GASTROENTEROLOGISTS, P.C.
1625 North Alston St.
Foley, Al 36535
251-970-1954 Phone
251-970-1960 Fax

New Patient

Dear Patient:

Our office is located at 1625 N. Alston Street, Foley, AL 36535. This is behind South Baldwin Regional Medical Center and next to Foley Nursing Home.

Please bring the following:

- Driver's License
- All Insurance Cards:
- List of your current medications with dosage amounts and how often you take them. This should include all over the counter medications such as herbal supplements, vitamins, aspirin, Tylenol, Advil, laxatives, etc.
- If possible, please try to obtain any prior medical records such as lab test and/or x-ray reports, procedure reports of any colonoscopies or EGD's, and the date and address of the facility where the procedure was performed, as well as the name and address of the physician who performed the procedure.

Insurance Information:

- If your insurance company requires a referral, please make sure that has been obtained prior to your appointment.
- Verify with your insurance company that the physician you are seeing is a member of your current HMO/PPO plan.

Co-pays, deductibles, and co-insurance are due at the time of service.

Our goal is to schedule appointments so that your needs and the needs of all of our patients are met with minimal waiting time. Occasionally, delays are unavoidable. We value your time and are committed to avoiding any unnecessary delays. In addition, you are the only one scheduled for your appointment time. We have implemented a reminder call program to contact you with your scheduled appointment time prior to your visit. If you are unable to keep your appointment, please follow the instructions from the House call program in order to cancel your appointment. This will alert our office to cancel your appointment in a timely manner. You may also contact our appointment desk to cancel. Please give at least a 24 hour notice so that we may offer your appointment time to another patient.

Thank you for your assistance and we look forward to seeing you at your scheduled appointment.

IMPORTANT: Prior to your arrival, please fill out the enclosed forms in their entirety, front and back, and sign where indicated.

***** Please arrive 15 minutes earlier than your scheduled time.
(Note: If your appointment is at 8am, or 1:00pm, you are not required to be 15 minutes early).

PLEASE VISIT OUR WEBSITE AT WWW.GASTROPC.COM

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Office Policy

Patients with Insurance Coverage:
To aid our patients in their overall health care, our office will submit claims to your insurance company. However, due to the enormous number of plans, it is impossible for us to determine the exact benefits and/or coverage guidelines that each plan provides. Therefore, we rely on you to be knowledgeable about your insurance plan and coverage benefits. **Please note that it is your responsibility to pay all deductibles, co-pays, co-insurance, and non-covered services at the time of your visit.**

Patients without Insurance:
It is expected that payment be made when the service is rendered unless prior arrangements have been made in advance.

Collection Efforts:
Upon receipt of statement, payment is due in full unless prior settlement has been arranged. If your account becomes necessary to turn over to our collection attorney, the fee charged by the collection agency (including any legal fees) will be added to your balance.

Cancellation / No Show:

We are committed to helping you manage and maintain your gastroenterology healthcare needs. When you schedule an appointment with one of our physicians that time is reserved exclusively for you to discuss and review your medical concerns. We do understand that on occasion unforeseen circumstances do arise and the need to cancel your scheduled appointment may be necessary. If you know that you will be unable to keep your appointment, we ask you to show consideration by calling our office **24 hours in advance**. Providing our office with adequate notice will allow us to offer that appointment time to another patient who needs to see the physician. The following no-show and/or late cancellation fees will be assessed:

- A **$35 charge** will be assessed for all no-show patients, or for patients that fail to give 24-hour notice of the need to cancel **appointments.**
- A **$100 charge** will be assessed for all no-show patients, or for patients that fail to give 24-hour notice of the need to cancel all **scheduled procedures**.

These charges are not billable to your insurance and will ultimately be the responsibility of the patient. All no show charges will need to be paid before your next appointment with the physician.

- I give permission for Gastroenterologists, P.C. to access my pharmacy data electronically through RxHub. This consent will enable the provider to determine pharmacy benefits, display therapeutic alternatives, check whether a prescribed medication is covered, and download medication history.

  Yes _____ No _____

- I, the undersigned, give Gastroenterologists, P.C. , its employees and /or agents “express prior consent” to contact me at any & all phone numbers, including cell phone numbers (by phone call, text message, and email), for the purpose of treatment, insurance or payment, and appointment reminders.

- I directly assign all insurance payments to Gastroenterologists, P.C., and understand that I am financially responsible for all charges not covered by my insurance.

By signing this document, I agree to all above statements and I further agree that a photocopy of this agreement shall be as valid as the original.

_____ _____

Patient or Authorized Person **Date**

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Patient Portal

Access your health information anytime, anywhere with our Patient Portal Website.

Registration is easy!

1. Provide us with your preferred e-mail address so we can give you access to the Patient Portal.
2. A portal registration email is automatically sent to you containing your registration link.
3. Click on the registration link that was sent to your email.
4. Enter the requested personal information to verify your identity.
5. Follow the instructions for creating a user name and password.
6. Go to the message tab of your portal account and click on "Compose" in the lower left hand corner. In the Question field, select "Medical Problem". In the subject box, type "Confirm". In the text box type "Confirm", and Send message. (This will send a message to our office of your successful registration).
7. Explore your health information. You may view, download, export your medical information, compose and receive secure messages to our office, and request appointments and medication refills.
8. After your initial login from your email link, you can then go to our website at any time at by visiting www.gastropc.com, and click on the Patient Portal link.

PLEASE NOTE: All procedure, radiology, and lab results will be sent to your patient portal account. You may check for your results at any time, but please be aware that it may take up to 10 days before results are available and posted to your account.

What is a Patient Portal?
A patient portal is a secure online website that gives you convenient 24 hour access to your personal health information and medical records- called and Electronic Health Record or EHR

Why is a Patient Portal Important?
Accessing your personal medical records through a patient portal can help you be more actively involved in your own health care. Accessing your family members' health information can help you take care of them more easily. Also, patient portals offer self-service options that can eliminate phone tag with your doctor's office.

Can my family access my portal?
You may choose to give family members access to your portal, or assign a personal representative to obtain information for you.

Is my information safe?
Yes. Patient portals have privacy and security safeguards in place to protect your health information. Always remember to protect your user name and password from others and only log on to the patient portal from a personal or secure computer.

Please do not use the patient portal for urgent messages. In the event of an emergency dial 911. We will normally respond to non-urgent inquiries within 24 hours, but no later than 3 business days after receipt. If you have not heard from us within 3 business days, please call our office to check the status of your request. Please be as concise as possible when sending messages to our office. If your communication is complex in nature, you will be asked to make an appointment to discuss your concerns, and any questions you may have. The patient portal is not designed to replace the face-to-face encounter with your physician. Rather, it is designed to supplement those encounters. Please note that all communications will become part of your medical record.

GASTROENTEROLOGISTS, P.C. **TODAY'S DATE** _____

First Name: _____ **MI:** _____ **Last Name:** _____

Date of Birth: _____/_____/_____ **Social Security #:** _____-_____-_____ **Gender: Male or Female**

Marital Status: Single / Married / Widowed / Divorced **Employed: None / Retired / FT / PT**

Name of Employer: _____ **Phone:** _____

Driver's License # _____ **Do you have a living will? Yes ____ No ____(Please provide)**

Race: _____ **Ethnicity:** _____ **Preferred 1st Language**: _____

Spouse or Guarantor: _____ **Phone #:** _____
Relationship: _____**Guarantor SSN:** _____ **Guarantor DOB:** _____

(Permanent Mailing Address): _____

City: _____ **State:** _____ **Zip Code:** _____

(Temporary Mailing Address): _____

City: _____ **State:**_____ **Zip Code:** _____

Phone #:_____ **Cell #**_____ **Email:** _____

Do you authorize messages to be left? _____ Yes _____ NO
Please note: Our office routinely contacts patients by phone for appointment reminders. Procedure, lab, pathology, Xray, and all other clinical results are available to you through our patient portal, or Labcalls. Clinical reminders for non-scheduled visits or tests may be sent via letter format or through the patient portal.

Primary Care Physician: _____ **Phone:** _____

Referring Physician: (who referred you) _____ **Phone:** _____

How did you hear about us? (check one): □ Our Web-site □ Internet □ Phone book □ Physician
□ Friend/relative □ Hospital □ Insurance □ Other

Primary Insurance: _____

ID #: _____ **Group #:** _____

Policy Holder: _____ **Relationship to Patient:** _____

Policy Holder SSN: _____ **Policy Holder DOB:** _____ /_____/_____

Secondary Insurance: _____

ID #: _____ **Group #:** _____

Policy Holder: _____ **Relationship to Patient:** _____

Policy Holder SSN: _____ **Policy Holder DOB:** _____ /_____/_____

PHARMACY INFORMATION: (This is where prescriptions will be sent)

Name: _____ **Address:** _____

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Medication List

Date: _____

PATIENT Name: _____ DOB: _____

Please list ALL medications including Vitamins, herbs, over the counter drugs, and supplements.

IMPORTANT: PLEASE MAKE SURE TO LIST DOSAGE AMOUNT

MEDICATION	DOSAGE	HOW OFTEN	PURPOSE	*WHO PRESCRIBED*

Allergies to Medications

Medication	What happened?

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ROS- Review

Patient Name: _____ Date: _____

CONSTITUTIONAL	Yes	No
Chills		
Fatigue		
Fever		
Night sweats		
Weight gain		
Weight loss		
EYES	Yes	No
Blurred vision		
Eye pain		
Glasses / Contacts		
EARS / NOSE/ THROAT	Yes	No
Ear pain		
Hearing problems		
Nose bleeds		
Nasal congestion		
dentures		
hoarseness		
CARDIOVASCULAR	Yes	No
Chest pain		
Dizziness		
Palpitations		
Foot / leg swelling		
Tachycardia		
RESPIRATORY	Yes	No
Shortness of breath		
Exposure to TB		
Wheezing		
GASTROINTESTINAL	Yes	No
Abdominal pain		
Acid reflux		
Anorexia		
Bloating		
Difficulty swallowing		
Constipation		
Diarrhea		
Heartburn / Indigestion		
Coughing up blood		
Blood in stool		
Hemorrhoids		
Black stool / melena		
Nausea		
Vomiting		

GENITOURINARY	Yes	No
Painful urination		
Genital lesions		
Frequent urinary tract infections		
Impotence (male)		
MUSCULOSKELETAL	Yes	No
Arthritis		
Back pain		
Joint stiffness / pain		
INTEGUMENTARY	Yes	No
Jaundice		
Itching		
Rashes		
NEUROLOGICAL	Yes	No
Dizziness		
Fainting		
Headaches		
Memory loss		
Seizures		
Vertigo		
HEMATOLOGIC/LYMPH	Yes	No
Easy bruising		
Excessive bleeding		
Hx. of blood transfusion		
ENDOCRINE	Yes	No
Hair loss		
Heat / Cold intolerance		
Excessive thirst		
IMMUNOLOGIC	Yes	No
Freq. upper resp. illness		
HIV risk factors		
PSYCHIATRIC	Yes	No
Anxiety		
Depression		
Recreational drug use		
Sleep Disturbance		

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HIPAA Consent

PATIENT NAME _____ DOB _____

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have the right to request that communications concerning your personal health information be made through confidential channels. Gastroenterologists, P.C. will not ask why you are making your request, and will try to accommodate all reasonable requests.

How may we contact you? Please select the column that best fits how communication should be relayed to you. Include phone numbers and email address where indicated.

Contact Source	Phone # or Email	May leave message	Do not leave message
Home Phone			
Work Phone			
Cell Phone			
Email			
Fax			

I have read the privacy policy of Gastroenterologists, P.C., and I understand that Gastroenterologists, P.C., strives to protect my privacy as related to any and all individually identifiable health information concerning me. I do hereby give my permission, and authorize Gastroenterologists, P.C. to release information from my medical record to the following:

- Referring Physician
- Primary Physician
- Consulting Physicians/Hospitals
- Insurance Company
- Any organization required by the law of the country, or the State of Alabama
- Other health care operations in relation to my healthcare treatment
- Listed relatives or other caregivers as defined below. Gastroenterologists, P.C., has my permission to leave a message with any of the below listed persons, or leave a message on my answering machine.

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

CONFIDENTIAL INFORMATION (PLEASE READ EACH ITEM AND MARK APPROPRIATELY)

If the requested portion of the record contains information pertaining to mental health, drug or alcohol treatment, or contains HIV related information, you must specifically authorize the release of such information by initialing one or both of the following:

- I understand that if my record contains information concerning mental health and/or drug and alcohol treatment, such information will be released pursuant to this authorization. Yes ____ No ____

- I understand that if my record contains confidential HIV related information, such information will be released pursuant to this authorization form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has potentially been exposed to HIV. I understand that I do not have to allow release of HIV related information and that I can change my mind at any time before it is released. Yes ____ No _____

This authorization will remain valid until <u>I notify Gastroenterologists, P.C., in writing</u> that I wish to terminate my patient consent for release of personal health information and confidential communication request. I understand that I have the right to revoke this authorization at any time.

_____ _____

Signature of Patient / Representative / or Legal Guardian Date

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ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices. I understand that I have the right to refuse to sign this document.

PATIENT NAME: _____DOB: _____

_____ _____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

- □ **The patient or individual refused to sign this document**
- □ **Communication conflicts prohibited us from obtaining acknowledgement**
- □ **An emergency situation prevented us from obtaining acknowledgement**

Gastroenterologists, P.C. HIPAA/Privacy Policy

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. If you have any questions about this Notice please contact our Privacy Contact who is the Manager of this location. Gastroenterologists, P.C. is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by accessing our website (**www.gastropc.com**), calling our 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.

This notice was updated on August 20, 2013

1. Uses and Disclosures of Protected Health Information

You will be asked by Gastroenterologists, P.C. to sign a form stating that you have received this notice. Gastroenterologists, P.C. will use or disclose your PHI as described in this Section 1. Your PHI may be used and disclosed by Gastroenterologists, P.C , our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of Gastroenterologists, P.C.

Following are examples of the types of uses and disclosures of your protected health care information that Gastroenterologists, P.C is 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 will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your PHI. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. We will also disclose PHI to other physicians who may be treating you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care 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. For example, obtaining approval for a hospital stay or tests may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of Gastroenterologists, P.C. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.

For example, we may disclose your PHI to medical school students that see patients at our office or in the hospital. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may also use your name and exam information for patient flow tracking in the office. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

2. Your Rights

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that Gastroenterologists, P.C. and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record. ***All requests to copy or inspect your PHI must be submitted in writing to our Privacy Contact. A fee will be charged for copying your PHI***.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI 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. Your request must state the specific restriction requested and to whom you want the restriction to apply. ***All requests to restrict your PHI must be submitted in writing to our Privacy Contact***.

Gastroenterologists, P.C. is not required to agree to a restriction that you may request. If Gastroenterologists, P.C. believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If Gastroenterologists, P.C. does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. **With this in mind, please make this request in writing to one of our Privacy Contacts listed below**.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. **Please make this request in writing to our Privacy Contact**.

You may have the right to have your physician amend your PHI. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact if you have questions about amending your medical record. ***All requests to amend your PHI must be submitted in writing to our Privacy Contact along with the reason the amendment is being requested***.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after August 20, 2013 for a 6 year time frame. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. All requests should be submitted in writing to our Office Manager, 1625 N. Alston Street Foley, Al. 36535.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. 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 contact listed below of your complaint. We will not retaliate against you for filing a complaint.

Privacy Officer
Gastroenterologists, P.C.
1625 N. Alston Street
Foley, Al. 36535
251-970-1954
251-970-1960 (fax)
www.gastropc.com

We will share your PHI with third party “business associates” that perform various activities (e.g., billing, appointment reminder services, labs, etc. for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

We may use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your PHI for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that Gastroenterologists, P.C. has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then Gastroenterologists, P.C. may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

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 you identify, your PHI that directly relates to that person’s involvement in your health care. 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 PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens, Gastroenterologists, P.C. shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If Gastroenterologists, P.C. or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your PHI to treat you.

Communication Barriers: We may use and disclose your PHI if Gastroenterologists, P.C. or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your PHI in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your PHI, 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.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI 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 consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose PHI 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.

Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, 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 PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI 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 services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and Gastroenterologists, P.C. created or received your PHI in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.