The Perry County School District (PCSD) and Primary Care Centers of Eastern Kentucky (PCCEK) have partnered to provide on-site healthcare services at our schools. PCCEK School Based Clinics are comprehensive primary care health centers staffed by ARNP, PA, RN, LPN, CNA, with physicians and specialists available. Our goal is to create a healthier school environment by promoting general health, increasing attendance, and improving classroom behavior for the benefit of our students and staff. Your child can receive care during the school day, so they don't miss school. PCCEK School Based Clinics are primarily for acute care services and chronic care ailments will be managed and treated at one of PCCEK's five clinics and/or by your primary care provider.

School & Sports Physical Examination, Immunizations, and Preventative Medicine services will only be provided on scheduled dates determined by PCCEK and PCSD.

Consent to Treat: To receive PCCEK School Based Clinic services, students must have this consent packet completed and signed by their parent or guardian. If the student is 18 years or older, or emancipated, the student can sign their own consent packet. Each year the PCCEK School Based Clinic services consent packet must be completed for your child to remain a patient. The consent will remain in effect until the end of the current school year, unless your child is no longer enrolled in Perry County School District or if you revoke the consent for treatment. You may revoke the consent to treat your child at any time by notifying PCCEK, in writing, that the PCCEK School Based Clinic no longer has consent to treat your child as a patient. Please notify us at the following number and in writing, if there are any changes in guardianship of your child or if you have any general questions 606-439-1300.

ATTENTION:

This packet must be completed and returned for your child to see the school nurse and/or provider.

PCCEK School Based Clinic Registration Form

School	❑ Buckhorn School	❑ East Perry Elementary	❑ Viper Elementary
	❑ Robinson Elementary	❑ R. W. Combs Elementary	
	❑ West Perry Elementary	❑ Perry County Central High School	

Patient Information

Name	Last	First	MI	SSN
Date of Birth	____/____/_____	Marital Status	□ Single □ Married □ Divorced □ Other _____	
Mailing Address	Street/PO Box			
	City	State	Zip	
Physical Address □ Same As Mailing	Street			
	City	State	Zip	
Phone	Home | Cell	| Work	Ext	
Email Address				
Gender	□ Male □ Female □ Transgender			
Preferred Pharmacy		City/State		
Race	□ American Indian □ African American □ Asian □ Caucasian/White □ Hispanic □ Native Hawaiian or Pacific Islander □ Other _____			
Ethnicity	□ Non-Hispanic □ Hispanic	Language	□ English □ Spanish □ Other _____	

INSURANCE INFORMATION

Insurance Type	□ COMMERCIAL □ MEDICAID □ NONE/SELF PAY □ OTHER _____		
Primary	Name	Subscriber DOB:	Policy #
Secondary	Name	Subscriber DOB:	Policy #

If you do not have health insurance, you may qualify for the PCCEK sliding scale. Please call 606-439-1300 with any questions.

Responsible Party Information

Name	Last	First	MI	SSN
Mailing Address □ Same As Above	Street/PO Box			
	City	State	Zip	
Date of Birth	____/____/_____	Relationship To Patient		
Phone	Home | Cell	| Work	Ext	

For Minors Only

Mother DOB ____/____/_____ SSN

Father DOB ____/____/_____ SSN

In Your Absence / Emergency Contact Information

In the absence of the legal guardian the following people are authorized to bring this minor for medical treatment and have access to his/her medical information IE: patient's condition, treatment, and/or appointment. (You may name relatives, friends, grandparents, stepparent, non-custodian parent, day care provider, foster parent or others.)

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

If no other person is authorized please circle: None

Signature of Patient's Parent or Legal Guardian: _____

Relationship to Patient: _____ Date: _____

PCCEK School Based Clinic
MEDICAL HISTORY

I, parent/guardian, understand it is my responsibility to provide PCCEK School Based Clinic with my child's medical records, including prescriptions and medical provider orders, for PCCEK School Based Clinic to provide required treatments and medications ordered by my child's healthcare providers. Providing PCCEK School Based Clinic access to diagnoses and current medications, treatment plans, and care instructions after an injury, illness, surgery or hospitalization can ensure consistency in health services for your child. Requests from a parent/guardian to change a prescribed medication or treatment will not be accepted without the documentation from the prescribing healthcare provider.

MEDICAL HISTORY

The following list of medications will be on hand at the PCCEK School Based Clinic to be administered after your child's complaint has been evaluated. Please review the list and place a check mark by the ones you will allow your child to have:

❑ Tylenol (Acetaminophen)	❑ Anti-Nausea Liquid	❑ Hydrocortisone 1% Cream
❑ Advil (Ibuprofen)	❑ Antacids (Liquid/Chewable)	❑ Triple Antibiotic Ointment
❑ Cough Drops	❑ Aloe Vera Gel	❑ Glucose Gel/Tablets
❑ Bactine Cleansing Spray	❑ Blistex	
❑ Robitussin (Tussin)	❑ Benadryl (Diphenhydramine)	
❑ Orajel	❑ Calamine Lotion	

The following information will aid the School Based Clinic in making an accurate assessment of your child in case of illness or emergency. Please check the appropriate box if your child has ever had any of the following:

❑ Measles	❑ Chest Pain	❑ Persistent Cough
❑ Mumps	❑ Scarlet Fever	❑ Stomach or Bowel Problems
❑ Anemia	❑ Birth Defects	❑ Diabetes
❑ Chicken Pox	❑ Rheumatic Fever	❑ Asthma
❑ Cancer	❑ Exposed to Tuberculosis	❑ Shortness of Breath
❑ Head, Eyes, Ears, Throat Problems	❑ Blood Transfusion	❑ Anaphylactic Episodes

❑ Other: _____

CURRENT MEDICATIONS:	**ALLERGIES**:	**CHRONIC ILLNESSES/SURGICAL HISTORY**:
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

DOES YOUR CHILD USE ANY OF THE FOLLOWING: ❑ Alcohol ❑ Tobacco ❑ Drugs	**NAME OF YOUR CHILD'S PRIMARY CARE PROVIDER:** _____ **DATE OF LAST VISIT:** _____	**NAME OF YOUR CHILD'S DENTIST:** _____ **DATE OF LAST VISIT:** _____

ANY INFORMATION REGARDING YOUR CHILD'S MEDICAL HISTORY NOT LISTED ABOVE:

_____

_____

_____

Students Full Name: _____ Students Date of Birth: _____

Check all that apply:

- **Nurse Visit Only (not billed to insurance and not seen by a provider)**
- **Yes, treat my child via telehealth if unable to contact me. (billed to insurance)**
- **No, DO NOT treat my child via telehealth without contacting me.**

By signing this form, I, the parent/guardian or student, have read, understand, and agree to all of the above.

Parent/Legal Guardian Full Name: _____

Parent/Legal Guardian Signature: _____ **Date: _____**

ATTENTION:

We are now part of a new program that is designated by the state. We are REQUIRED to ask the following questions to all patients, regardless of age. While we do understand that some of these questions do seem invasive, your participation allows us to better serve you and our communities.

STI SCREENING QUESTIONNAIRE

Have you ever had an accidental needle stick?	Yes / No (please circle one)
Have you ever consumed illicit drugs?	Yes / No (please circle one)
Have you ever been tested for a STI?	Yes / No (please circle one)
Are you sexually active?	Yes / No (please circle one)
Do you practice safe sex?	Yes / No/Not Applicable (please circle one)
Screening responses provided on behalf of the patient by:	Patient / Legal Guardian (please circle one)

PCCEK Staff Signature: _____ **Date: _____**

Primary Care Centers of Eastern Kentucky complies with all applicable federal civil rights laws, including Section 1557 of the Affordable Care Act (Section 1557).
Primary Care Centers of Eastern Kentucky does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)) or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).
In compliance with Section 1557 and other federal civil rights laws, we provide individuals the following in a timely manner and free of charge:
***Primary Care Centers of Eastern Kentucky*:**
Will provide free language assistance services for individuals with limited English proficiency (including individuals' companions with limited English proficiency) to ensure meaningful access to our programs, activities, services, and other benefits. Language assistance services may include:

- Qualified Interpreters – via Voyce Interpretation Services
- Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Appropriate auxiliary aids and services: *Primary Care Centers of Eastern Kentucky* will provide appropriate auxiliary aids and services for individuals with disabilities (including individuals' companions with disabilities) to ensure effective communication.
- Reasonable modifications**:** Primary Care Centers of Eastern Kentucky will provide reasonable modifications for qualified individuals with disabilities, when necessary to ensure accessibility and equal opportunity to participate in our programs, activities, services, or other benefits.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact:

Section 1557 Coordinator: Carrie Campbell, RN
If you believe that *Primary Care Centers of Eastern Kentucky* has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Primary Care Centers of Eastern Kentucky
Section 1557 Coordinator: Carrie Campbell, RN
101 Town and Country Lane Hazard KY, 41701
Phone: (606)439-1300 ext. 3410 Fax: (606)435-7684 Email: ccampbell@pccek.com
You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Carrie Campbell, RN is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

This notice is available on Primary Care Centers of Eastern Kentucky's website: www.pccek.com

Parent/Legal Guardian Signature: _____ Date:_____

AIDS...WHAT YOU SHOULD KNOW

What is AIDS?

Acquired immunodeficiency syndrome, AIDS, is a disease caused by a virus that destroys the body's natural ability to fight illness. This allows diseases such as cancer and infections such as pneumonia to invade that body and cause death. At this time, there is no cure or vaccine for AIDS.

How does AIDS spread?

The human immunodeficiency virus (HIV) which causes AIDS is transmitted through blood, semen, and vaginal secretions. The main ways the virus is spread includes:

- Having sex (anal, oral or vaginal intercourse) with an infected person when blood, semen, or cervical / vaginal secretions are exchanged;
- Sharing a syringe / needle with someone who is infected;
- Being born with the virus if your mother has been infected;
- Receiving contaminated blood or blood products, organ / tissue transplants, and artificial insemination from an infected person (rare now since testing for HIV antibodies began).

How can I prevent getting AIDS?

The way to prevent getting AIDS is to avoid those behaviors which provide an opportunity for the virus to be passed from one person to another. A few simple rules apply:

- Do not have sex with someone who has AIDS or is infected with the virus;
- When unsure of a sex partner's health status, practice safe sex by using a latex condom, female condom, or dental dam;
- Limit the number of sexual partners to reduce your chances of exposure to the virus;
- Do not share syringes or needles with anyone;
- You should be tested for HIV if you are pregnant or plan to become pregnant;
- Avoid alcohol and other drugs which affect judgment and make one more likely to engage in risky behavior;
- Educate yourself and others about HIV infection and AIDS.

Other facts about AIDS

- Donating blood is SAFE.
- The virus is NOT spread by casual contact such as touching, coughing, sneezing, or using bathrooms, water fountains, swimming pools, and telephones that an infected person has used.
- Birth control pills and diaphragms DO NOT protect against AIDS.
- A person can be infected with HIV / AIDS and be able to transmit it before he or she shows symptoms of AIDS.
- A blood test is one way to know whether or not a person is infected.
- For additional information or advice regarding HIV / AIDS, contact your physician or other healthcare professional.

Signature:_____	Date:_____

This information corresponds with Center for Disease Control recommendations and is provided in compliance with Kentucky State Law (KRS 214.620)

General Consent to Treat

I am the parent/guardian of the above named patient. I have the legal right to consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that Primary Care Centers of Eastern Kentucky (PCCEK) believe are necessary for this child. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, and other health care providers in this medical office to provide treatment, which may include HIV and Hepatitis, to this child as long as this child is a patient in this office, or until I withdraw my consent. I am aware that the practice of medicine is not an exact science and that no guarantee can be made concerning the results of treatment. The minor named in this consent form may receive all medical care provided according to generally and currently accepted standards of pediatric medical care. If a minor is brought by any other person not recorded above, Primary Care Centers of Eastern Kentucky will make reasonable attempts to contact me for verbal consent to treat. If the parent/legal guardian or other authorized person as written above cannot be reached in emergent situation, I consent to Primary Care Centers of Eastern Kentucky to render medical care as deemed necessary. If the custody or guardianship of this minor has changed, I will furnish Primary Care Centers of Eastern Kentucky with the legal forms that are required to be included in the minor's medical record to explain the change in guardianship. This will alleviate any confusion that may occur over who may or may not consent to minor's treatment. I have the right to revoke or change this consent to treat in writing.

Minor Child's Right to Consent:

Kentucky law does not require the consent of a parent or a legal guardian for a minor child, under the age of 18, who have given their consent, to be examined, advised, tested, treated and/or prescribed medication, for venereal diseases, pregnancy (including contraception), childbirth and alcohol or other drug abuse or addiction issues. The parent or legal guardian will not be notified of the minor's consent to be treated or the outcome of the treatment or other aspect of the care of the minor. Emancipated minors or any minor who has contracted a lawful marriage or borne a child may give consent to the furnishing of medical care to his or her child or himself or herself. A healthcare professional may inform the minor's parent or legal guardian of any treatment given or needed where, in the judgment of the healthcare professional, informing the parent or guardian would benefit the health of the minor patient.

Electronic Prescriptions (E-Prescribing)

I voluntarily authorize PCCEK to allow E-Prescribing for the patient's prescriptions, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispense history as long as this child is a patient in this office, or until I withdraw my consent.

Personal Information

I certify the information supplied for my registration to be current, complete, and accurate to the best of my knowledge. I understand by not supplying PCCEK with all possible insurance coverage could result in a delay of treatment, referrals, diagnostic testing, and create an account balance that I would be solely responsible for.

Consent to Release and Obtain Information

In agreement with federal and state law, I agree to allow Primary Care Centers of Eastern Kentucky (PCCEK) to deliver the necessary care to this child in order to provide continuity of care and treatment. PCCEK and/or the patient's provider may obtain from any source and examine and use, or discuss and disclose, the patient's medical record and information to treating hospital personnel and agents, other health care providers, medical records auditors, professional committees, care evaluators and governmental agencies. We may make your protected information available electronically through an information exchange service to other health care providers that request your information. Participation in information exchange services also lets us see their information about you. This information can include, but is not limited to: medical history, examinations, diagnoses, treatments, any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information. This consent to release and obtain information is valid until revoked. The undersigned may revoke the consent in writing at any time, except with regard to disclosures that have already been made in reliance on such consent.

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

WRITTEN ACKNOWLEDGMENT OF RECEIPT OF PCCEK NOTICE OF PRIVACY PRACTICES

I acknowledge receiving the Primary Care Centers of Eastern Kentucky ("PCCEK") Notice of Privacy Practices ("Notice"). The Notice explains how PCCEK may use and disclose your protected health information for treatment, payment and health care operations purpose. "Protected health information" means your personal health information, or the personal health information of your minor child, found in your, or your child's, medical and billing records.

If you have questions about the Notice, please contact the PCCEK Privacy Office. Contact information is located in the Notice.

Release of Medical Records

PCCEK School Based Clinic may release medical records to my child's school to assist in the treatment and/or continuity of care for my child.

Financial Policy Agreement and Consent to Treat:

It is my responsibility as this child's parent to:

- Supply insurance card/information (we accept most insurance plans; Medicare, Medicaid, Commercial)
- Understand that any care not covered under my insurance will be billed to me and I am responsible for payment.

I also authorize the release of any medical or other information necessary to process my child's insurance claim as well as authorizing payment of medical benefits to Primary Care Centers of Eastern Kentucky.

Telehealth and Telemedicine

Telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient and the healthcare provider at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment that provide a two-way interactive video and audio. Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care. This consent to release and obtain information is valid until revoked. I understand that I may revoke the consent in writing at any time, except with regard to disclosures that have already been made in reliance on such consent.

Possible Risks:

There are potential risks associated with the use of telemedicine which include, but may not be limited to:

- A provider may determine that the telemedicine is not yielding enough information to make an appropriate clinical decision and stop the telehealth visit;
- Technology problems may delay medical evaluation and treatment for today's encounter;
- In very rare instances, security protocols could fail, causing a breach of privacy or personal medical information.

By signing this form, I, parent/guardian or student, understand the following:

1. The laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies my child will be disclosed to researchers or other entities without my consent.
2. I have the right to withdraw my consent to the use of telemedicine in the course of my child's care at any time, without affecting my child's right to future care or treatment.
3. If the provider believes my child would be better served by a traditional face -to-face encounter, they may, at any time stop the telehealth visit and schedule a face-to-face visit.
4. Although I may anticipate benefits from the use of telemedicine in my child's care, I understand that no results can be guaranteed or assured. I hereby release PCCEK School Based Clinic from liability due to unintentional breach of privacy of my child's medical information, and unintentional interruption or technical difficulties.

Consent to the Use of Telemedicine

I have the legal authority to consent for my child to receive Telemedicine treatment and services from PCCEK School Based Clinic. I have read and understand the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care.

I give PCCEK School Based Clinic permission to provide Telehealth services and perform necessary medical tests. I understand that some parts of a Telemedicine exam may involve physical tests conducted by the individuals at my child's location at the direction of the telemedicine consulting health care provider. I understand that video conferencing will not be the same as a direct patient care visit due to the fact that my child will not be in the same room as the health care provider. I understand the potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue my child's telemedicine visit if it is felt that the videoconferencing connections are not adequate for the situation.

A PCCEK employee will attempt to contact child's parent/legal guardian in order to receive verbal consent before telemedicine visit. If we are unable to reach you within 10 minutes, we will proceed to examine your child as deemed necessary.

Parent/Legal Guardian Signature: _____ Date: _____

PCCEK Staff Signature: _____ Date: _____

PCCEK HIPAA NOTICE OF PRIVACY PRACTICES

THIS FORM DOES NOT CONSTITUTE LEGAL ADVICE AND COVERS ONLY FEDERAL, NOT STATE, LAW

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This notice will take effect immediately and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice available upon re quest. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Carrie Campbell, RN. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

(a) Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and/or business operations. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. There may be a fee charged for copies, based upon the amount of information requested and the time required to locate and copy your health information. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

(b) Right to Request Restriction of PHI: You may request a restriction on our use and disclosure of PHI, but we are not required to agree to your request. The HITECH Act restricts provider's refusal of an individual's request not to disclose PHI in instances where the disclosure is to a health plan for purposes of carrying out payment or health operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a healthcare item or service for which out facility has been paid out of pocket in full.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. There may be a fee charged for copies, based upon the amount of information requested and the time required to locate and copy your health information. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (*Example: If you request information on May 15, 2004 the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information.
This request must be submitted in writing.

Breach Notification Requirements: Beginning September 23, 2009, in the event unsecured protected information about you is "breached" and the use of the information poses a significant risk of financial, reputable or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform the United States Department of Health & Human Services (HHS) and take any other steps required by law.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us, in writing, by requesting a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with HHS.

HOW TO CONTACT US: Practice Name: Primary Care Centers of Eastern Kentucky **Privacy Officer:** Carrie Campbell, RN
Ph: 606-439-1300 ext: 3410 **Address:** 101 Town & Country Ln Ste 100, Hazard KY 41701 **Fax:** 606-439-7684