General Client Registration

Please answer all information as completely as possible. Information is kept confidential and is used to help us serve you

Name:	**Date of Birth:**	**Phone:**	
Address:	**City:**	**State:**	**Zip:**
Email Address:			
Race: Caucasian Black/African American Asian American Indian Pacific Islander Native Hawaiian			
Ethnicity: Hispanic/Latino Not Hispanic/Latino			
Do you belong to a religious organization? Yes No **Yes, I attend:**			
Preferred Pharmacy:			
Emergency Contact:	**Phone:**	**Relationship:**	

Below, please circle the number of persons in the household and estimated gross household Income. (Include child support, unemployment, gifts, SSI/SSDI).

Persons in family/household	Annual Income (Circle One)
1	$25,520
2	$34,480
3	$43,440
4	$52,400
5	$61,360
6	$70,320
7	$79,280
8	$88,240

We will need current proof of income updated every year.

Please provide us with one of the following: Paycheck stubs, Tax returns, letter from employer or letter of support.

Do you have any medical insurance? Yes No If so, Insurance Name: _____

May we contact you via text, email or phone calls? Yes No

Are there any other services or resources that you would like information for? _____

_____ Patient Name

_____ Patient Signature/Person Authorized to consent for patient

_____ Date

OFFICE USE ONLY:
☐ NO INSURANCE
☐ PROOF OF ADDRESS
☐ PROOF OF INCOME
☐ ID/LICENSE
PHARMACY_____

ADULT MEDICAL HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

ALLERGIES

ALLERGY:	REACTION/SIDE EFFECT:

☐ No known drug allergies (NKDA)

MEDICAL DIAGNOSIS:

List any medical problems that other doctors have diagnosed

☐ No known medical problems

MEDICATIONS:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Medication	Strength	Frequency Taken

☐ No medications to report

Please describe the problems you are having and why you are needing to see a doctor

Please turn to next page

FAMILY HEALTH HISTORY

RELATION	AGE	ALIVE?	SIGNIFICANT HEALTH PROBLEMS
Father		☐YES ☐NO	☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐Diabetes ☐heart disease ☐Hypertension ☐Osteoporosis ☐Stroke ☐Other_____
Mother		☐YES ☐NO	☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐Diabetes ☐heart disease ☐Hypertension ☐Osteoporosis ☐Stroke ☐Other_____
Grandmother *Maternal*		☐YES ☐NO	☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐Diabetes ☐heart disease ☐Hypertension ☐Osteoporosis ☐Stroke ☐Other_____
Grandfather *Maternal*		☐YES ☐NO	☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐Diabetes ☐heart disease ☐Hypertension ☐Osteoporosis ☐Stroke ☐Other_____
Grandmother *Paternal*		☐YES ☐NO	☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐Diabetes ☐heart disease ☐Hypertension ☐Osteoporosis ☐Stroke ☐Other_____
Grandfather *Paternal*		☐YES ☐NO	☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐Diabetes ☐heart disease ☐Hypertension ☐Osteoporosis ☐Stroke ☐Other_____
Brother/Sister		☐YES ☐NO	☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐Diabetes ☐heart disease ☐Hypertension ☐Osteoporosis ☐Stroke ☐Other_____
Brother/Sister		☐YES ☐NO	☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐Diabetes ☐heart disease ☐Hypertension ☐Osteoporosis ☐Stroke ☐Other_____
Children		☐YES ☐NO	☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐Diabetes ☐heart disease ☐Hypertension ☐Osteoporosis ☐Stroke ☐Other_____
Other		☐YES ☐NO	☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐Diabetes ☐heart disease ☐Hypertension ☐Osteoporosis ☐Stroke ☐Other_____

SOCIAL HISTORY AND HEALTH HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Diet & Exercise	Are you dieting?			☐ Yes	☐ No
	If yes, what type of diet are you following? _____				
	Exercise Level:	☐ Sedentary (None)	☐ Occasional	☐ Moderate	☐ Heavy
	How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? _____				
	What types of sporting activities do you participate in? _____				
Substance Use	Do you or have you ever smoked tobacco?	☐ Never	☐ Former	☐ Current everyday	☐ Current somedays
	If yes, how many years have you smoked tobacco? _____	What age did you start? _____	How much tobacco do you smoke? (pack/day) _____	When did you quit smoking? _____	
	Do you or have you ever used any other forms of tobacco or nicotine?			☐ Yes ☐ No	If yes:_____
	What is your level of alcohol consumption?	☐ None	☐ Occasional	☐ Moderate	☐ Heavy
	How many times a week do you consume alcohol? _____	How many years have you consumed alcohol? _____	Have you ever been counseled for unhealthy alcohol use? ☐Yes ☐No		

	Do you use any illicit or recreational drugs?					☐ Yes	☐ No
	Which illicit or recreational drugs have you used?	How many years have you used illicit or recreational drugs?	Have you used IV drugs?			☐ Yes	☐ No
	What is your level of caffeine consumption?	☐ None	☐ Occasional	☐ Moderate	☐ Heavy		
Relationship & Sexuality	What is your relationship status?	☐ Single	☐ Married	☐ Divorced	☐ Separated	☐ Widowed	☐ Other _____
	Are you sexually active?					☐ Yes	☐ No
	Do you use protection during sex?					☐ Yes	☐ No
	Which type of protection is used? _____						
	How many children do you have? _____						
Lifestyle	Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)?					☐ Yes	☐ No
	Have you ever: ☐ Attempted suicide ☐ Seriously thought about hurting yourself					If so, when: _____	
	Do you participate in social media?						
	Do you wear a helmet when biking?					☐ Yes	☐ No
	Do you use your seat belt or car seat routinely?					☐ Yes	☐ No
Activities of Daily Living	Are you able to care for yourself?					☐ Yes	☐ No
	Are you blind or do you have difficulty seeing?					☐ Yes	☐ No
	Are you deaf or do you have serious difficulty hearing?					☐ Yes	☐ No
	Do you have difficulty concentrating, remembering, or making decisions?					☐ Yes	☐ No
	Do you have difficulty walking or climbing stairs?					☐ Yes	☐ No
	Do you have difficulty dressing or bathing?					☐ Yes	☐ No
	Do you have difficulty doing errands alone?					☐ Yes	☐ No
	Are you able to walk? If no, explain: _____					☐ Yes	☐ No
	Do you have transportation difficulties?					☐ Yes	☐ No
Home & Environment	Have there been any changes to your family or social situation?					☐ Yes	☐ No
	Where do you live?	☐ Single-level house	☐ Multi-level house	☐ Apartment	☐ Trailer	☐ Other: _____	
	Do you have any pets?					☐ Yes	☐ No
	Do you have smoke and carbon monoxide detectors in your home?					☐ Yes	☐ No
	Are you passively exposed to smoke?					☐ Yes	☐ No
	Are there any guns present in your home?					☐ Yes	☐ No
	Do you use sunscreen routinely?					☐ Yes	☐ No
Education & Occupation	What is the highest grade or level of school you have completed or the highest degree you have received?					_____	
	Are you currently in school? If so, what grade? _____					☐ Yes	☐ No
	Are you currently employed?					☐ Yes	☐ No
	What is your occupation?					☐ Yes	☐ No
	Are there any occupational health risks where you work?					☐ Yes	☐ No
Advanced Directive	Do you have an advanced directive?					☐ Yes	☐ No
	Do you have an out of hospital DNR?					☐ Yes	☐ No

	Is blood transfusion acceptable in an emergency?	☐ Yes	☐ No
Public Health and Travel	Have you recently traveled abroad?	☐ Yes	☐ No
	Have you been to an area known to be high risk for COVID-19?	☐ Yes	☐ No
	Have you had close contact with a laboratory-confirmed COVID-19 while that case was ill?	☐ Yes	☐ No
	In the 14 days before symptom onset, have you had close contact with a person who is under investigation for COVID-19 while that person was ill?	☐ Yes	No

SURGICAL HISTORY		
Surgeries & Dates	*Surgery:*	*Date:*

WOMEN ONLY			
Date of last Pap smear:			
Have you ever had an abnormal Pap smear?		☐ Yes	☐ No
Have you ever had a colposcopy?		☐ Yes	☐ No
Date of last Mammogram:			
Date of last Colonoscopy:			
Age at menarche (first menstrual cycle):			
Date of LMP:			
Menses monthly?		☐ Yes	☐ No
Flow?	☐ Light ☐ Moderate	☐ Heavy	
Duration of flow (days)?			
Frequency of cycle (Q days)			
If post-menopausal, age at menopause:			
If post-menopausal, do you have post-menopausal bleeding?		☐ Yes	☐ No
Are you sexually active?		☐ Yes	☐ No
STIs/STDs?		☐ Yes	☐ No
Current birth control method?			
Are you currently pregnant or breastfeeding?		☐ Yes	☐ No
Age at first child?			
Total living children:			
Of the living children, how many: Full term: _____ Premature: _____ Multiple births: _____			
How many of the following have you had: Eptopic pregnancies: _____ Abortions induced: _____ Miscarriages: _____			

Please turn to next page

PAST MEDICAL HISTORY			
Do you currently have any of the following diseases or medical conditions? (Check if YES)			
☐Abuse/Domestic Violence	☐Congestive Heart Failure	☐Heart Disease	☐Neurologic Illness
☐Acid Reflux (GERD)	☐Constipation	☐Heart Problems	☐Obesity
☐Acne	☐COPD	☐Hematologic disorders	☐Osteoporosis
☐ADD/ADHD	☐Coronary Artery Disease (CAD)	☐Hepatitis	☐Other:_____ _____
☐AIDS/HIV	☐Depression	☐Hepatitis/Liver Disease	☐Ovarian Cancer
☐Allergies (Food, seasonal, environmental)	☐Depression/Postpartum depression	☐High Cholesterol	☐Polycystic ovary syndrome
☐Allergies/Hay fever	☐Dermatologic Disorders	☐History of abnormal pap	☐Polyps
☐Anemia	☐Developmental or Behavioral Disorders	☐History of STI	☐Pre-Eclampsia
☐Anesthesia Complications	☐Diabetes	☐Hospitalizations	☐Psychiatric Illness
☐Anxiety Disorder	☐Difficulty Swallowing	☐Hypertension	☐Pulmonary disease
☐Art (IVF or FET)	☐Diverticulitis	☐Hyperthyroidism	☐Pulmonary Embolism
☐Arthritis	☐Drug/Latex Allergies/Reactions	☐Hypothyroidism	☐Reflux/GERD
☐Asthma	☐Ear or Hearing Problems	☐Infertility	☐Seizures/Epilepsy
☐Autism Spectrum Disorder	☐Eating Disorder	☐Kidney Disease	☐Skin Problems
☐Autoimmune disease	☐Eczema	☐Kidney or Bladder Problems	☐Stroke
☐Birth Defects or Inherited Disease	☐Endometriosis	☐Kidney Stones	☐Thrombophilia
☐Blood Diseases	☐Fibromyalgia	☐Liver Disease	☐Thyroid Problems
☐Blood Transfusion	☐Gestational Diabetes	☐Lung Disease	☐Trauma/Violence
☐Breast Cancer	☐GI Problems	☐Meniere's disease	☐Tuberculosis
☐Breast Problem	☐Gout	☐Mental Disorder/Illness	☐Varicosities (Varicose veins)
☐Cancer	☐Headaches	☐MRSA exposure	☐Vision or Eye Problems
☐Chronic Ear Infections	☐Heart Attack	☐Muscle, Joint, or Bone Problems	☐Other: _____

Please include any other information about your health that you would like your provider to know here:

_____
_____
_____
_____

I understand that my health information is strictly confidential. I have answered the above information honestly and to the best of my ability.

_____	_____	_____
Patient Name	Patient Signature/Person Authorized to consent for patient	Date

Please turn to next page

FirstRefuge ministries

SPIRITUAL SCREEN		
Do you have any spiritual, cultural or ethical/practices that we should be aware of? If Yes, please describe: _____	☐ Yes	☐ No
Would you like someone to pray with you today?	☐ Yes	☐ No
Would you like some information about a church in the area today? If yes, what faith? _____	☐ Yes	☐ No
ABUSE/NEGLECT SCREEN		
Have you ever been in a relationship where you were physically hurt, threatened or made to feel afraid?	☐ Yes	☐ No
Have you ever been hurt, kicked, slapped or pushed by your spouse or anyone close to you?	☐ Yes	☐ No
Behavioral clues of potential abuse (Circle all the following that apply): Defensive Evasive Listless/depressed Withdraws from touch Poor eye contact Frequent Injuries Abnormally frightened		
NUTRITIONAL SCREEN		
How many servings of vegetables do you eat per day?	☐ 0	☐ ___
How many servings of fruit do you eat per day?	☐ 0	☐ ___
How many glasses of water do you drink per day?	☐ 0	☐ ___
Circle all the following that apply: No nutritional risk Skip Meals Eats frequent high calorie snacks		
FUNCTIONAL SCREEN		
Are you ambulatory (able to walk/move around without assistance)?	☐ Yes	☐ No
Are you non-ambulatory (NOT able to walk/move around without assistance)?	☐ Yes	☐ No
Do you use a wheelchair?	☐ Yes	☐ No
Comments:		
PAIN SCREEN		
Are you currently in pain? Pain level (0-10): _____	☐ Yes	☐ No
Is the pain constant? Duration of pain? _____	☐ Yes	☐ No
Pain Location?		
Medication/Treatments used to alleviate pain: _____		
LEARNING ASSESSMENT		
What are any barriers to learning you might have? Language Unable to read Sight Hearing Mental status Cultural/Religious Explain: _____		
How do you learn the best? Explanation Demonstration Listening Handouts Other		
HOW DID YOU HEAR ABOUT US? _____		

_____ Patient Name

_____ Patient Signature/Person Authorized to consent for patient

_____ Date

Please turn to next page

FirstRefuge ministries

PATIENT'S CONSENT TO TREATMENT

I_____(Self/Parent/Guardian), of_____ Herby consent(s) voluntarily to outpatient care encompassing diagnostic procedures, examination and medical treatment including but not limited to, routine laboratory work (Blood, urine and other studies) heart tracing and administration of medications prescribed by the Physician, Physician's Assistant/Associate (PA) or Advanced Nurse Practitioners (ANP).
I further consent to the performances of minor surgery, mole removal, suturing lacerations, etc.…
I further consent to the photographs or X-rays necessary for the diagnosis and for educational purposes.
I further consent to Immunizations and/or screening exams to include; PPD skin test, Influenza (Flu) injections and/or Pneumococcal Injections for myself, my child or person(s) I am assigned legal guardianship.

Patient's Consent to Treatment by Volunteers

I understand that services I receive from First Refuge Ministries Medical Clinic may be provided by a volunteer, who is providing care that is not for or in expectation of compensation.
I further understand that Texas law imposes limits on the recovery of damages from such a volunteer in exchange for receiving health care services. Those limitations include immunity from civil liability for any act or omission resulting in death or injury to a patient if:

1. The volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization
2. The volunteer commits the act or omission in the course of providing health care services to the patient.
3. The services provided are within the scope pf the license of the volunteer, and before the volunteer provides health care services, the patient or, if the patient is a minor or is otherwise legally incompetent, the patient's parent, managing conservator, legal guardian, or other person with legal responsibility for the care of the patient signs a written statement that acknowledges:
    a. That the volunteer is providing care that is not administered for or in expectation of compensation; and
    b. The limitations of the recovery of damages from the volunteer in exchange for receiving the health care services.

I acknowledge that the health care providers, as volunteers, are providing me with care that is not administered for or in expectation of compensation and in exchange for receiving the health care services, recovery of damages is limited.

_____	_____	_____
Patient Name	Patient Signature/Person Authorized to consent for patient	Date

If the patient is a minor or is unable to give the consent, complete the following:

Patient is a minor_____years of age. Father: _____ Mother: _____
Patient is unable to give consent due to:_____

CONSENT TO RELEASE OF INFORMATION

RELEASE OF INFORMATION: I authorize the First Refuge Ministries Medical Clinic to release medical information to third party carriers for the purpose of filing insurance claims related to my medical care. I also authorize payment to the First Refuge Medical Clinic but not to exceed the customary charges for these services. I also authorize the First Refuge Ministries Medical Clinic to release information to other Health Care providers, Childcare providers and/or Federal and/or State Health related agencies. I understand the information released may contain information on; immunization history and/or status, communicable diseases, sexually transmitted diseases, which may include but is not limited to: Hepatitis, Syphilis, Gonorrhea and the Human Immunodeficiency Virus (HIV) also known as Acquired Immune Deficiency (AIDS) as well as information about drugs, alcohol and Sickle Cell Anemia (62 O.S. (B)). Payment history may also be released.

I understand that this consent form will be valid and remain in effect as long as I/ We use First Refuge Ministries Medical Clinic, or until revoked in writing.

This form has been fully explained to me and I understand its contents.

_____	_____	_____
Patient Name	Patient Signature/Person Authorized to consent for patient	Date

If the patient is a minor or is unable to give the consent, complete the following:

Patient is a minor_____years of age. Father: _____ Mother: _____
Patient is unable to give consent due to:_____

FirstRefuge ministries

PATIENT RESPONSIBILITES

1. YOU ARE RESPONSIBLE FOR COMING TO YOUR APPOINTMENTS. If you cannot keep an appointment for any clinic service, you MUST call (940) 484-4384 before the appointment time and tell the receptionist or leave a message on our phone system. This will not count against you if you call BEFORE your appointment time. Three missed appointments within a 6-month period without calling ahead will results in suspension of patient privileges at the clinic. Also, three consecutively missed appointments is grounds for dismissal from the clinic.
2. Every patient, NO EXCEPTIONS, must update patient information each year. This involves completing the paperwork and supplying the clinic with a copy of your current verification of income.
3. When you move or change telephone numbers, it is your responsibility to notify us by calling (940) 484-4384. This will allow us to contact you when your medicine or lab results are ready.
4. Refills can only be ordered by calling us at (940) 484-4384, 5to 7 days ahead of the day you wish to pick up the medicine. Alternately, your pharmacy may fax a refill request to us at (940) 213-3125. Patient Assistance Program (PAP) medications not picked up within 30 days after the patient notification that medications are in the office, will be cancelled. Cancelled PAP medications must be returned to the pharmaceutical company. If the patient requests medication refill after the 30 days, the patient will be given a written prescription to be filled at the patient's expense at a pharmacy until the medication can be reordered through PAP and received in the clinic.
   MEDICATION CANNOT BE FILLED BEFORE IT IS DUE TO BE REFILLED.
5. Call (940) 484-4384 to leave a message and you will be called back.
6. Patients are responsible for taking medications as ordered by the doctor. Patients may not skip doses, nor double up on doses without the doctor's written order. Doing so puts your health at risk and will results in not getting refills when needed. If you have problems with your medication, call and leave a message for the nurse. She will talk with the Nurse Practitioner or Director to see what needs to be done and will get back to you as soon as possible.

I have read and understand my responsibilities as a patient of First Refuge Ministries Medical Clinic.
I agree to comply with these requirements.

_____	_____	_____
Patient Name	Patient Signature/Person Authorized to consent for patient	Date

PATIENT DISMISSAL POILCY ACKNOWLEDGEMENT

First Refuge Ministries Medical Clinic (FRMMC) is a non-profit, no cost center for the purpose of ministering to the whole person spirit, soul and body. Because of our limited mission statement and limited resources, we reserve the right to refuse to treat any patient:

1. If we do not have the resources to provide the perceived need of the patient, we can refuse to treat that patient.
2. If a patient is deemed to be uncooperative, overly aggressive, or behaviorally unmanageable, we can refuse to treat the patient.
3. If a patient is rude or uses profanity with clinic staff, we can refuse to treat the patient.
4. If a patient is a NO-SHOW for 3 consecutive appointments, we can refuse to treat the patient.
5. If a patient is deemed to be dangerous to others, we can refuse to treat that patient.
6. If a patient is found to be consistently untruthful, we can refuse to treat that patient.
7. If a patient is deemed to be beyond our scope of care, we can refuse to treat that patient.

Patient Name	Patient Signature/Person Authorized to consent for patient	Date

MISCONDUCT POLICY

First Refuge Ministries Medical Clinic (FRMMC) reserves the right to refuse services to patients that have conducted themselves in a manner that is considered inappropriate. Inappropriate behavior is defined as using foul language towards a member of the staff or another patient, being loud and disruptive in the waiting area, being intoxicated by drugs and/or alcohol, threatening any staff member or another patient, or harassing a staff member or another patient. These are examples of misconduct, and misconduct is not limited to these actions only.

I understand that if I should behave inappropriately, I will be warned, and could be dismissed from the clinic and will no longer be eligible to obtain services from FRMMC. I also understand that, depending on the severity of the incident, dismissal may be immediate. All incidents will be reviewed by a FRMMC Physician and the Clinic Director.

Patient Name	Patient Signature/Person Authorized to consent for patient	Date

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WARNING

(Only to be filled out when a warning is given)

I understand that I have conducted myself in a manner deemed inappropriate by First Refuge Ministries Medical Clinic. I also understand that if I should behave inappropriately again, I will be dismissed from the clinic and will no longer be eligible to obtain services from the First Refuge Ministries Medical Clinic. My questions were answered, and I have received a copy of this policy.

Patient Signature/Person Authorized to consent for patient	Date

CLINIC POLICY ON DISCLOSURE OF HEALTH INFORMATION

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: The following categories describe different ways that we use health information within First Refuge Ministries Medical Clinic (FRMMC) and disclose health information to person and entities outside of FRMMC. Each description is of a category of uses or disclosures. We have not listed every use or disclosure within the categories, but all permitted uses and disclosures will fall within one of the following categories. Disclosure of Health Information will involve only the minimum necessary amount of information needed.

WITH WRITTEN CONSENT: In compliance with the Federal Health Insurance Portability and Accountability Act (HIPPAA), we will obtain in writing, informed consent when patient first visits FRMMC. The informed consent is necessary to allow us to use health information within FMMC and to disclose health information outside of FRMMC.

TREATMENT: We may use health information about patient to provide with medical treatment and services. We may disclose health information to doctors, nurses, technicians, medical students, interns, or other personnel who are involved in treatment.

PAYMENT: Although payment is not applicable for most services that FRMMC provides, HIPPA provides that we may use and disclose health information about patient to an insurance company or third party for payment purposes.

HEALTH CARE OPERATIONS: We may use and disclose health information about patient for health care operations, including quality assurance activities; granting medical staff credentials to physicians; administrative activities, including FRMMC financial and business planning and development; and customer service activities, including investigation of complaints, etc. These uses and disclosures are necessary to operate our health care facility and to make sure all of our patients receive quality care.

BUSINESS ASSOCIATES: There are some services provided in our organization through contracts with business associates. Examples of business associat3es include laboratory services, accreditation agencies, service consultants, quality assurance reviewers, etc. We may disclose health information to our business associates so that they can perform the job we've asked them to do. To protect health information, we require our business associates to sign an agreement that stated they will appropriately safeguard information.

APPOINTMENT REMINDERS: We may use and disclose health information to contact patient or healthcare designee as a reminder of an appointment for treatment or medical care at our health care facility.

DRUG AND ALOHOL ABUSE: We will disclose drug and alcohol treatment information about patient in accordance with the federal Privacy Act. In general, the privacy Act requires written authorization for such disclosures.

DISCLOSURE OF MENTAL HEALTH INFORMATION: We will disclose mental health information about patient only in accordance with state law. In most cases, state law requires that patient's written authorization or the written authorization of representative for such disclosures.

DISCLOSURES REQUESTED BY FRMMC: We may ask patient to sign an authorization allowing us to disclose health information to others for specific purposes such as notifying patient of future educational or social events that you may enjoy.

SPECIAL SITUATION THAT DO NOT REQUIRE INFORMED CONSENT OR AUTHORZATION: The following disclosures of patient's health information are permitted by law without any oral or written permission from the patient:

ORGAN AND TISSUE DONATION: If patient is an organ donor, we may release health information to organizations that handle organ procurement; or organ, eye, or tissue transplant, or to an organ donation bank as necessary to facilitate organ tissue donation and transplantation.

MILITARY AND VETERANS: If patient is a member of the armed forces, we may release health information as required by military command authorities.

WORKERS COMPENSATION: We may release health information about patient for workers' compensations or similar programs if patient has a work-related injury.

AVERTING SERIOUS THREAT: We may use and disclose health information about a patient when necessary to prevent a serious threat to health or safety or the health and safety of another person or the public. These disclosures would be made only to someone able to help prevent the threat.

PUBLIC HEALTH ACTIVITIES: we may disclose health information for public health activities. These generally include the following:

1. To prevent or control diseases, injury or disability
2. To report births and deaths
3. To report child abuse or neglect.
4. To report reactions to medication, problems with products or other adverse events.
5. To notify people of recalls of products they may be using
6. To notify a person who may have been exposed to a disease or may be at risk for contacting or spreading a disease or condition.
7. As authorized by law
8. To notify the appropriate government authority if we believe a patient has been the victim of abuse (Including elder abuse), neglect or domestic violence.

HEALTH OVERSIGHT ACTIVITES: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

LAWSUITS AND DISPUTES: If a patient is involved in a lawsuit or a dispute, we may disclose health information in response to a court or administrative order. We may disclose health information in response to a subpoena; discovery request or other lawful process by someone else involved in the dispute. We would only disclose this information in if efforts have been made to tell the patient about the request to allow patient to obtain an order protecting the information requested.

LAW INFORCEMENT: We may disclose health information if asked to do so by law enforcement officials for the following reasons:

1. In response to a court order, subpoena, warrant, summons or similar process.
2. To identify or locate a suspect, fugitive, material witness or missing person.
3. About the victim of a crime or, under certain circumstances, we are unable to obtain the person's agreement.
4. About a criminal conduct at our facility.
5. In emergency circumstances to report a crime, the location of the crime or victims or the identity, description or location of the person who committed the crime.

NATIONAL SECURITY: We may disclose health information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

INMATES: If the patient is an inmate of a correctional Institution or under custody of a law enforcement official, we may disclose health information to the correctional institution or the law enforcement official. This is necessary for the correctional institution to provide patient with health care, to protect health and safety and the health and safety of others, for the safety and security of the correctional Institution.

REQUIRED BY LAW: We will disclose health information about patient without their permission when required to do so by federal, state or local law.

I have read this clinic policy on disclosure of health information, had the opportunity to ask questions, understand it, and agree to abide by these policies.

_____	_____	_____
Patient Name	Patient Signature/Person Authorized to consent for patient	Date