MISSOURI DELTA
PHYSICIAN SERVICES

Dear New Patient,

Thank you for choosing Dr. Minni Malhotra with Missouri Delta Physician Services!

To save time during your first appointment, please print and complete the attached New Patient paperwork.

Along with completed paperwork, please remember to bring the following:

- Your insurance cards and photo identification (preferably driver's license).
- Any prescription medicines you are taking (in the original packaging).
- Any over-the-counter supplements.

The above items are ***REQUIRED*** to be seen by the medical provider. Not bringing the above listed may result in your appointment being rescheduled.

We look forward to meeting you. If you have any questions, please let us know!

Missouri Delta Physician Services

MISSOURI DELTA PHYSICIAN SERVICES
Minni Malhotra, M.D.

Family Medicine

1019 S. Main
Sikeston, MO 63801
(573) 472-7702
Fax: (573) 472-7719

PRE – VISIT QUESTIONNAIRE
FAMILY MEDICINE

Thank you for completing this form before your visit. It will allow your doctor to perform the most complete evaluation possible when you arrive for your appointment. Your time and effort is much appreciated.

1. **Date form completed:** ________/_______/________
   month day year

2. **Name of patient**: ____

3. **Home Address:** ____

   ____

4. **Phone**: (_____)____________________________

5. **Date of birth:** ________/_______/________
   month day year

6. **Sex**: ☐ Male ☐ Female

7. **Who filled out this form?** ☐ Self ☐ Other (please give name below)

   Name:_________________________________Phone number: (____) __________________

   If other person completed this form, what is the relationship of the person to the patient?

   ☐ Spouse ☐ Child ☐Friend ☐ Other (specify) ___________________________

8. **Who has been your primary care doctor?**

   Name: ____

   Address: ____

   ____

   Phone number: (_____)______________________

   Fax Number: (_____)______________________

9. **Do you plan to continue seeing the above listed primary care doctor?**

   ☐ Yes ☐ No ☐ Not sure

PAST MEDICAL HISTORY

10. Which medical conditions do you have now or have you had in the past?
Please check all that apply.

EYE & EAR
☐ Macular degeneration
☐ Cataracts
☐ Glaucoma
☐ Hearing loss/hearing aid
☐ Other (specify): ____________

HEART
☐ Heart attack, year: _________
☐ Heart failure
☐ High blood pressure
☐ Aortic stenosis
☐ Heart valve problem
☐ Angina
☐ High cholesterol
☐ Pacemaker
☐ Atrial fibrillation
☐ Irregular heartbeats (arrhythmias)
☐ Other (specify): ____________

GASTROINTESTINAL TRACT
☐ Heartburn/reflux/GERD
☐ Ulcers
☐ Irritable bowel
☐ Liver disease/cirrhosis
☐ Hepatitis
☐ Gallbladder disease
☐ Colon polyps
☐ Diverticulosis
☐ Bleeding problems
☐ Constipation
☐ Hemorrhoids
☐ Other (specify): ____________

LUNGS
☐ Asthma
☐ COPD/emphysema
☐ Bronchitis
☐ Recurrent pneumonias
☐ Other (specify): ____________

KIDNEY & URINARY TRACT
☐ Frequent bladder infections
☐ Kidney disease
☐ Enlarged prostate
☐ Urinary incontinence
☐ Kidney stones
☐ Other (specify): ____________

BONES & JOINTS
☐ Gout
☐ Lower back pain
☐ Osteoporosis
☐ Arthritis (indicate location):
- ☐ hip
- ☐ knee
- ☐ shoulder
- ☐ back
- ☐ hands

☐ Fractured bone (indicate location):
- ☐ hip
- ☐ spine
- ☐ wrist
- ☐ Other (specify):

☐ Other (specify): ____________

GLANDS

☐ Thyroid overactive (high)
☐ Thyroid underactive (low)
☐ Diabetes
☐ Other (specify): ___________

NERVOUS SYSTEM

☐ Dementia or Alzheimer's disease
☐ Parkinson's disease
☐ Stroke
☐ Epilepsy or seizures
☐ Neuropathy/nerve damage
☐ Depression
☐ Anxiety
☐ Other (specify): ___________

OTHER HEALTH PROBLEMS

☐ Thrombosis/blood clots: ☐ In the leg ☐ In the lung
☐ Syncope (loss of consciousness)
☐ Hernia
☐ Anemia
☐ Sexual function problems (specify): ________________________________
☐ Cancer: ☐ Breast ☐ Prostate ☐ Colon/Rectum ☐ Lung ☐ Skin ☐ Lymphatic
☐ Other (specify):________________________________

List Surgeries (Operations):

☐ Heart bypass Date: ____________
☐ Heart stent placement Date: ____________
☐ Heart valve replacement. ☐ Aortic ☐ Mitral ☐ Other:____________Date: _____________
☐ Pacemaker placement Date: ____________
☐ Defibrillator/ICD placement Date: ____________
☐ Tonsils removed Date: ____________
☐ Appendix removed Date: ____________
☐ Gallbladder removed Date: ____________
☐ Knee replacement Date: ____________
☐ Hysterectomy Date: ____________
☐ Hip repair due to hip fracture Date: ____________
☐ Hip replacement not due to hip fracture Date: ____________
☐ Cataract Date: ____________
☐ Other Surgeries: (Please list below.)

____ Date:____________
____ Date:____________
____ Date:____________
____ Date: ____________

11. List hospitalizations for the last 5 years.

Reason for hospitalization	Year

12. Do you have any drug allergies? ☐ Yes ☐ No
If yes, please list name of drug and specify reaction.

	Indicate Reaction			
Name of Drug	**Rash**	**Shortness of Breath**	**Nausea**	**Other (specify)**

13. List all medicines that you use. (Include all Prescription, Non-Prescription, and Natural Products)

Current Medication	What strength?	How do you use it? (How many? How many times a day?)
Example: Tylenol	500mg	1 pill 3x a day

14. SOCIAL HISTORY

1) With whom do you live?
Please check all that apply

☐ Alone
☐ Spouse or Partner
☐ Child
☐ Other family member (specify): ____________________
☐ Others, not family (specify): ____________________

2) Which of the following best describes your residence?

☐ Single-family house
☐ Condo
☐ Apartment
☐ Board & care/Assisted living
☐ Nursing home
☐ Other (specify): ____________

3) If living at a facility, please list name of person and the contact number for medical treatment orders:

Name:________________________________
Phone number: (______)_________________

4) You are presently:

☐ Single/Never married
☐ Married
☐ Divorced/Separated
☐ Widowed
☐ Living with significant other

5) How many children do you have?
Number:__________________
Are you in regular contact with your children? ☐ Yes ☐ No

6) How much school did you complete?

☐ Less than 8th grade
☐ Some high school
☐ High school graduate
☐ Some college
☐ College graduate
☐ Graduate school

7) You are presently (check one):

☐ Retired/Not working
☐ Working part-time
☐ Working full-time

8) List your principal occupation and any other significant past occupations.

1.____________________________
2.____________________________
3.____________________________
4.____________________________
5.____________________________

9. Who would you call if you were sick and needed help? (Check all that apply.)
☐ Spouse/Partner
☐ Son
☐ Daughter
☐ Friend
☐ Neighbor
☐ Other (specify): ___________

a) Please list name(s) and phone number(s):

Name:_________________________________Phone number: (_____)__________________

Name:_________________________________Phone number: (_____)__________________

Name:_________________________________Phone number: (_____)__________________

b) Do we have your permission to speak to the person(s) listed above on your behalf?

☐ Yes ☐ No

Do you employ someone to provide health related care or help you in your home?

☐ Yes ☐ No

If yes, please indicate the number of hours per day and days per week, your paid helper is available to you.

Hours per day	Days per week
List number of hours:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Is this sufficient to meet your needs? ☐ Yes ☐ No

Do you get help from family members or friends in your home? ☐ Yes ☐ No

If yes, please indicate the number of hours per day and days per week, your family member(s) or friend(s) are available to you.

Hours per day	Days per week
List number of hours:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Is this sufficient to meet your needs? ☐ Yes ☐ No

Do you provide care for a family member? ☐ Yes ☐ No

Do you drink alcohol, including beer and wine, or other alcohol (such as vodka, whiskey, gin)?

☐ Daily

☐ A few days a week (specify number of days:_______)

☐ Less than once a week

☐ Never

How much do you drink at a time? (One drink = 12 oz of beer or 8-9 of malt liquor or 5 oz of table wine or 1.5 oz of hard alcohol.)

☐ 1 drink

☐ 2 drinks

☐ 3 drinks

☐ 4 drinks

☐ 5 or more drinks (number:_________)

Has anyone ever been concerned about your drinking? ☐ Yes ☐ No

Have you ever smoked cigarettes? ☐ Yes ☐ No

If yes:

Do you currently smoke cigarettes?

☐ Yes – If yes, how many packs per day? ☐ ¼ ☐ ½ ☐ 1 ☐ 1½ ☐ 2+

☐ No – If no, when did you quit? Year: __________________

For how many years did you smoke? Number of years:_________

How many packs per day? ☐ ¼ ☐ ½ ☐ 1 ☐ 1½ ☐ 2+

15. FAMILY HISTORY

Have any members of your family had any of the following conditions?

(Check all that apply and indicate who had condition.)

☐ Dementia or Alzheimer's disease Family Member ________________________

☐ Heart disease Family Member ________________________

☐ Stroke Family Member ________________________

☐ Diabetes Family Member ________________________

☐ Depression Family Member ________________________

☐ Cancer: ☐ Breast ☐ Prostate ☐Colon/Rectum ☐ Lung ☐ Skin ☐Lymphatic

☐ Other (specify): ________________________________

Family Member _________________________

16. PLANNING FOR FUTURE HEALTH CARE

Do you have a medical Durable Power of Attorney for health care?

☐ Yes ☐ No If yes, please bring a copy.

Who should speak for you if you are unable to make health decisions?

Name:____Relationship:______________________

Phone number: (_______)____________

Do you have a living will/advanced directive/out of hospital DNR form/POLST (Physicians Orders for Life Sustaining Treatment)? ☐ Yes ☐ No If yes, please bring a copy.

17. GENERAL OUTLOOK

Task	No Help Needed	Help Needed	Who Helps?
Feeding yourself			
Getting from bed to chair			
Getting to the toilet			
Getting dressed			
Bathing or showering			
Walking across the room (includes using cane or walker)			
Using the telephone			
Taking your medicines			
Preparing meals			
Managing money (like keeping track of expenses or paying bills)			
Moderately strenuous housework such as doing the laundry			
Shopping for personal items like toiletries or medicines			
Shopping for groceries			
Driving			
Climbing a flight of stairs			
Getting to places beyond walking distance (e.g. by bus, taxi, or car)			

Compared to other people your age, how would you describe your health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

18. SAFETY ASSESSMENT

Do you have a driver's license? Yes ☐ No ☐

If yes, are you currently driving? Yes ☐ No ☐

Do you always wear a seatbelt when you ride in a car? Yes ☐ No ☐

Do you own any firearms? Yes ☐ No ☐

Are there firearms in your home? Yes ☐ No ☐

Do you have a history of wandering of getting lost while outside of the home? Yes ☐ No ☐

Do you use a walking aid such as a cane or a walker? Yes ☐ No ☐
If yes, which ones? ☐ Cane ☐ Walker? ☐ Wheelchair

Are you afraid of falling? Yes ☐ No ☐

Have you had a fall in the past year? Yes ☐ No ☐

If yes, please describe the circumstances surrounding the fall:

Did you trip over something?	Yes ☐ No ☐
Did you have lightheadedness or palpitation prior?	Yes ☐ No ☐
Did you lose consciousness?	Yes ☐ No ☐
Were you injured?	Yes ☐ No ☐
Did you need to see a doctor?	Yes ☐ No ☐
Were you able to get up by yourself?	Yes ☐ No ☐

19. HEALTH MAINTENANCE

Do you currently participate in any regular activity to improve or maintain your physical fitness? (either on your own or in a formal class) Yes ☐ No ☐

If yes, which ones:

- ☐ Bicycling or stationary bike
- ☐ Aerobics or exercises classes
- ☐ Dancing
- ☐ Jogging
- ☐ Walking
- ☐ Swimming
- ☐ Tennis
- ☐ Golf
- ☐ Bowling or bocce
- ☐ Yoga
- ☐ Pilates
- ☐ Other (specify): ___________________

Days per week	Amount of time per day (in minutes or hours)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7	

Dates of your last vaccinations:

Influenza	Year:	Reaction: ☐ Yes ☐ No
Pneumovax	Year:	Reaction: ☐ Yes ☐ No
Tetanus booster	Year:	Reaction: ☐ Yes ☐ No
Zoster (Shingles)	Year:	Reaction: ☐ Yes ☐ No

Screening tests:

Test	Date most recently done	Results (if relevant)
Eye examination		
Hearing test		
Cards to check for blood in your stool		
Sigmoidoscopy		
Colonoscopy		

For men only:

Test	Date most recently done	Results (if relevant)
Prostate examination (rectal examination)		
PSA blood test (prostate cancer screening)		
If you ever smoked: abdominal ultrasound to check for abdominal aorta aneurysm.		
If age 80 or older: bone density test (DXA scan) to check for osteoporosis.		

For women only:

Test	Date most recently done	Results (if relevant)
Mammogram		
Pap smear		
Bone density test (DXA scan) to check for osteoporosis		

20. During the LAST 3 MONTHS, have you had any of the following symptoms or problems?
(Please check all that apply):

General Problems
☐ Weight loss
☐ Weight gain
☐ Fevers
☐ Chills
☐ Sweats
☐ Change of appetite

Ear, Nose, Mouth, Throat
☐ Trouble hearing
☐ Sore throat
☐ Allergies
☐ Sinus problems
☐ Teeth problems
☐ Hoarseness

Lung Problems
☐ Persistent cough
☐ Coughing up blood
☐ Wheezing
☐ Difficulty breathing or shortness of breath

Heart Problems
☐ Chest pain or tightness
☐ Swelling of feet
☐ Irregular heart beat
☐ Rapid heart beat

Eyes
☐ Trouble seeing
☐ Eye pain
☐ Dry eyes

Digestive Problems

☐ Difficulty swallowing
☐ Abdominal pain
☐ Change in bowel habits
☐ Frequent indigestion or heartburn
☐ Frequent nausea or vomiting
☐ Persistent constipation
☐ Frequent diarrhea
☐ Bleeding from rectum
☐ Black bowel movement

Gynecology Problems

☐ Vaginal bleeding
☐ Breast lumps or discomfort
☐ Vaginal discharge

Kidney & Urinary Tract Problems

☐ Frequent urination
☐ Painful urination
☐ Difficulty starting or stopping urination
☐ Frequent urine infection
☐ Urination at night
If yes, how many times a night:__________
☐ Loss of urine or getting wet
If yes:
☐ Sudden urge to void
☐ Loss with cough or laughing
☐ Continuous leakage
☐ Hard to start urination
☐ Cannot empty bladder
☐ Problem getting to toilet

Bone and Joint Problems

☐ Leg pain on walking
☐ Back or neck pain
☐ Joint pain or stiffness
☐ Foot problems
☐ Falls

Brain and Nervous System Problems

☐ Frequent headaches
☐ Frequent dizzy spells
☐ Passing out or fainting
☐ Paralysis, leg or arm weakness
☐ Hallucinations
☐ Serious problem with memory or difficulty thinking
☐ Tremor or shaking
☐ Problems with sleep
☐ Numbness or loss of feeling

Mood/Sadness Problems

☐ Depression
☐ Anxiety
☐ Sleepiness
☐ Fatigue
☐ Lack of Sleep

SKIN PROBLEMS

☐ Rash
☐ Itching
☐ Sores
☐ Easy bruising

Miscellaneous

☐ Excessive thirst
☐ Feel too hot or too cold
☐ Problems with sexual function
☐ Bleeding problems

21. **Please list specific health concerns that you would like your doctor to know about before your visit.** Please be sure to include any information not already reported in this form.

1) ____
____
____

2) ____
____
____

3) ____
____
____

4) ____
____
____

Patient or Representative Signature ____

Date_______________Time _____________

If signed by someone other than the patient, please specify relationship to the patient: ___________

Interpreter Signature____

Date________________Time ________________

Physician Signature____ID # ___________

Date________________Time ________________

Phy.S-150-M Orig 4/24

MISSOURI DELTA
PHYSICIAN SERVICES

PATIENT INFORMATION

Date: _________________

Name: First_______________________________Middle_____________Last______________________________

DOB ___________ SSN__________________ Sex ________ Marital Status _____________ Race_____________

Mailing Address____

City ______________________________ State ____________ Zip ______________

Physical Address (*if different from above*) ____

Home Phone Number _____________________ Mobile Phone Number _____________________

Email Address (*required for access to your Patent Portal*) ____

Primary Care Provider ________________________ Preferred Pharmacy ___________________________

Circle one:

Employed Full-Time Employed Part-Time Unemployed Retired Disabled

Retired/Disabled Date: ___________

Employer ____ Phone________________________

Address ____

City_____________________________ State____________ Zip______________

Guarantor/Responsible Party (if not patient)

Note: The guarantor is always the patient, unless the patient is a minor or an incapacitated adult.

Name____ Relationship to patient _______________________

DOB______________ SSN _______________________ Phone__________________________

Address (if different from patient) ____

City_____________________________ State____________ Zip______________

Emergency Contact

(Spouse or Parent if Patient is a minor)

Name____ Relationship to patient _______________________

DOB______________ SSN _______________________ Phone__________________________

Address (if different from patient) ____

City _____________________________ State ____________ Zip ______________

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Effective 4–14–2003

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third–party payer can verify that services billed were actually provided
- tool in educating health professionals
- source of facts for medical research
- source of information for public health officials in charge of improving the health of the nation
- source of data for hospital planning and marketing
- tool to evaluate and continually work to improve the care we provide and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- make sure it is accurate
- better understand who, what, when, where, and why others may see your health information
- make more informed decisions when authorizing release of information to others

Your Health Information Rights

Although your health record is the physical property of the hospital or the healthcare provider who gathered it, the information belongs to you. You have the right to:

- provide a password for friends or family to use to receive information while you are a patient
- request a restriction on certain uses and releases of your information
  We reserve the right to determine if this is reasonable. We must notify you if we are unable to agree to a requested restriction.
- obtain a paper copy of the notice of information practices upon request (this information sheet)
- inspect and receive a copy of your health record in paper or electronic form
- request an amendment to your health record
  We reserve the right to determine if this is reasonable. If the request is granted, the original information will be kept in the chart and the amendment added.
- obtain an accounting of releases of your health information except for purposes of treatment, payment, hospital operations, and releases you have authorized. Disclosures that are reported as *required* (i.e. all births, deaths, tumors, communicable diseases, infections, newborn hearing screen, suspected abuse or neglect, Mid America Transplant for all deaths, or to the coroner will not be listed on the Disclosure Log.
- receive confidential communications of protected health information
- request communications of your health information by alternative means or at alternative locations
- cancel your authorization to use or release health information except to the extent that action has already been taken
- restrict disclosure to a health plan concerning treatment for which the individual has paid out of pocket in full

SUMMARY OF NOTICE OF PRIVACY PRACTICES

We have summarized the attached Notice of Privacy Practices on this first page. For a complete description of your rights and responsibilities, please review the entire notice.

This notice describes how information about you may be used and released and how you can get access to this information. Please review it carefully.

In regard to your health information, you have the right to:

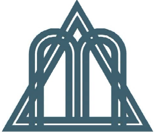
- Request a restriction on certain uses and releases of your health information
- Obtain a copy of this Notice
- Inspect and receive a copy of your health information
- Request that we amend your health information
- Know how we have used or disclosed your health information
- Receive confidential communication about your health information
- Request communication about your health information in alternative ways
- Cancel your authorization to release information

It is our responsibility to:

- Protect the privacy of your health information
- Provide you with this Notice of our Privacy Practices
- Abide by the terms of this Notice
- Accommodate reasonable requests.

We may make changes in our privacy practices based on laws and regulations. If we do change them, we will change this Notice and post the changes in our hospital and on our website.

If you have any questions and/or would like additional information, please contact the Privacy Officer at (573) 472–7595 or (573) 472–6021.



MISSOURI DELTA
MEDICAL CENTER

OUR RESPONSIBILITIES

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of the notice currently in effect
- accommodate reasonable requests you may have to communicate health information by alternative means, at alternative locations, or to alternative persons.
- determine the probability that a breach of unsecured information has been compromised
- notify you of a breach of unsecured information that has been compromised
- prohibit sale of information without your consent

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain.

We will not use or disclose your health information without your authorization, except as described in this notice.

Examples of release of information for Treatment, Payment and Health Operations

***We will use your health information for treatment*.**

For example: Information taken by a nurse, physician, or other member of your health care team will be documented in your record and used to decide the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a following health care provider with copies of various reports that should help him or her in treating you once you re discharged from this hospital.

We will use your health information for payment.

For example: A bill may be sent to you or a third–party payer such as Medicare, Medicaid, your insurance company, workman's compensation, etc. The information on, or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

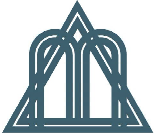
***We will use your health information for operations*.**

For example: Members of the Medical Staff, the Risk or Quality Management Director, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide. Also, the state, JCAHO, and auditors may see your information in the course of a survey for accreditation, licensure or audit of financial records.

Other Possible Uses and Releases of Health Information (These examples are not all inclusive.)

Health Information Exchange: We may make your protected health information available electronically through a secure health information exchange service to facilitate the exchange of your health information between and among other healthcare providers or other health care entities for your treatment, payment, or other healthcare operations purposes. This means we may share information we obtain or create about you with outside entities (such as hospitals, physician offices, pharmacies or insurance companies) or we may receive information they create or obtain about you (such as medication history, medical history, or other information) so each of us can provide better treatment and coordination of your healthcare services. You have the right to opt–out of participation in the Health Information Exchange.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include services in the radiology and laboratory departments. When these services are contracted, we may release your health information to our business associate so that they can perform the job we ve asked them to do and bill you or your third–party payer for services provided. To protect your health information, however, we require the business associate to appropriately safeguard your information.



OUR RESPONSIBILITIES

***Directory*:** Unless you notify us that you object, we will use your name, location in the facility, and general condition for directory purposes. This information may be released to people only who ask for you by name.
Your religious affiliation may be provided to members of the clergy.

***Notification*:** In an emergency, Health Care Professionals, using their best judgment, may release to a family member, relative, friend or any other person you identify, health information necessary for their involvement in your care or payment related to your care.

Also, we may contact you to provide appointment reminders

Funeral directors: We may release health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we will release health information to organ procurement organizations or other entities involved in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

***Food and Drug Administration (FDA)*:** We may release to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may release health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we will release your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may release to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may release health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Disaster relief purposes: We may use or release health information to a public or private party authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating the uses or releases described in *Notification* above. Privacy requirements apply to the extent that we may use professional judgment to determine they do not interfere with the ability to respond to the emergency circumstances.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Situations that require your authorization:

Communication: with other persons such as family members, friends, and clergy, except in emergencies as described above.

Marketing: to receive information about treatment alternatives or other health–related benefits and services that may be of interest to you.

Fund raising: to contact you as part of a fund–raising effort.

For More Information or to Report a Problem:
If you have questions and would like additional information, you may contact the Privacy Officer. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

MISSOURI DELTA
PHYSICIAN SERVICES

ACKNOWLEDGMENT: RECEIPT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have been provided with Missouri Delta Medical Center's Notice of Privacy Practices.

Patient or legal representative: ______________________________________

Patient's DOB: ______________

Date: __________________________________

□ Patient was unable /unwilling to sign acknowledgment.
Reason: ____
Staff initials: _____________
Date: ___________________
Time: ______________

Below is a list of people that may receive full disclosure of my medical information:

____

____

____

Copy of Notice was included in patient's Admission Information Packet