Patient Questionnaire

First Name:______________________ Middle Initial:______ Last Name:_______________________________

Date of Birth:_______________________ Age:_____________ Male ☐ Female ☐

Mailing Address:____

City:_____________________ State:______ Zip:____________ Home Phone:(   )__________________

Daytime Phone:(   )________________________ Mobile Phone:(   )__________________________

Email Address: ____

You will automatically be enrolled in our patient portal unless you indicate otherwise. ☐ I would like to opt out of Patient Portal

Appointment Reminders: ☐ Voice Calls ☐ Text Messages ☐ Both Voice & Text

Coming Soon! Please let us know how you would like to receive your appointment reminder calls. We can notify you by voice call, by text message (standard rates may apply) or both. Please indicate your preference above.

Social Sec. #:____ Married ☐ Single ☐ Widow ☐

Spouse's First Name:____ Middle Initial:______

Last Name:____________________________________ Daytime Phone:(   )_________________________

Emergency Contact and Relationship: ____

Emergency Phone:(   )__________________________ Referring Physician:________________________

Ethnicity:______________________________ Race:_________________ Language(s) Spoken:____________

Pharmacy Name:____

Pharmacy Address:____ Pharmacy Phone:________________

Prescription Benefit Plan:____

Primary Insurance Company:_________________________ Card Holder's Name:__________________________

ID:____________________ Group #:___________________ Patient's Relationship:______________________

Secondary Insurance Company:_______________________ Card Holder's Name:__________________________

ID:____________________ Group #:___________________ Patient's Relationship:______________________

Other Insurance Company:___________________________ Card Holder's Name:__________________________

ID:____________________ Group #:___________________ Patient's Relationship:______________________

Please list all doctors you see:

Doctor's Name	Type of Doctor	Reason for Seeing	PCP?
________________________	________________________	____________________________________	☐
________________________	________________________	____________________________________	☐
________________________	________________________	____________________________________	☐

Name:_____________________________________ **Date of Birth:**______________ **MR #**_____________

Briefly describe your reason for consulting a heart doctor today:

____

____

____

Current Allergies:

Do you have ALLERGIES TO IODINE, seafood, or radiographic contrast dye? ☐ YES ☐ NO

Please list any other allergies and describe the reaction:

Allergy to:	Reaction:

Current Medications: ♥ **Remember to bring all medications with you at time of appointment**

Please list all medication (prescription / non-prescription) that you are now taking or occasionally take:

Medication	Dosage	How often taken?	Who prescribed?

Review of Systems:

Instructions: Check yes or no to all of the following questions. If you answer yes, please explain on the right side of the page.

General:

Decreased exercise tolerance? ☐ YES ☐ NO ________________
Fatigue? ☐ YES ☐ NO ________________
Weight change? ☐ YES ☐ NO ________________
☐ Increase? ☐ Decrease?
Change in Appetite? ☐ YES ☐ NO ________________
☐ Increase? ☐ Decrease?

Integumentary (Skin):

Rash? ☐ YES ☐ NO ________________
Itching? ☐ YES ☐ NO ________________
Changes in hair? ☐ YES ☐ NO ________________
Changes in nails? ☐ YES ☐ NO ________________

Eyes:

Do you wear glasses/contact lenses? ☐ YES ☐ NO ________________
Do you have blurred vision? ☐ YES ☐ NO ________________
Do you experience double vision? ☐ YES ☐ NO ________________
Do you have a history of cataracts? ☐ YES ☐ NO ________________
Glaucoma? ☐ YES ☐ NO ________________

Ear, Nose, Mouth and Throat:

Do you have a hearing deficit? ☐ YES ☐ NO ________________
Do you wear dentures/braces? ☐ YES ☐ NO ________________
Chronic sinus problems? ☐ YES ☐ NO ________________
Do you have nose bleeds? ☐ YES ☐ NO ________________
Hoarseness/Change in voice? ☐ YES ☐ NO ________________

Respiratory:

Do you wheeze? ☐ YES ☐ NO ________________
Do you have chronic cough? ☐ YES ☐ NO ________________
Have you coughed up blood? ☐ YES ☐ NO ________________
Do you experience shortness of breath? ☐ YES ☐ NO ________________
☐ At rest? ☐ With activity?
Do you snore? ☐ YES ☐ NO ________________
Obstructive Sleep Apnea? ☐ YES ☐ NO ________________
C-PAP? ☐ YES ☐ NO ________________
Do you use Oxygen? ☐ YES ☐ NO ________________
☐ Continuous? ☐ As needed?
COPD? ☐ YES ☐ NO ________________

Cardiovascular:

Chest pain, pressure or tightness?	☐ YES	☐ NO	____
☐ At rest? ☐ With activity?			
Heart palpitations (racing)?	☐ YES	☐ NO	____
Irregular heartbeats?	☐ YES	☐ NO	____
Short of breath lying flat?	☐ YES	☐ NO	____
Waking up panicky, short of breath?	☐ YES	☐ NO	____
Have you passed out?	☐ YES	☐ NO	____
Swelling of feet or ankles?	☐ YES	☐ NO	____
Pain in legs with walking?	☐ YES	☐ NO	____
Atrial Fibrillation?	☐ YES	☐ NO	____

Gastrointestinal System:

Frequent nausea?	☐ YES	☐ NO	____
Frequent vomiting?	☐ YES	☐ NO	____
Abdominal pain?	☐ YES	☐ NO	____
Black, tarry stool?	☐ YES	☐ NO	____
Bright red blood in stool/Hemorrhoids?	☐ YES	☐ NO	____
History of stomach ulcers?	☐ YES	☐ NO	____
Frequent diarrhea?	☐ YES	☐ NO	____
History of gallbladder problems?	☐ YES	☐ NO	____
History of liver problems?	☐ YES	☐ NO	____
GI Bleed?	☐ YES	☐ NO	____

Genitourinary:

Do you have pain with urination?	☐ YES	☐ NO	____
Sense of urgency to urinate?	☐ YES	☐ NO	____
Awaken frequently to urinate?	☐ YES	☐ NO	____
History of bladder, kidney infection?	☐ YES	☐ NO	____
History of kidney stone?	☐ YES	☐ NO	____
History of Kidney Disease?	☐ YES	☐ NO	____
Birth Control Usage?	☐ YES	☐ NO	____
Currently Pregnant?	☐ YES	☐ NO	____
Males: Prostate problems?	☐ YES	☐ NO	____
Females: Post-menopausal?	☐ YES	☐ NO	____
Currently taking hormone replacement?	☐ YES	☐ NO	____

Musculoskeletal:

Chronic back pain?	☐ YES	☐ NO	____
Arthritis?	☐ YES	☐ NO	____
History of gout?	☐ YES	☐ NO	____
Joint pain or stiffness?	☐ YES	☐ NO	____
Muscle pain or cramps?	☐ YES	☐ NO	____
Muscle weakness?	☐ YES	☐ NO	____
History of blood clots in legs?	☐ YES	☐ NO	____
History of varicose veins?	☐ YES	☐ NO	____
History of Peripheral Vascular Disease?	☐ YES	☐ NO	____

Neurological:

Temporary blurred vision/loss of vision?	☐ YES	☐ NO	____________
Temporary weakness and/or tingling	☐ YES	☐ NO	____________
involving an arm or leg?	☐ YES	☐ NO	
Severe headaches?	☐ YES	☐ NO	____________
Migraine headaches?	☐ YES	☐ NO	____________
Convulsions/Seizures?	☐ YES	☐ NO	____________
History of Brain Bleed?	☐ YES	☐ NO	____________
History of Stroke?	☐ YES	☐ NO	____________

Psychiatric:

History of depression?	☐ YES	☐ NO	____________
Chronic Anxiety?	☐ YES	☐ NO	____________
Stress at work or home?	☐ YES	☐ NO	____________
History of drug or alcohol abuse?	☐ YES	☐ NO	____________
Trouble sleeping?	☐ YES	☐ NO	____________
Thoughts of suicide?	☐ YES	☐ NO	____________
If yes, Active Thoughts Now?	☐ YES	☐ NO	____________

Endocrine:

Fatigue?	☐ YES	☐ NO	____________
High cholesterol?	☐ YES	☐ NO	____________
Diabetes?	☐ YES	☐ NO	____________
Neuropathy?	☐ YES	☐ NO	____________
Thyroid problems?	☐ YES	☐ NO	____________

Hematological/Immunologic:

Chronic low blood count/anemia?	☐ YES	☐ NO	____________
Bleeding problems?	☐ YES	☐ NO	____________
Seasonal allergies?	☐ YES	☐ NO	____________
Food allergies?	☐ YES	☐ NO	____________

Other:

____________________ ____________

____________________ ____________

____________________ ____________

____________________ ____________

____________________ ____________

<u>Past Medical Illnesses:</u>

Please list any serious illness for which you have been hospitalized (except admissions just for surgery)

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

Past Medical History: Please check if you had any of the following problems in the past

- ☐ Abnormal EKG?
- ☐ Abnormal heart rhythms?
- ☐ Aneurysm?
- ☐ Blackouts or Fainting spells?
- ☐ Blood clots in lungs or legs?
- ☐ Blood clots in veins or legs?
- ☐ Cancer Type:________________
- ☐ Carotid Disease?
- ☐ Chest Pain, pressure, or tightness?
- ☐ Congestive Heart Failure?
- ☐ COPD?
- ☐ CVA / Stroke / TIA?
- ☐ Diabetes?
- ☐ Frequent dizzy spells?
- ☐ Heart Attack?
- ☐ Hepatitis?
- ☐ High blood pressure?
- ☐ History of HIV?
- ☐ Infection in the heart?
- ☐ Kidney Disease?
- ☐ Pain in the arms, throat, jaw or upper back?
- ☐ Palpitations, skips, or irregular heartbeat?
- ☐ Pulmonary Hypertension?
- ☐ Rheumatic Heart Disease?
- ☐ Other:____

Past Infectious History:

____ ____

____ ____

____ ____

Past Trauma History:

____ ____

____ ____

____ ____

Past Surgeries: Please provide the year for all that apply

Appendix	______________	Hernia	______________	Joint-*Shoulder*	______________
Breast biopsy	______________	Hysterectomy	______________	Mastectomy	______________
Carpal Tunnel	______________	Joint-*Hip*	______________	Prostate	______________
Gallbladder	______________	Joint–*Knee*	______________	Tonsillectomy	______________

Past Cardiac Procedures or Tests:	Date	Location	Physician
Ablation?	__________	______________________	__________________
Cardioversion?	__________	______________________	__________________
Echocardiogram?	__________	______________________	__________________
Electrophysiology Study?	__________	______________________	__________________
EKG?	__________	______________________	__________________
Heart Catheterization (dye test)	__________	______________________	__________________
Heart Surgery (bypass, valve replacement)?	__________	______________________	__________________
Holter Monitor?	__________	______________________	__________________
LVAD Device?	__________	______________________	__________________
Other blood vessel surgery?	__________	______________________	__________________
Pacemaker or AICD Implantation?	__________	______________________	__________________
Stress Test (Treadmill, etc.)?	__________	______________________	__________________
Watchman Device?	__________	______________________	__________________

Social History and Lifestyle:

Do you drink alcohol? ☐ YES ☐ NO

If YES, how many drinks on an average day? ______________________

Do you currently smoke? ☐ YES ☐ NO

Do you currently vape? ☐ YES ☐ NO

If YES, how much do you smoke? ______________________

How long have you been smoking? ______________________

How many packs a day did you smoke? ______________________

If you quit smoking, when did you quit? ______________________

How many years did you smoke before quitting? ______________________

Are you on a special diet? ☐ YES ☐ NO

If YES, what type of diet? ______________________

How many cups of caffeinated beverages do you drink on an average day? ______________

Do you exercise on a regular basis? ☐ YES ☐ NO

If YES, what type of exercising and how often? ______________________

Do you have a history of drug dependency? ☐ YES ☐ NO

If YES, what type of drug? ______________________

Are you currently a Medical Marijuana card holder? ☐ YES ☐ NO

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

What is your highest level of education? ______________________

Are you visually or hearing impaired and require the service of an interpreter? ☐ YES ☐ NO

Are you a non-English speaking person who requires an interpreter? ☐ YES ☐ NO

If you answered yes, what language do you speak? ______________________

Do you have difficulties learning? ☐ YES ☐ NO

How do you learn best? ☐ BY LISTENING ☐ VISUALLY ☐ BY TOUCH

Do you have a history of falling? ☐ YES ☐ NO

Do you fall frequently? ☐ YES ☐ NO

Are you currently on any medications that make you dizzy, lightheaded or cause you to fall? ☐ YES ☐ NO

If YES, what type of medications? ______________________________

Occupation:______________________________ Hours Worked per Week:________

Do you live: ☐ Alone ☐ With Spouse ☐ With Children ☐ Other

Religion:____

Place of Birth:____

Patient Choices:

Do you have a living will and/or durable power of attorney for your healthcare needs? ☐ YES ☐ NO
If yes, please bring that document with you to your visit.

If no, would you like more information on this subject? ☐ YES ☐ NO

Family History:

Please list any brothers, sisters, parents, or children who have had heart attack, stroke, angioplasty, heart disease, cardiac arrest, blackout spells, hypertension, or sudden cardiac death?

Relationship:____________________ Condition: ____________________ at what age: Deceased: Y N

Relationship:____________________ Condition: ____________________ at what age: Deceased: Y N

Relationship:____________________ Condition: ____________________ at what age: Deceased: Y N

Consent and Approval:

By providing my landline, cell number and/or email address, I expressly consent to receiving communications from CHI St. Vincent Heart Clinic Arkansas, it's staff, or its contractors, including collection agents, to any landline, cell number, email, or other electronic communication I provide or that you later acquire for me. SVHCA may use this information to contact me live or leave voicemail, text, email or pre-recorded messages regarding my account(s) and/or healthcare service(s) provided to me. SVHCA may use an auto dialer to deliver messages to me. Providing you with my contact information is not a condition of receiving healthcare services.

A copy of this form shall have the same force and effect as the original. The undersigned is the patient or is duly authorized to act on behalf of the patient to sign for the patient and accept the terms written above. A signed copy of these forms is available upon request.

Patient/Responsible Party Signature:____ Date: _________________

Print Name:____

If signed by other than patient, indicate relationship:____

Witness:____ Date: _________________

Thank you. Again, please be sure to bring all your medicines to each visit with us.

Sale of Health Information. CHI St. Vincent will obtain your authorization for any disclosure of your health information which CHI St. Vincent directly or indirectly receives remuneration in exchange for the health information.

THIS NOTICE DOES NOT APPLY TO THE FOLLOWING HEALTH RELATED ACTIVITIES

Some activities of CHI St. Vincent may not be covered by this notice. If you seek services at wellness or health fairs, for occupational health services, employee health related services, or direct access lab services this notice and its components do not apply.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding your health information:

Right to Inspect and Copy. You have the right to inspect your health information and receive a copy of medical, billing, or other records that may be used to make decisions about your care. The right to inspect and receive a copy may not apply to psychotherapy notes that are maintained separately from your health information.

Your request to inspect and receive a copy of your health information must be submitted in writing. We may charge a fee for document requests to cover the costs of copying, mailing, or other supplies. You have the right to request your health information in electronic format. CHI St. Vincent will provide your health information in the form and format you request, if feasible, or in a mutually agreeable form and format.

In limited circumstances we may deny your request to inspect or receive a copy of your health information. If we deny your request we will notify you of the reason. If you are denied access to your health information, you may request that the denial be reviewed. A licensed health care professional chosen by CHI St. Vincent will review your request and the denial. The person who conducts the review will not be the same person who denied your request. We will comply with the outcome of the review.

Right to Amend. You have the right to request an amendment to your health information that you believe is incorrect or incomplete.

Submit your request in writing, including your reason for the amendment, using our "Request for Amendment to PHI" form and send to the custodian of the record or Health Information Management, CHI St. Vincent, Two St. Vincent Circle, Little Rock, Arkansas 72205, 501-552-3000.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that:

- Was not created by CHI St. Vincent unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for CHI St. Vincent;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. We are required to maintain a list of certain disclosures of your health information. However, we are not required to maintain a list of disclosures that we made by acting upon your written authorizations. You have the right to request an accounting of disclosures that are not subject to your written authorization.

Submit your request in writing using our "Request for Accounting of Disclosures of PHI" form and send to the custodian of the record or Health Information Management, CHI St. Vincent, Two St. Vincent Circle, Little Rock, Arkansas 72205, 501-552-3000. Your request must state a time period, not longer than six years from the date of request. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on how much of your health information we use or disclose for treatment, payment, or health care operations. You also have the right to request a restriction on the disclosure of your health information to someone who is involved in your care or payment for your care, such as a family member or friend.

We are not required to agree to your request. However, if we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

You have the right to request to restrict the disclosure of your information to a health plan regarding a specific health care item or service that you, or someone on your behalf (other than a health plan), has paid for in full. We are required to comply with your request for this specific type of restriction. For example, if you sought counseling services and paid in full for the services rather than submitting the expenses to a health plan, you may request that your health information related to the counseling services not be disclosed to your health plan.

Submit your request in writing or request and submit a "Request for Restrictions to Use or Disclose Protected Health Information" form and send to the custodian of the record or Health Information Management, CHI St. Vincent, Two St. Vincent Circle, Little Rock, Arkansas 72205, 501-552-3000. You must include: a description of the information that you want to restrict, whether you want to restrict our use or disclosure or both; and to whom you want the restriction to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health care matters in a certain way or at a certain location. For example, you can ask that we only contact you at an alternative location from your home address, such as work, or only contact you by mail instead of by phone. Your request must specify how or where you wish to be contacted. We do not require a reason for the request. We will accommodate all reasonable requests.

Right to Receive Notice of a Privacy Breach. You have the right to receive written notification if CHI St. Vincent discovers a breach of unsecured protected health information involving your health information. Breach means the unauthorized acquisition, access, use, or disclosure of protected health information which compromises the security or privacy of the information. The Notice will include a description of the breach, health information involved, steps we have taken to mitigate the breach, and actions that you may need to take in response to the breach.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. If you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.
To ask questions about any of these rights, or to obtain a paper copy of this notice, contact CHI St. Vincent Privacy Officer at Two St. Vincent Circle, Little Rock, Arkansas 72205, 501-552-3000. Or, you may obtain a copy of this notice at our Web site, http://www.chistvincent.com/.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you and for any information we may receive in the future. We will post a copy of the current notice in the facility and on our web site (if applicable) at http://www.chistvincent.com/. The notice will contain the effective date. Upon your initial registration or admittance to the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the notice currently in effect. Whenever the notice is revised, it will be available to you upon request.

COMPLAINTS

You may file a complaint with us or with the Secretary of the Department of Health and Human Services if you believe that we have not complied with our privacy practices.

You may file a complaint with us by contacting the CHI St. Vincent Privacy Officer at Two St. Vincent Circle, Little Rock, Arkansas 72205, 501-552-3000.

If you file a complaint, we will not take any action against you or change our treatment of you in any way.

If you have any questions about this notice please contact the CHI St. Vincent Privacy Officer Two St. Vincent Circle • Little Rock, Arkansas 72205 501-552-3000.

SVHS 5889 (1014)

Notice of Privacy Practices

DEFINITIONS

Notice of Privacy Practices (The Notice) – a written notice in compliance with the requirements of Health Insurance Portability and Accountability Act (HIPAA), and the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009, made available from CHI St. Vincent to an individual or the individual's personal representative at the first delivery of service, or at the individual's next visit following a revision to the Notice, that describes the uses and disclosures of protected health information that may be made by CHI St. Vincent and the individual's rights and CHI St. Vincent's legal duties with respect to protected health information.

Protected Health Information (PHI) – individually identifiable health information that is transmitted or maintained in any form or medium, including electronic media. Protected health information does not include employment records held by CHI St. Vincent in its role as an employer.

CHI St. Vincent, an affiliate member of Catholic Health Initiatives (CHI), and other affiliated members of CHI participate in an Organized Health Care Arrangement (OHCA) in order to share health information to manage joint operational activities. A complete list of CHI affiliated members is available at **www.catholichealthinitiatives.org** by clicking on "Locations". A paper copy is available upon request. The CHI OHCA may use and disclose your health information to provide treatment, payment, or health care operations for the affiliated members and includes activities such as integrated information system management, health information exchange, financial and billing services, insurance, quality improvement, and risk management activities.

CHI St. Vincent including CHI St. Vincent Infirmary, CHI St. Vincent North, CHI St. Vincent Morrilton, CHI St. Vincent Hot Springs, affiliated hospitals, affiliated physician practices, and affiliated clinics participates in an OHCA to manage their joint operating activities similar to the CHI OHCA. The CHI St. Vincent OHCA may use and disclose your health information to provide treatment, payment, or health care operations for the affiliated members and includes activities such as integrated information system management, health information exchange, financial and billing services, insurance, quality improvement, and risk management activities.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

For Treatment. We will use your health information to provide you with health care treatment and to coordinate or manage services with other health care providers, including third parties. We may disclose all or any portion of your health information to your attending physician, consulting physician(s), nurses, technicians, health profession students, or other facility or health care personnel who have a legitimate need for such information in order to take care of you. Different departments of the facility will share your health information in order to coordinate the health care services you need, such as prescriptions, lab work and X-rays. We may disclose your health information to family members or friends, guardians or personal representatives who are involved with your health care. We may also use and disclose your health information to contact you for appointment reminders and to provide you with information about possible treatment options or alternatives and other health-related benefits and services. We also may disclose your health information to people outside the facility who may be involved in your health care after you leave the facility, such as other physicians involved in your care, specialty hospitals, skilled nursing care facilities, and other healthcare-related services. We may use and disclose your health information to prescription networks to obtain your prescription benefits from payers, to obtain your medication history from different health care providers in the community such as pharmacies, and to send your prescriptions electronically to your pharmacy.

For Payment. We will use and disclose your health information for activities that are necessary to receive payment for our services, such as determining insurance coverage, billing, payment and collection, claims management, and medical data processing. For example, we may tell your health plan about a treatment you are planning in order to receive approval or to determine whether your plan will pay for the proposed treatment. We may disclose your health information to other health care providers so they can receive payment for health care services that they provided to you, such as your personal physician, and other physicians involved in your health care such as an anesthesiologist, pathologist, radiologist, or emergency physician, and ambulance services. We may also give information to other third parties or individuals who are responsible for payment for your health care, such as the named insured under the health policy who will receive an explanation of benefits (EOB) for all beneficiaries who are covered under the insured's plan.

For Health Care Operations. We may use and disclose your health information for routine facility operations, such as business planning and development, quality review of services provided, internal auditing, accreditation, certification, licensing or credentialing activities (including the licensing or credentialing activities of health care professionals), medical research and education for staff and students, assessing your satisfaction with our services, and to other healthcare entities that have a relationship with you and need the information for operational purposes. We may use and disclose your health information to the external agencies responsible for oversight of health care activities such as The Joint Commission, external quality assurance and peer review organizations, and credentialing organizations. We may also disclose health information to business associates we have contracted with to perform services for or on our behalf such as patient satisfaction survey organizations. We may also disclose your health information to medical device manufacturers or pharmaceutical companies in order for those companies to carry out their legal obligations to state and federal agencies.

CHI Health Information Exchange. CHI St. Vincent, as a member of the CHI OHCA, participates in the CHI Health Information Exchange (HIE). Your health information is maintained electronically and healthcare providers, employed, under contract, or otherwise associated with CHI St. Vincent, and the CHI OHCA members may access, use, and disclose your health information for treatment, payment, and healthcare operations.

Arkansas Health Alliance for Records Exchange (SHARE) is Arkansas' statewide Health Information Exchange (HIE) that is overseen by the Arkansas Office of Health Information Technology (OHIT). To the extent that CHI St. Vincent participates with SHARE and as permitted by law, your health information may be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may 'opt-out' and prevent sharing of your health information through SHARE, by calling them at 501-410-1999, or completing and submitting an 'opt-out' form to your healthcare provider.

Facility Directory. The facility directory is available so that your family, friends, and clergy can visit you in the hospital and generally know how you are doing. We may include your name, location in the facility, your general condition (for example, fair or stable), and your religious affiliation in the facility directory. The directory information, except for your religious affiliation, may be released to people who ask for you by name. Your name and religious affiliation may be given to a member of the clergy such as a priest or rabbi, even if they don't ask for you by name. You must notify Bed Control, CHI St. Vincent, Two St. Vincent Circle, Little Rock, Arkansas 72205, 501-552-3000, verbally or in writing if you do not want us to release information about you in the facility directory. If you do not want information released in the facility directory, we cannot tell members of the public such as flower or other delivery services or friends and family that you are here or about your general condition.

Future Communications. We may provide communications to you with newsletters or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our facility is participating.

Fundraising Activities. We may use your health information, or disclose your health information to a foundation related to us for CHI St. Vincent's fundraising efforts. These funds would be used to expand and improve services and programs we provide to the community. We would only release information such as your name, address, other contact information, age, gender, dates of birth, health insurance status, dates you received treatment or services from us, the department of service and the outcome of those services. You have a right to opt out of receiving such communications. To opt out of these communications, contact CHI St. Vincent Foundation, Two St. Vincent Circle, Little Rock, Arkansas 72205, 501-552-3000.

Research. We may use and disclose your health information to researchers either when you authorize the use and disclosure of your health information, or an Institutional Review Board and/or Privacy Board approves an authorization waiver for the use and disclosure of your health information for a research study. A waiver may allow a researcher to use or disclose your health information to prepare for research, to screen and identify participants for inclusion in a research study, or to conduct research on a decedent's information.

Organ and Tissue Donation. If you are an organ donor, we may release your health information to organizations that handle organ procurement and transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

USES & DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

Subject to requirements of federal, state and local laws, we are either required or permitted to report your health information for various purposes. Some of these reporting requirements and permissions include:

Public Health Activities. We may disclose your health information to public health officials for activities such as for the prevention or control of communicable disease, bioterrorism, injury, or disability; to report births and deaths; to report suspected child, elder, or spouse abuse or neglect; to report reactions to medications or problems with medical products; to report information to the federal Centers for Disease Control or to authorized national or state cancer registries for their data aggregation.

Disaster Relief Efforts. We may disclose your health information to an entity assisting in a disaster relief effort, such as the American Red Cross, so that your family can be notified about your condition and location.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. Such agencies include federal Centers for Medicare and Medicaid Services, and state health professional oversight agencies or boards such as state medical or nursing boards. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor activities such as health care treatment and spending, government programs, and compliance with civil rights laws.

Judicial or Administrative Proceeding. We may disclose your health information in response to a legal court or administrative order, a subpoena, discovery request, civil or criminal proceedings, or other lawful process.

Law Enforcement. We may release your health information if asked to do so by a law enforcement official or if we have a legal obligation to notify the appropriate law enforcement or other agencies:

- In response to a court order, subpoena, warrant, summons or similar legal process;
- Regarding a victim or death of a victim of a crime in limited circumstances;
- In emergency circumstances to report a crime, the location or victims of a crime, or the identity, description or location of a person who is alleged to have committed a crime, including crimes that may occur at our facility, such as theft, drug diversion, or attempts to obtain drugs illegally.

Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or a medical examiner. This may be necessary to identify a person who died or to determine the cause of death. We may release health information to help a funeral director to carry out his/her duties.

Workers' Compensation. We may release your health information for workers compensation benefits or similar programs that provide benefits for work-related injuries or illnesses if you tell us that workers' compensation is the payer for your visit(s). Your employer or their workers' compensation carrier may request the entire medical record pertinent to your workers' compensation claim. This medical record may include details regarding your health history, current medications you are taking, and treatments.

To Avert a Serious Threat to Health or Safety. We may disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public.

National Security. We may disclose your health information to federal official(s) for national security activities and for the protection of the President and other Heads of State.

Military and Veterans. If you are a member of the armed forces, we may release your health information as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Inmates. If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may release your health information to the institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

OTHER USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Other uses and disclosures of your health information not covered by this notice or the laws that apply to CHI St. Vincent will be made only with your written authorization. If you provide us with authorization to use or disclose your health information, you may revoke that authorization in writing at any time. When we receive your written revocation we will no longer use or disclose your health information for the purpose of that authorization. However, we are unable to retrieve any disclosures already made based on your prior authorization.

CHI St. Vincent will obtain your authorization to use and disclose your health information for these specific purposes when required by law and regulation:

Marketing. Marketing is a communication about a product or service that you may be interested in purchasing. If CHI St. Vincent receives payments from a third party in order for CHI St. Vincent to promote the product or service to you, then CHI St. Vincent is required to obtain your written authorization before we can use or disclose your health information. CHI St. Vincent is not required to obtain your authorization to discuss with you CHI St. Vincent health care treatment options, health-related products, case management or care coordination, or to direct or recommend alternative treatments, therapies, providers, or settings of care, providing face to face discussions and offering samples or promotional gifts of nominal value.

You have the right to revoke your marketing authorization and CHI St. Vincent will honor the revocation. To opt out of these communications, please contact CHI St. Vincent Marketing Department, Two St. Vincent Circle, Little Rock, Arkansas 72205, 501-552-3000.

Psychotherapy notes. Psychotherapy notes are notes by a mental health professional that document or analyze the contents of a conversation during a private counseling session or a group, joint, or family counseling session. If psychotherapy notes are maintained separate from the rest of your health information they may not be used or disclosed without your written authorization, except as may be required by law.

Sensitive Medical Information. We may obtain a separate authorization from you, when required by specific state and federal laws, to use or disclose sensitive medical information, such as psychiatric, substance abuse, infectious disease, or genetic testing information.