  |
| Y | N | Difficulty swallowing          | Y | N | Blood, sugar or protein in urine               |
| Y | N | Chest pain or pressure         | Y | N | Arthritis                                      |
| Y | N | Heartburn or indigestion       | Y | N | Back pain                                      |
| Y | N | Nausea and/or vomiting         | Y | N | Thirsty or hungry all the time                 |
| Y | N | Diarrhea                       | Y | N | Tingling feeling in extremities                |
| Y | N | Constipation                   | Y | N | Unconsciousness for any reason                 |
| Y | N | Change in bowel habits         | Y | N | Dizziness                                      |
| Y | N | Blood in stool                 | Y | N | Nervousness                                    |
| Y | N | Hemorrhoids                    | Y | N | Bruising                                       |
| Y | N | Change in weight               | Y | N | Skin rashes and/or disorders                   |



## PAD Screening Form

If you are over 65 (50 with diabetes), or smoke, or have known heart disease, please complete the following screening form:

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Office: \_\_\_\_\_

1. When you walk or exercise, do you experience aching, cramping or pain in your arms, legs, thighs or buttocks?  Yes  No
2. If you answered yes, does the pain subside with rest?
3. Do you have any painful sores or ulcers on your legs or feet that aren't healing?  Yes  No
4. Have you experienced temporary loss of vision in one eye?  Yes  No
5. Have you experienced temporary slurred speech  Yes  No
6. Have you ever had stent placement, balloon procedure or by-pass surgery in the arteries surrounding your heart?  Yes  No
7. Do you have numbness or tingling in your arm(s), leg(s) or feet?  Yes  No
8. Do your legs or feet fall asleep regularly?  Yes  No
9. Do you have reduced feeling (sensation) in your legs, feet?  Yes  No
10. Do you have swelling in your legs, feet?  Yes  No
11. Are your hands or feet cold to the touch?  Yes  No
12. Do you have diabetes?  Yes  No
13. Do you have high blood pressure?  Yes  No
14. Do you have high cholesterol?  Yes  No
15. History of Smoking?  Yes  No
16. Other \_\_\_\_\_



7.30

### Patient Authorization for Personal Representative

Please print all information, then sign and date form at bottom.

**Patient Name:**

\_\_\_\_\_

**Purpose of request:** I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

\_\_\_\_\_

Phone

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Please designate this person as my Emergency Contact

- **Description of information to be disclosed:** I authorize the practice to disclose all of my protected health information to my designated personal representative.
- **Expirations or termination of authorization:** This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- **Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request. This can be done in-person or by mailing a request to: Centers for Foot and Ankle Care, 4700 Smith Road, Suite A, Cincinnati, OH 45212.

**Redisclosure:** We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

\_\_\_\_\_

\_\_\_\_\_

## Notice of Privacy Practices

Form 7.20

**This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.**

Protected health information, about you, is maintained as a record of your contacts or visits for healthcare services with our practice. Specifically, "protected health information" is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

Our practice is required to follow specific rules on maintaining the confidentiality of your protected health information, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow applicable rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law.

We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. A copy of a revised Notice of Privacy Practices may be obtained by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

**If you have any questions about this Notice, please contact our Privacy Manager at 513-533-6530.**

### Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

- **You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices** - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

- **You have the right to authorize other use and disclosure** - This means you have the right to authorize or deny any other use or disclosure of protected health information that is not specified within this notice. You may revoke an authorization, at any time, in writing, except to the extent that your Healthcare Provider or our office has taken an action in reliance on the use or disclosure indicated in the authorization.
- **You have the right to designate a personal representative** – This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.
- **You have the right to inspect and copy your protected health information** - This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. We have the right to charge a reasonable fee for copies as established by professional, state, or federal guidelines.
- **You have the right to request a restriction of your protected health information** - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases, we may deny your request for a restriction.
- **You may have the right to request an amendment to your protected health information** - This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.
- **You have the right to request a disclosure accountability** - This means that you may request a listing of disclosures that we have made, of your protected health information, to entities or persons outside of our office.

### **How We May Use or Disclose Protected Health Information**

Following are examples of uses and disclosures of your protected health care information that the we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

- **Treatment** - We may use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as

necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other Healthcare Providers who may be involved in your care and treatment.

We may also call you by name in the waiting room when your Healthcare Provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health related benefits and services offered by our office.

- **Payment** - Your protected health information will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.
- **Healthcare Operations** - We may use or disclose, as-needed, your protected health information in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance-related activities. Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

### **Other Permitted and Required Uses and Disclosures**

We may also use and disclose your protected health information in the following instances as outlined below. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

- **To Others Involved in Your Healthcare** - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your protected health information that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your Healthcare Provider may, using

professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your healthcare will be disclosed.

- **As Required By Law** - We may use or disclose your protected health information to the extent that is required by law.
- **For Public Health** - We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.
- **For Communicable Diseases** - We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **For Health Oversight** - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
- **In Cases of Abuse or Neglect** - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made in a manner that is consistent with the requirements of applicable federal and state laws.
- **To The Food and Drug Administration** - We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, to monitor product defects or problems, to report biologic product deviations, to track products, to enable product recalls, to make repairs or replacements, or to conduct post-marketing surveillance, as required.
- **For Legal Proceedings** - We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
- **To Law Enforcement** - We may also disclose protected health information, as long as applicable legal requirements are met, for law enforcement purposes.
- **To Coroners, Funeral Directors, and Organ Donation** - We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. Protected health

information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

- **For Research** - We may disclose your protected health information to researchers when an institutional review board has reviewed and approved the research proposal and established protocols to ensure the privacy of your protected health information.
- **In Cases of Criminal Activity** - Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information, if it is necessary for law enforcement authorities, to identify or apprehend an individual.
- **For Military Activity and National Security** - When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military service.
- **For Workers' Compensation** - Your protected health information may be disclosed as authorized to comply with workers' compensation laws and other similar legally-established programs.
- **When an Inmate** - We may use or disclose your protected health information if you are an inmate of a correctional facility and your Healthcare Provider created or received your protected health information in the course of providing care to you.
- **Required Uses and Disclosures** - Under the law, we must make disclosures about you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

## Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager of your complaint.