Illinois Breast and Cervical Cancer Program
Eligibility Determination Form

Shaded area is for IBCCP office use only

☐ **New Client** Registration Date: ______	☐ **Established Client** Annual Date: ________	☐ **Navigation Only** Date: __________	**Cornerstone #** ________

Name: ______________________________

Previous Last Name: ______________________

Age: ________ Birth Date: ______/______/________

Address: ______________________________

City: ____________________ State: ______

Zip Code: ______________ County: __________

Home Phone: __________________________

Cell Phone: __________________________

Day Phone: __________________________

Medical/Insurance Coverage: *Check all that apply.*

- ☐ Medicare Part B – Not eligible for IBCCP
- ☐ Medicaid ID number ______________________
- ☐ I DO NOT have insurance
- ☐ I have Insurance – Name of Carrier: __________
- ☐ Are you covered under a parent or spouse insurance? ☐ No ☐ Yes

If yes, Insurer Name: ______________________

Does insurance pay for: Pap tests? ☐ No ☐ Yes
Mammograms? ☐ No ☐ Yes

Do you have a deductible that must be met before diagnostic procedures are covered? ☐ No ☐ Yes

Please provide a copy of the front and back of your insurance card.

Employment Status:

- ☐ Employed full-time (35+ hours weekly) (EFT)
- ☐ Employed part-time (EPT)
- ☐ Not in the labor force (NLF)
- ☐ Seasonal/Migrant Farm Worker (SMF)
- ☐ Self-employed (SE)
- ☐ Temporary Worker (TW)
- ☐ Unemployed (UNE)

Marital Status:

- ☐ Never Married (01)
- ☐ Married (02)
- ☐ Other: ____________

Years of Education Completed:

- ☐ ________ (EO # of years)
- ☐ Unknown (E099)

Income determination:

Total income before taxes (if married - total combined income before taxes): $__________ per month/year (circle one)

Number of people under age 18, your spouse (if applicable), and yourself, who are supported by this income: ________

Office Use Only: Income status for number in household:

At or below 250% of federal poverty level: ☐ Above 250% of federal poverty level: ☐

Are you of Hispanic or Latino origin?

☐ Yes (01) ☐ No (00)

Preferred language for delivery of service:

- ☐ English (E)
- ☐ Spanish (S)
- ☐ Other (O): ______________

What races do you consider yourself? Mark ALL that apply.

- ☐ White
- ☐ Black or African American
- ☐ Asian
  - ☐ Chinese ☐ Indian ☐ Japanese
  - ☐ Vietnamese ☐ Korean ☐ Filipino
  - ☐ Other ____________
- ☐ Native Hawaiian/Other Pacific Islanders
- ☐ American Indian/Alaskan Native

How did you hear about this program?

- ☐ Poster (PO)
- ☐ Newspaper (ME)
- ☐ Flier (FL)
- ☐ Radio (ME)
- ☐ Brochure (BR)
- ☐ Television (ME)
- ☐ Community Navigator (C)
- ☐ Website (Agency/State) (WB)
- ☐ Community Event (CE)
- ☐ Physician or Health Care Provider (P)
  Who: ____________ Phone #: ________
- ☐ Other (OTH), Specify: ______________

Barriers:

☐ None ☐ Transportation ☐ Child/family Care ☐ Work schedule
☐ Understanding medical needs ☐ Special needs ☐ Financial
☐ Need Interpreter ☐ Travel Distance ☐ Making appointments
☐ Other: ____________________

Comments:

____

____

What is the best time to schedule your appointments?
(Please mark your choices.) **Preferred Healthcare Provider:** ______________________

Day of the week: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Time of day: ☐ Early morning ☐ Mid-morning ☐ Early afternoon ☐ Late afternoon

I certify that the information I have provided on this application form is the truth to the best of my knowledge.

Applicant's Signature ______________________________ **Date** ______________

IBCCP Health Assessment

Name: **Date:**

YES	NO	BREAST HEALTH QUESTIONS
☐	☐	1. Do you perform a monthly breast self-exam?
☐	☐	2. Have you noticed a lump in your breasts?
☐	☐	3. If yes, which breast? Right___ Left____
☐	☐	4. Have you noticed any breast tenderness or pain?
☐	☐	5. If yes, did the breast tenderness or pain increase around the time of your menstrual period?
☐	☐	6. If you answered yes to question #4, which breast? Right ________ Left______
☐	☐	7. Have you noticed any spontaneous discharge (not from stimulation or squeezing) from your nipples?
☐	☐	8. If yes, which breast? Right ________ Left______
☐	☐	9. Have you noticed any other symptoms related to your breasts? If yes, explain: ________________________
☐	☐	10. Have you ever had a breast exam done by a doctor or nurse?
☐	☐	11. If yes, list provider/clinic where breast exam was done: ________________________
☐	☐	12. If yes, date of last exam (before this current visit): _____/_____
☐	☐	13. Have you ever had a mammogram?
☐	☐	14. If yes, list provider/clinic where mammogram was done: ____________________________
☐	☐	15. If yes, date of last two mammograms (before this current visit):___/_____, ____/_____
☐	☐	16. If unknown was it more than 5 years?
☐	☐	17. Have you ever had breast cancer?
☐	☐	18. Has your mother, sibling (sister/brother) or daughter had breast cancer? If no, go to question 22.
☐	☐	19. If yes, who ____________________________
☐	☐	20. Are they BRCA positive (if known)?
☐	☐	21. If yes, at what age? __________ years old
☐	☐	22. Do you have a breast implant or implants?
☐	☐	23. Have you ever had a breast biopsy, breast cyst aspiration or surgery on your breast?
☐	☐	24. If yes, which breast? Right ________ Left______
☐	☐	25. If yes, list the provider who performed the procedure__________________
☐	☐	26. Have you ever had radiation to the chest area?

YES	NO	CERVICAL HEALTH QUESTIONS
☐	☐	27. Have you ever had a Pap test?
☐	☐	28. If yes, list provider where Pap test was done: ________________________
☐	☐	29. If yes, date of last two Pap tests: (before this current visit): ____/____, ___/____
☐	☐	30. If unknown was it more than 5 years?
☐	☐	31. Were your last Pap test results normal?
☐	☐	32. What was the date of your last menstrual period? _____/_____/_____
☐	☐	33. Are you pregnant?
☐	☐	34. Have you had a hysterectomy?
☐	☐	35. If yes, was your cervix removed? I do not know_____
☐	☐	36. If you had a hysterectomy, was it due to a past history of cervical disease or cervical cancer?
☐	☐	37. Were you exposed to Diethylstilbestrol (DES)?
☐	☐	38. Is your immune system weakened in any way? (medication, HIV, organ transplant or other health condition)

YES	NO	TOBACCO QUESTIONS
☐	☐	39. Do you smoke cigarettes?
☐	☐	40. If yes, are you ready to quit smoking?
☐	☐	41. If yes, are you interested in being referred to the Illinois Tobacco Quitline?
		(Shaded area for IBCCP office use)
		42. What date was the referral sent to the Tobacco Quitline? _____/_____/_____

BARRIER/RISK ASSESSMENT QUESTIONS

Barrier Assessment

43. from Eligibility Determination form

Breast Cancer Risk Assessment

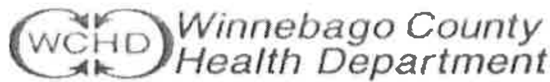
(from Summary Office Visit form)

44. Life time risk_______

45. High risk for breast cancer
- ☐ yes
- ☐ no
- ☐ not assessed/unknown

Cervical Cancer Risk Assessment

46. High risk for cervical cancer
- ☐ yes
- ☐ no
- ☐ not assessed/unknown



Illinois Breast and Cervical Cancer Program of Winnebago, Boone, and DeKalb Counties

CLIENT NAME: ________________________________ Client Date of Birth: ______________

Please list **all** persons living in the household on the worksheet. This includes client, spouse, children, step-children, grandchildren, elderly parents, and other family member or non-family members residing in the household.

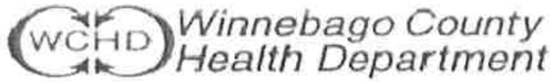
Household Member	*Relationship to client*	*Age*	*Employment Income (Monthly)*	*Other Income (Monthly)*	*Source of Other Income**
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	

*Other Income may include: Social Security, child support, spousal support, rental property, unemployment benefits, pensions, and trusts.

Client Signature________________________________ Date____________________

PLEASE SEND PROOF OF INCOME FOR CLIENT AND SPOUSE

This section to be completed by IBCCP staff only:
Total Household Size (include only client, spouse, and children or stepchildren of the client who are under age 19) _________
Total Income (include income from only the individuals included in the total household size) $______________



Illinois Breast & Cervical Cancer Program
Income and Age Affidavit

You are being asked to complete this form because you do not have written documentation of income and/or age.

I, ______________________________, reside at ____

and attest to the fact that I have received $_________________________ income for the period covering a month/year (circle one). This is my income before taxes. I am single/married (circle one). This income supports _________ (number of people in household. I further attest that my birth date is ____/_____/_____ and that I am ________ years of age.

I understand that to perjure myself in order to obtain assistance is a fraudulent offense for which I will be terminated from the Illinois Breast and Cervical Cancer Program.

Signature ______________________________________

Witness ______________________________________

Date ______________________________________

**If you cannot provide proof of age and/or income you <u>must provide a reasonable explanation why</u>. IBCCP staff will evaluate upon receipt if we will accept your age/income affidavit alone.

<u>Provide explanation here:</u>

____

____

____

____

If any questions, please call the IBCCP office at 1-815-720-4000 option #6.

ILLINOIS BREAST AND CERVICAL CANCER PROGRAM

CLIENT PARTICIPATION AGREEMENT AND RELEASE OF INFORMATION

I. PROGRAM DESCRIPTION:

The Illinois Breast and Cervical Cancer Program (program) is a cooperative effort between the Illinois Department of Public Health, Office of Women's Health and Family Services, and the U.S. Centers for Disease Control and Prevention (CDC). The program encourages routine breast and cervical cancer screening and provides free screening and some diagnostic examinations to eligible Illinois women. The purpose of routine breast and cervical screening is to detect cancer, if present, at an early stage so it can be treated or cured. Screening for breast cancer involves a clinical breast examination and a mammogram (a breast X-ray). Screening for cervical cancer involves a pelvic examination and a Pap test (scraping from the cervix).

II. CONSENT TO PARTICIPATE AND RELEASE OF INFORMATION:

I understand and agree to the following:

- I will provide proof of age and income to determine program eligibility. If I have insurance coverage, I will provide a copy of my insurance card and written verification of covered services. If while enrolled in IBCCP I obtain insurance, I will inform Lead Agency staff.

- I give permission to my health care provider(s), insurance company, hospital, clinic, laboratory and/or mammography facility to provide information concerning my breast and cervical cancer screening, diagnostic examinations and/or treatment status to program staff.

- I understand that the program must obtain certain statistical information for reports, including but not limited to age, income, insurance and any services I am provided through this program. This information may be used by the program and the CDC to learn more about breast and cervical cancer and to ensure the quality of services provided through the program. **My name will not be used in these reports, except as required by law.**

- My health care provider and/or the program staff will try to contact me regarding my test results. I understand that, despite efforts to find me, my health is my own responsibility and I may need to contact my provider for my test results.

- I understand that if the provider orders tests not covered by the program or my insurance that I may be responsible for payment of those IBCCP services as the program cannot pay for some diagnostic exams. A list of allowable services is available upon request.

- If I am diagnosed with a pre-cancerous or cancerous condition of my breasts or cervix, information from my IBCCP file will be released to the Illinois Department of Healthcare and Family Services. This information will be used to determine if I am eligible for state paid health benefits through Medicaid.

- If I am not eligible for Medicaid coverage, the program staff will assist with referral for treatment services through private sources, community based sources, other governmental grants or pro bono from a provider.

- If I am eligible for state paid health benefits through Medicaid, I give my permission for program staff to obtain information about my treatment for breast or cervical cancer. This information will be used to determine my treatment status and my continued enrollment in Medicaid.

- I will receive notification from the program staff to remind me when it is time for me to go back to my medical provider for my annual examination and follow-up testing, if appropriate (This does not apply to insured clients).

- I will notify the program of any change in my address and/or telephone number.

- I will write or call the local program staff to inform them if I no longer wish to be a part of this program. This notification will be recorded in my program records.

- I understand the importance of keeping all appointments made for me so my care can be provided in a timely manner. When it is necessary to cancel or change an appointment, I will notify the agency of this change.

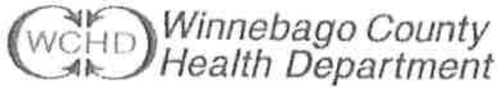
- Missed appointments or repeated "no show" appointments are not acceptable and I can potentially lose my ability to receive IBCCP services if this happens.

III. ACKNOWLEDGMENTS:

- I have received literature and/or education on all of the following: breast health, mammograms, and Pap tests. ______
(initial here)

- The University of Illinois at Chicago (UIC), an IBCCP partner, conducts an annual survey for the purpose of helping the Department improve the quality of the program so that the Department can provide better services to program participants. UIC will be contacting you about this survey at a future date. We hope that you will participate, but your participation is completely voluntary, and your program eligibility will not be affected if you choose not to participate. Your initials here acknowledge that you have received notification of this voluntary survey. ______
(initial here)

Client Signature ______________________________ **Date** ______________



Winnebago County Health Department
401 Division Street, PO Box 4009
Rockford, IL 61110

AUTHORIZATION TO RELEASE CLIENT INFORMATION

CLIENT NAME:			BIRTHDATE:
ADDRESS:			SS#:
CITY:	STATE:	ZIP:	MEDICAL RECORD NO.

This is to authorize that health information regarding the above-name person be forwarded.

FROM PERSON/INSTITUTION:		
ADDRESS:		
CITY:	STATE:	ZIP:

TO PERSON/INSTITUTION: **Winnebago County Health Department IBCCP**		
ADDRESS: **555 N. Court St**		
CITY: **Rockford**	STATE: **IL**	ZIP: **61103**

PURPOSE/NEED FOR DATA: **continued medical care**

DATES OF SERVICE: FROM: ______ (Month) ______ (Year) TO: ______ (Month) ______ (Year)

DISCLOSURE IS LIMITED TO: **breast exams, mammogram, biopsy, pathology, PAP, HPV, colposcopy, and progress notes**
(State specific nature of information to be disclosed)

(Please initial all that apply.)
1. __x__ Records relating to Health Care.
2. _____ Records relating to Mental Health, Alcohol and/or Drug Abuse.
3. _____ Records relating to HIV/AIDS condition.

This Consent is valid until Date: ___/___/___

I understand that I may revoke this consent at any time and that the above named person authorized to receive this information has the right to inspect and copy the information to be disclosed.

Notice to receiving agency/person: Under the provision of the *ILLINOIS MENTAL DEVELOPMENT AND DISABILITIES CONFIDENTIALITY ACT,* you may not redisclose any of the information unless the person who consented to the disclosure specifically consents to such redisclosure.

Under the *FEDERAL ACT OF JULY 1, 1975, CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS,* no such records, nor information from such records may be further disclosed without specific authorization for such redisclosure.

Under the *AIDS CONFIDENTIALITY ACT,* you may not redisclose any of this information unless the person who consented to the disclosure specifically consents to such redisclosure.

Client's Signature: ______________________

Parent/Legal Guardian: ______________ Relationship to Client ______________
(Indicate legal relationship to client)

Witness: ______________________ Date: ______________

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ______________________________ DOB: __________________

By signing below, I (or my authorized representative on my behalf) hereby acknowledge that I have received a copy of Winnebago County Health Department's Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. A copy can also be found on our website at www.wchd.org.

______________________________________ ______________

Signature of patient or authorized representative Date

______________________________________ ______________________________

Print name of authorized representative Relationship to patient

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FOR OFFICE USE ONLY

I made a good faith effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Other (please specify): ____

__________________________________ __________________

Staff Member Signature Date

STATE OF ILLINOIS
CORNERSTONE
CORNERSTONE INFORMED CONSENT FORM

Name of Participant:

Last Name ______ First Name ______ Middle Initial ______

Date of Birth (Month/Day/Year) ______ O Male O Female Participant s ID Number ______

It is important that you read the following. If there is anything that you do not understand, or if you have any questions, be sure to ASK.

Welcome to Cornerstone, a system that collects data on a wide range of health care services to individuals. These services include WIC (Women, Infants and Children); Immunizations; Case Management; Prenatal and Postpartum Care; Pediatric Primary Care; Early Intervention; Breast and Cervical Cancer; Diabetes Control; Healthy Families Illinois; and Family Health History Questionnaire/Genetics.

We are asking for permission to collect information about the participant and store it in a centralized computer system maintained by the Illinois Department of Human Services and Public Health. Based on the information collected during the enrollment or registration process, we will determine whether you need further service. Only those authorized health care professionals with a direct need to know about you will have access to this information. Information may be released for service authorization, audit, and evaluation purposes. Necessary information, without any client s name, will be sent to federal agencies that fund these programs.

By signing this consent form, you agree to allow certain information to be collected by this agency/clinic. The person(s) receiving this information has a legal and ethical duty to keep the information confidential and private, and not release it to anyone else without your written permission unless the law allows it.

A. I authorize **Winnebago County Health Department** to collect information during the enrollment/registration process.

B. This authorization covers all the medical, social and financial information about the participant, including: participant background and demographic information; health visit information; medical and developmental history; prenatal; birth, and postpartum data; infant/child visit data; immunization records; participant risks; problems or factors that prevent the participant from receiving proper medical care; appointments made and services received; goals and care plan; WIC food packages; program information; information required by the federal Maternal and Child Health Block Grant Program; and Early Intervention. Any information you do not want released should be written in Part D.

C. This authorization also covers information about mental health, AIDS, HIV, sexually transmissible diseases, alcoholism, and drug use which may be reported by me. I understand that I am not required to report or discuss those matters with anybody.

D. The following information I do NOT want to be shared;

E. I am making this consent within the limits of my legal authority. I understand that I may revoke this consent orally or in writing at any time, but that revoking this consent will not cancel what was done before I revoked it. I also understand and agree not to hold the Illinois Department of Human Services and Public Health liable for the release of any information about me in accordance with the terms of this consent form.

F. A photo static copy/facsimile of this consent will be as valid as the original.

For Child Participant: ______ Signature of parent/legal guardian/caretaker/Date

OR

For Adult Participant: ______ Signature of adult participant/Date

Signature of Witness: ______ Date: ______

ILLINOIS BREAST AND CERVICAL CANCER PROGRAM OF WINNEBAGO, BOONE, AND DEKALB COUNTIES

REQUIRED VERIFICATION

PLEASE READ THIS FORM CAREFULLY. THIS INFORMATION MUST BE RECEIVED BY IBCCP BEFORE YOUR APPOINTMENTS CAN BE SCHEDULED.

You **must** include the following verification with your enrollment/re-enrollment packet in order for your paperwork to be processed and your appointments to be scheduled. **This income requirement is for you and your spouse, if married.**

- **Age Verification** (required for new IBCCP clients only): include copy of whichever you have: your driver's license, ID card or birth certificate
- **Income Verification**: copy of whichever you have: 2 current paycheck stubs, W-2s, or first page of recent tax return 1040 for you and your spouse, if married
  - Income includes Social Security, Disability pay, unemployment, child support, alimony: provide documentation (copy of eligibility letter, copy of bank statement if direct deposits, copy of check stubs, etc.)
  - If self-employed, include copy of first page and expenses page of 1040 tax return
  - If you receive food stamps and have no documented income, your food stamp eligibility letter can count as eligible income: include a copy of the eligibility letter.

*****If you have no income or income documentation, please fill out the Affidavit Form. If you have further questions, please call our office at (815) 720-4000 option #6.**

Medicaid Verification

If you have Medicaid, it should cover the charges for your exams and screenings. If you are on a spend-down, you may still qualify for the Program. **Please include the amount of any spend-down payment that is required to be paid by you**

Amount of spend-down $ ____________

Insurance Verification

If you have private insurance, and it will cover any of the charges for your exams, you do not qualify for the program. If your insurance does not cover your annual exams and screenings, you must submit documentation that the specific services are not covered by the insurance. **Please include a copy of the front and back of your insurance card.**

Promoting A Safer and Healthier Community Since 1854

Notice of Privacy Practices

Your Rights **You have the right to:**

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices **You have some choices in the way that we use and share information as we:**

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures **We may use and share your information as we:**

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights **When it comes to your health information, you have certain rights.**

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights contact Kari Nimmo, Privacy officer at (815) 720-4209 knimmo@wchd.org.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Promoting A Safer and Healthier Community Since 1854

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: May 26, 2015