

New Patient

Change of Information

Date Replaced: _____

Patient Information

Patient Name _____ Social Security _____

Nickname / Other (i.e. Maiden Name) _____

Mailing Address _____

City _____ State _____ ZIP _____

Date of Birth _____ Marital Status: Single / Married / Partnered / Widowed / Separated / Divorced

Primary Physician _____ Referring Physician _____

Are you transferring care from another physician? No Yes – Name _____

I authorize Trinity Womens Care to contact me at the following telephone numbers, until I notify otherwise in writing:

<u>Telephone Number (Include Area Code)</u>	<u>Home</u>	<u>Cell</u>	<u>Work</u>	<u>Family</u>	<u>Other</u>	<u>A voice mail message can be left on this telephone:</u>
() _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
() _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
() _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

E-mail _____ Use only for general health bulletins, announcements
 Appointment reminders may also be sent here

Occupation _____ Employer _____

Name of School, If Student _____ Do you have a Living Will? Yes No

Designated Relative/Representative

I authorize discussion and release of my general medical condition and diagnosis (including treatment, payment, health care operations, or in case of emergency) with the following people, until I notify otherwise in writing:

<u>Name</u>	<u>Relationship</u>	<u>Phone</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Permission For Treatment

I voluntarily consent to medical care by Trinity Womens Care deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

HIPAA Privacy Notice

I acknowledge that I have received a copy of Trinity Womens Care's "Notice of Privacy Practices."

Signature _____ Date _____

Insurance Authorization and Assignment

Patient Name _____ Date of Birth _____

Please Check ONE:	<input type="checkbox"/> I have NO insurance coverage at this time	<input type="checkbox"/> I have listed below ALL insurance policies in effect that may cover services provided by Trinity Womens Care
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Insurance Company	Policy #	Group #	Are You The Primary Person On This Policy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Primary Insured, If Not Yourself		Relation To You	Date of Birth
			Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> MA <input type="checkbox"/> Supplement Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No
Insurance Company	Policy #	Group #	Are You The Primary Person On This Policy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Primary Insured, If Not Yourself		Relation To You	Date of Birth
			Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> MA <input type="checkbox"/> Supplement Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No
Insurance Company	Policy #	Group #	Are You The Primary Person On This Policy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Primary Insured, If Not Yourself		Relation To You	Date of Birth
			Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> MA <input type="checkbox"/> Supplement Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No

I authorize Trinity Womens Care to **release any information needed** in order to determine benefits or obtain payment. I also authorize direct payment of benefits to Trinity Womens Care from my insurance company for services rendered.

I understand that my insurance company **may not cover all services**, and ultimately I am financially responsible for payment for all services. I also understand that while Trinity Womens Care attempts to verify benefits under my insurance policy, it is my responsibility to be aware of what services are covered.

If my insurance company requires a **referral from my primary care physician**, I understand that it is my responsibility to have the referral sent to Trinity Womens Care prior to my appointment.

I acknowledge that it is my responsibility to notify Trinity Womens Care of any changes in my insurance coverage. If I do not provide insurance information before a service is provided to me, then Trinity Womens Care is not required to bill the insurance company for the service, and I will be responsible for payment.

Office Payment Policy

If I have **co-payments**, they must be paid at the time of each office visit. Any additional **deductible** or **coinsurance** determined by my insurance company is to be paid upon billing by Trinity Womens Care.

Any balance that remains unpaid will incur a **finance charge** of 1.5% per month. If my account is forwarded to a collection agency I will be charged with all costs associated with collection activity.

I understand that if a check written by me is returned for **insufficient or unavailable funds**, I will be charged the fee allowed by Florida statute, which currently range from \$25 to 5% of the check amount, whichever is greater.

I understand that I may make a written request to receive a **copy of my medical record**, which will be processed within the time frame allowed by law, and I will be charged the current price according to state law.

Patient Signature _____ **Date** _____

Other Responsible Party (Print Name) _____

(Signature) _____

(Relation To Insured) _____



[] New Patient [] Change of Information Date Replaced: _____

Patient Name _____ Date of Birth _____

Medical History

Age At First Period: _____ First Day of Last Menstrual Period: _____ Number of days between periods: _____ How long periods last: _____
 Total # of Pregnancies: _____ # of Live Births: _____ # of Miscarriages: _____ # of Terminations: _____ # of C-Sections: _____
 Date of First Pregnancy: _____ Date of Last Pregnancy: _____ Weight At Birth of Largest Baby: _____ Any Infertility Problems? _____
 Are You Currently Sexually Active? _____ Age At First Intercourse: _____ Total # of Partners: [] None [] One [] 2 to 4 [] 5 or more
 Present Method of Birth Control: _____ Long? _____ Change Desired? _____
 Types of Contraception Used Previously: _____
 Difficulties With Any Contraceptives: _____

Date of Last PAP: _____ Date of Last Mammogram: _____ Date of Last Bone Density Scan: _____ Date of Last Colonoscopy: _____

Height: _____ Usual Weight: _____ Any Significant Change In Weight? _____

Do you have now, or have you ever had:

	<u>Now</u>		<u>In The Past</u>			<u>Now</u>		<u>In The Past</u>	
Abnormal bleeding during periods:	Yes	No	Yes	No	Chlamydia:	Yes	No	Yes	No
Abnormal bleeding between periods:	Yes	No	Yes	No	Genital warts:	Yes	No	Yes	No
Abnormal bleeding after intercourse:	Yes	No	Yes	No	Gonorrhea:	Yes	No	Yes	No
Lower abdominal pain during periods:	Yes	No	Yes	No	Herpes virus:	Yes	No	Yes	No
Lower abdominal pain between periods:	Yes	No	Yes	No	Syphilis:	Yes	No	Yes	No
Heavy cramping during periods:	Yes	No	Yes	No	Known HIV exposure:	Yes	No	Yes	No
Pain / difficulty with intercourse:	Yes	No	Yes	No	Bladder infection:	Yes	No	Yes	No
Abnormal Pap smear:	Yes	No	Yes	No	Kidney infection:	Yes	No	Yes	No
Breast tenderness:	Yes	No	Yes	No	Vaginal discharge:	Yes	No	Yes	No
Breast lumps:	Yes	No	Yes	No	Vaginal irritation:	Yes	No	Yes	No
Breast discharge:	Yes	No	Yes	No	Vaginal dryness:	Yes	No	Yes	No
Heavy pressure in vagina:	Yes	No	Yes	No	Vaginal odor:	Yes	No	Yes	No
Pain / burning with urination:	Yes	No	Yes	No	Pelvic Inflammatory Disease:	Yes	No	Yes	No
Nighttime urination:	Yes	No	Yes	No	PMS:	Yes	No	Yes	No
Frequent urination:	Yes	No	Yes	No	Leaking urine:	Yes	No	Yes	No
Trouble emptying bladder:	Yes	No	Yes	No	Blood in urine:	Yes	No	Yes	No
Anemia:	Yes	No	Yes	No	Irritable Bowel Syndrome:	Yes	No	Yes	No
Blood clots:	Yes	No	Yes	No	Migraine headaches:	Yes	No	Yes	No
Blood transfusions:	Yes	No	Yes	No	Mitral valve prolapse:	Yes	No	Yes	No
Convulsions / Seizures:	Yes	No	Yes	No	Pneumonia:	Yes	No	Yes	No
Heart murmur:	Yes	No	Yes	No	Rheumatic Fever:	Yes	No	Yes	No
Hepatitis or Jaundice:	Yes	No	Yes	No	Stomach ulcers:	Yes	No	Yes	No
Gall bladder disease:	Yes	No	Yes	No	Tuberculosis:	Yes	No	Yes	No

Do you smoke? _____ How much? _____ Drink alcohol? _____ How much? _____ Drink caffeine? _____ How much? _____

Do you use any recreational drugs? _____ What types, and how often? _____

Do you get any form of regular exercise? _____ What types, and how often? _____

Have you been in a relationship in which you are being hurt or threatened, emotionally or physically? [] No [] Presently [] Past

List all surgeries and non-surgical hospitalizations other than pregnancy (include year): _____

Signature: _____ Date: _____

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Medical & Family History

Please mark all conditions that apply to you or your family members – include the family relationship and age at diagnosis in the appropriate column (or circle "None," if that applies).

		Yourself	Siblings / Children	Mother's Side	Father's Side
(For example: Diabetes)	None	30 yrs	Brother 36 yrs	Aunt 44 yrs Cousin 58 yrs	Grandfather 65 yrs
Alcoholism	None				
Arthritis	None				
Asthma	None				
Depression	None				
Diabetes	None				
Emphysema	None				
Heart Attack	None				
Heart Disease	None				
High Blood Pressure	None				
High Cholesterol	None				
Kidney Disease	None				
Lupus	None				
Obesity	None				
Osteoporosis	None				
Stroke	None				
Thyroid Disease	None				

Review of Systems - Please circle any problems you are currently having (or circle "None," if that applies).

- General:** None / fever / chills / fatigue / night sweats / insomnia / hot flashes
- Eyes:** None / vision changes / corrective lenses
- Ear, Nose & Throat:** None / headache / hearing loss / ulcers / sinusitis
- Cardiovascular:** None / swelling of ankles / chest pain / palpitations / dizzy spells / fainting / difficulty breathing while walking, laying flat
- Respiratory:** None / shortness of breath / wheezing / cough / coughing up blood
- Gastrointestinal:** None / constipation / diarrhea / bloody stool / nausea / vomiting / indigestion / fecal incontinence / flatulence / pain / problems swallowing
- Musculoskeletal:** None / muscle weakness / muscle pain / joint swelling / joint pain / back pain / limitations on physical activity
- Skin:** None / dry / rash / itch / ulcers / pigmented lesions / change in moles
- Neurologic:** None / fainting / numbness / severe memory problems / sleep problems / trouble walking / ringing in ears
- Psychiatric:** None / severe anxiety / severe sadness / crying spells / mood swings
- Endocrine:** None / hair loss / heat or cold intolerance / excessive sweating / excessive thirst
- Hematologic:** None / bleeding / bruising / swollen lymph nodes

Other medical conditions not listed elsewhere _____

Signature: _____ Date: _____

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date Completed: _____

Please mark below if there is a **personal or family history** of any of the following cancers. If yes, then indicate family relationship and **age at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	SIBLINGS/ CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
<i>For example:</i> Colorectal cancer		<i>Brother 36 yrs</i>	<i>Aunt 44 yrs Cousin 58 yrs</i>	<i>Grandfather 65 yrs</i>

BREAST AND OVARIAN CANCER

Breast cancer				
Ovarian cancer				
Breast cancer in both breasts OR multiple primary breast cancers				
Male breast cancer				
Are you of Ashkenazi Jewish descent?				

COLON AND UTERINE CANCER

Uterine (endometrial) cancer				
Colorectal cancer				
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer				
10 or more cumulative colon polyps				

MELANOMA

Melanoma				
Pancreatic cancer				

OTHER CANCER

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FOR OFFICE USE ONLY

- | | |
|--|--|
| <input type="checkbox"/> Patient appropriate for further risk assessment and/or genetic testing <ul style="list-style-type: none"> <input type="checkbox"/> BRACAnalysis® – A test for Hereditary Breast and Ovarian Cancer <input type="checkbox"/> COLARIS® – A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer) <input type="checkbox"/> COLARIS AP® – A test for Adenomatous Polyposis Syndromes <input type="checkbox"/> MELARIS® – A test for Hereditary Melanoma | <input type="checkbox"/> Discussed hereditary cancer risk with patient
<input type="checkbox"/> Patient offered genetic testing
<input type="checkbox"/> ACCEPTED <input type="checkbox"/> DECLINED
<input type="checkbox"/> Follow up appointment scheduled
Date: _____ |
|--|--|

Patient Name _____ Date of Birth _____

Our Appointment Policies...

Your appointment is the approximate time that has been reserved for your health care provider to meet with you, and not necessarily when you should plan to arrive at our office.

Please check in at our front desk 10 to 15 minutes prior to your appointment, to allow time for the following as needed:

- Updating information about yourself or emergency contacts
- Survey of changes in your health since your last visit with us
- Verification of any new insurance coverage
- Collecting copayment if required
- Recording vital signs

We appreciate that your time is valuable. However, since babies don't always arrive as expected, there may be occasional delays. Please feel free to call ahead on the day of your appointment to see if we are running on time.

If we need to adjust your appointment time due to an emergency, we will try to notify you as soon as we know. Please help us by making sure we have your current telephone numbers.

The length of time reserved for each appointment is determined by the primary reason for the visit. If you have several issues that need to be addressed, more than one visit may be scheduled. This allows us to help patients with urgent problems quickly, and also ensures that each of your concerns can be discussed thoroughly, with your health care provider's undivided attention.

If you are visiting multiple staff members on the same day (for example, the sonographer and a physician), we attempt to schedule the appointments with as little delay between them as possible. Sometimes, however, a brief wait is unavoidable.

Different providers have different appointment schedules. If it seems that patients are being called from the waiting area in a random fashion, please remember that they are not all here to see **your** provider. We take great care to ensure that patients who have arrived on time for their appointments are seen in the proper order.

If you arrive late, it may be necessary to reschedule your visit.

For the safety of your children (and to comply with insurance and state health regulations) they must be supervised at all times while in our office. This means that when you are in our lab area or an exam room, you will need a responsible person to remain with them in the waiting area. Our staff is not able to do this for you. In addition, please bring a car seat or stroller to provide safe seating for your infant.

We attempt to remind you by telephone one to two days prior to your scheduled visit, as a courtesy. This is not a guaranteed service, however, so we do advise all patients to note their appointments on their personal calendars.

I have read and understand the appointment policy of Trinity Womens Care.

Signature: _____ Date: _____

**UNIVERSAL PATIENT AUTHORIZATION FORM FOR
FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT & QUALITY OF CARE**

*****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW*****

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ State: _____ Zip: _____

You may use this form to allow your healthcare provider to see and obtain access to your health information. Your choice on whether to sign this form will not affect your ability to get medical care or health insurance coverage and cannot be used as the basis for denial of health services.

By signing this form, I voluntarily authorize and give my permission and allow disclosure:

OF WHAT: ALL MY HEALTH INFORMATION including any information about sensitive conditions (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: TRINITY WOMENS CARE Phone: (727) 372-0006

Address: 7633 CITA LANE STE 103, NEW PORT RICHEY FL 34653 Fax: (866) 372-4001

PURPOSE: To provide me with medical treatment and related services, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until the day I withdraw my permission.

WITHDRAWING MY PERMISSION: I can withdraw my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

X _____
Signature of Patient or Patient's Legal Representative

Date Signed (mm/dd/yyyy)

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

Parent of minor

Guardian

Other personal representative (explain: _____)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004

“Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care”

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

“Of What”: includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
 - a. Drug, alcohol, or substance abuse
 - b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes “psychotherapy notes” as defined in HIPAA at 45 CFR 164.501)
 - c. Sickle cell anemia
 - d. Birth control and family planning
 - e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
 - f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form.**

“From Whom” includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker’s compensation programs, state Medicaid, Medicare and any other governmental program.

“To Whom”: For those health care providers listed in the “TO WHOM” section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization’s facility or that person’s office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

“Purpose”: Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

“Withdrawal”: You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

“Re-disclosure of Information”: Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the “From Whom” or “To Whom” section to seek out the information you specified in the “Of What” section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

Note to recipient(s) of the information disclosed under this permission: *This information may have been disclosed to you from records protected by state and/or federal confidentiality rules (42 CFR Part 2 or 38 CFR Part 1). If so, the state and/or federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by state law and/or 42 CFR Part 2 (e.g., certain medical emergencies) or 38 CFR Part 1. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient or patient with sickle cell anemia or HIV infection.*

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under 45 CFR Parts 160 and 164 (“HIPAA”); Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009) §13405 (“HITECH Act”); 42 U.S. Code §290dd-2; 42 CFR Part 2; 38 U.S. Code section 7332; 38 CFR 1.475 (Veterans Affairs); 20 U.S. Code §1232g (“FERPA”); 34 CFR parts 99 and 300; Florida Statute 408.051(4) (“Universal Patient Authorization Form”); and all other Florida Statutes, the Florida Constitution, Florida regulations or administrative rules requiring patient authorization, consent or permission to release such records (including but not limited to Florida Statutes §456.057(7)(a), §395.3025(4), §394.4615(2)(a), §381.004, §397.501(7), §760.40(2), §392.65(1), §384.29(1), and §385.202(3)).

Notice of Privacy Practices for Protected Health Information (HIPAA)

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

As our patient, we want you to know that we respect the privacy of your personal medical data, and always strive to take reasonable precautions to secure and protect that privacy.

We are also required by law to maintain this privacy, to provide you a description of our privacy practices, and to abide by the terms of this notice.

Typical Uses and Disclosures of Medical Information

We may use your medical information for treatment and care; to bill and collect payment from you, insurers or third party payers; and for healthcare operations. Within our office we restrict the disclosure of this information to staff members who are involved in your care, or involved with insurance and billing. We may also have indirect treatment relationships with other entities involved in your care, such as laboratories, hospitals or other specialists, and may disclose Personal Health Information (PHI) in order to provide health care that is in your best interest.

We may also disclose PHI as required by law, including but not limited to:

- Public health agencies charged with controlling disease, injury or disability
- Appropriate law enforcement requests
- Coroners, medical examiners, funeral directors
- Correctional institutes
- Worker's compensation agents
- Health oversight agencies
- In response to a valid subpoena
- Organ and tissue donation organizations
- Military Command Authorities
- National security and intelligence agencies

Other uses or disclosures of your PHI not covered by this notice or the laws that apply to us will be made only with your written permission. Any written permission you provide may be revoked in writing at any time. Disclosures made while your permission was in effect can not be reversed.

You Have The Right To:

- Inspect and copy medical information from your record. You may be required to schedule an appointment for this purpose. You may pay the copy fee and receive a copy of your record.
- Request to amend information in your record that you feel is inaccurate or incomplete. If we deny your request, we must notify you of the reason.
- Request an accounting of any disclosures (other than for treatment, payment or healthcare operations purposes) made from your record over the last six years.
- Request restrictions on the amount of medical information we disclose. Your request may not supercede the typical disclosures listed above.
- Request that all communications from our office be confidential.

Your request to exercise any of these rights must be submitted in writing. Forms are available from our Privacy Officer.

Questions or complaints about our privacy policy or its execution may be submitted to our Privacy Officer, either in writing or verbally.

Our Privacy Officer can be reached at Trinity Women's Care, 7633 Cita Lane Suite 103, New Port Richey FL 34653. The telephone number is (727)372-0006.

You may also submit a written statement to the Secretary of Health and Human Services.

You have a right to receive a copy of this notice at any time, with an opportunity to review and understand it.

We reserve the right to make changes to this notice. The current notice will be posted in the office and include the effective date, and copies will be available for all patients.

Effective Date of Notice: June 2010