****You MUST arrive 30 minutes prior to your appointment time, or you WILL BE RESCHEDULED****

DOCU FAMILY MEDICINE CENTER

340 Eisenhower Drive Suite 910
Savannah, GA 31406
Phone: 912-354-3363
Fax: 912-354-3332
https://www.docufamilymedicine.com/

PATIENT REGISTRATION FORM

Patient's Last Name: First: MI:			Former Name:	DOB:	Sex:
Marital Status (circle one) Single Married Div. Separated Widow	Spouse Name and Number:		**Social Security No:**		
Mailing Address:		Primary Phone:		Additional Phone:	
City:	State:	Zip:	Email Address:		
Employment Status: □ *Full-time* □ *Part-time*	Employer:		How did you hear about us?		
Ethnicity: ☐ ***Hispanic/Latino*** ☐ ***Not Hispanic/***	**Race:** ☐ ***White*** ☐ ***Black*** ☐ ***Asian*** ☐ ***Hispanic*** ☐ ***Pac Islander*** ☐ ***Other:*** _____				

IN CASE OF EMERGENCY

Name:	Relationship:	Phone:

GRANT ACCESS TO YOUR MEDICAL INFORMATION

You may discuss my health information with the following people (caregivers, family members, etc.)

Name	Date of Birth	Phone Number	Relationship

INSURANCE INFORMATION

(Please present insurance cards to the receptionist)

Primary Insurance Company:	**Member ID:**	Patient's relationship to subscriber: ☐*Self* ☐*Spouse* ☐*Child* ☐*Other:* _____
Policy Holder's Name:	Birth Date:	Policy Holder's Social Security Number(if not self):
Secondary Insurance Company:	**Member ID:**	Patient's relationship to subscriber: ☐*Self* ☐*Spouse* ☐*Child* ☐*Other:* _____
Policy Holder's Name:	Birth Date:	Policy Holder's Social Security Number(if not self):

SIGNATURE

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I also Authorize Docu Family Medicine Center to release any information required to process my claims. I have also reviewed and received a copy of the Practice Policies, Notice of Privacy Practices and Authorization & Assignment of Benefits.

Patient or Guardian Signature: _____ **Date**: _____

Patient Health History

Previous Primary Care Physician:_____Date of Last Physical Exam: _____

Main Issues/Reason for appointment (List by importance to you)
1.)
2.)
3.)

MEDICAL HISTORY/ILLNESSES/OPERATIONS	DATE DIAGNOSED	PHYSICIAN/SPECIALIST TREATING

☐ NO PAST MEDICAL ILLNESSES/OPERATIONS

Current Medications & Vitamins	Dose	Times/Day

☐ NOT CURRENTLY TAKING ANY MEDICATION

Allergies (Medication or Substance)	Type of Reaction

☐NO KNOWN ALLERGIES

PREFERRED PHARMACY
Name:
Address/Location:

Patient Initials:_____ DOB:_____

FAMILY HISTORY						
Relation	**Age**	**Healthy?**	**Age of Death**	**Cause of Death**	Check if any of your blood relatives had any of the following: **Disease**	**Relationship**
Father						
Mother					High Blood Pressure	
Sister					Diabetes	
Sister					Stroke	
Brother					Cancer	
Brother					Psychiatric Problems	

Total number of siblings (living and deceased): Brothers: _____ Sisters_____

HEALTH MAINTAINANCE: When did you last have the following:							
Tetanus Shot		COVID19 Vaccine		Eye Exam		Mammogram	
Pneumovax		Colon Exam		Cholesterol		Prostate Exam	
Hepatitis Vaccine		Bone Density		EKG		Hemoccult Test	

SOCIAL HISTORY		
MARITAL STATUS: ☐Married ☐Single ☐Divorced ☐Widowed	**EDUCATION LEVEL COMPLETED:** ☐High School ☐College ☐Professional School ☐Other: _____	**OCCUPATION:** ☐Retired ☐Student ☐Business Owner ☐ Full Time ☐ Part Time ☐Other: _____
LIVING ARRANGEMENT: ☐Alone ☐ Family ☐Significate Other ☐Roommate		DO YOU HAVE CHILDREN? ☐ Yes ☐ No How many? Males: _____ Females: _____
Do you smoke cigarettes/cigars? ☐ Yes ☐ No If yes how many? _____# years _____ packs per day		
Do you drink alcohol? ☐ Yes ☐ No How many drinks per day? _____ How many days per week? _____		

Authorization for Use/Disclosure of Health Information

Name: _____ **Date of Birth:**_____

I voluntarily authorize and direct my health care provider, ***Docu Family Medical Center***, to obtain my personal health record from the provider or entity listed below.

☒ **OBTAIN FROM:**	**SEND RECORDS TO:**
_____ Name of Entity or Physician	**DOCU FAMILY MEDICINE CENTER** 340 Eisenhower Drive Suite 910 Savannah, GA 31406 Phone: (912) 354-3363 Fax: (912) 354-3332
_____ Address	
_____ City, State, Zip	(It is important that you submit the requested health information **as soon as possible** for proper medical treatment)
_____ Phone and **Fax Number**	

Information to be Released: *(Check all that apply)*

□ ALL/Entire Record □ Lab Results □ Nursing Notes □ Demographics

□ Emergency Room □ Radiology Results □ Physician Orders

□ Dictated Reports (H&P, Discharge Summary, OP Note, Consults, Test Results, etc.)

□ Medication Administration Record

For dates of service rendered _____ through _____
For the purpose of: _____

I understand that I can revoke this authorization by providing written notice to DOCU FAMILY MEDICINE CENTER at the address listed above or in a manner described in the Notice of Privacy Rights. I also understand that if information has been released by relying upon this Authorization, that revocation will not be valid.
I PLACE NO LIMITATIONS ON HISTORY OR ILLNESS OR DIAGNOSTIC AND THERAPUTIC INFORMATION, INCLUDING ANY TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, PSYCHIATRIC OR PSYCHOLOGICAL ILLNESS, MENTAL ILLNESS, OR RETARDATION AND ACQUIRED IMMUNE DEFFICIENCY (AIDS) SYNDROME.
The Entity listed above may not condition treatment, payment, on the signing of this authorization unless allowed by law.
I understand that I am waiving my rights to privacy by releasing my medical information to the parties listed above and this information may be re-disclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above.
I understand that this Release of Information will expire within **ninety (90) days** from the date listed below.

Patient or Guardian Signature: _____ **Date:** _____

Relationship to Patient: _____

Keep this packet for your records

PRACTICE POLICIES

*Upon arrival to EVERY appointment, patients must have their current insurance cards, photo ID, and payment for copay and/or balance. We also ask that you bring all current medications in their bottles.

Late Appointment/Cancellation Policy:
All appointments must be cancelled or rescheduled at least 24 hours prior to appointment.

- ***Missed office visit*: *$35 Fee***
- ***Missed imaging appointment: $100+ Fee***

(All no-show fees must be paid in full prior to being seen again. After two no-shows, the patient will be discharged from the practice.)

We ask patients to be on time to their scheduled appointments. Any patient that is more than 15 minutes late to their appointment will be asked to reschedule their appointment to a later date and time.

Prescription Refill Policy:
For all prescription refill requests, patients must call their pharmacy and have them fax a refill request. Refill requests will be assessed within 24-48 hours, excluding holidays and weekends. We ask that patients refrain from calling our office multiple times regarding refills. We will notify you as soon as your refill request has been assessed. For controlled medication refills, patients must be seen for an appointment. NO EXCEPTIONS.

Some insurance companies require prior authorization for certain medications which can take 5-10 business days to complete. Once the insurance company has authorized a prescription to be filled, our office will contact you and your pharmacy.

Controlled Substances Policy:
Docu Family Medicine Center is not a pain management clinic. If the reason for your visit is chronic pain or pain related, Dr. Docu will refer you to a physician that specializes in pain management.

Please be advised that if you misrepresent the purpose for your appointment, Dr. Docu reserves the right conclude the visit immediately and you will be discharged from the practice. There will be no reimbursement of payment.

Insurance Policy:
Prior to your appointment, you must verify that Dr. Docu is a listed provider with your insurance plan and that he is the listed PCP on your card, if one is required. Failure to do so will result in your appointment being rescheduled.
It is the patient's responsibility to know what benefits are covered under their insurance plan. The patient will be held financially responsible for any and all non-covered services.

Payment Policy:
Payment for copays and/or account balances must be paid upon arrival to your appointment. If you do not have this payment, your appointment will be rescheduled. A $37.00 fee will be applied for any returned checks or insufficient funds.

Account balances that are 90 days delinquent will be subject to a service charge and will be added to the amount due. Patient is responsible to pay balance in full including finance fee prior to making another appointment.

Docu Family Medicine Center

Authorization & Assignment of Benefits

Consent to Treat

The term "health care provider(s)" in this document means Docu Family Medicine Center, its agent and employees, members of the medical staff, their agents and employees, and other health care practitioners who provide care to patients.

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plan for care including future treatments. I understand that this information serves as:

1. Basic for planning my treatment and care.
2. Information used to file my claim with the insurance company (procedure and diagnosis).
3. Means by which a third-party payer can verify that billed services were actually provided.
4. A tool for routine health care operations including assessing quality and reviewing competency of your staff and/or other health care providers.

I understand that I have been provided with the Notice of Information Practices that provides more complete information of uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand that the organization reserves the right to change their notice and practices and before implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to restrict how my health information may be used or disclosed to carry out payment, treatment, or health care operations and that the organization is not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that the organization has already taken action on my behalf.

Permission is hereby granted to all health care providers involved with my care to administer such examination, treatment, testing, and procedures as are deemed necessary in the course of my care.

Financial Responsibility/Assignment of Benefits

For those health care providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those health care providers who have rendered services to me and who accept such assignment. I agree to pay all charges that are not paid in full by assigned insurance. If such amounts due to the health care providers are not paid after reasonable notice, that account shall be deemed delinquent and a service charge shall be added to the amount due. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default.

Medicare Lifetime Beneficiary Claim Authorization and Release of Information

I request that payment of authorized medical benefits be made either to me or on my behalf to Docu Family Medicine Center for any services furnished me by the physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for related services.

I understand my signature requests that payment be made, and I authorize release of medical information necessary to pay the claim. If other health insurance is indicated on item 9 of the CMS-1500 claim form or elsewhere on the approved claim form or electronically submitted claim, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Docu Family Medicine Center

NOTICE OF PRIVACY PRACTICES

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

Effective Date: 08/01/2013

If you have questions about this notice, please contact Docu Family Medicine Center's Privacy Officer at (912)354-3363.

WHO WILL FOLLOW THIS NOTICE

This notice describes the practices of:

- Docu Family Medicine Center.
- Any health care professional authorized to enter information into your medical record maintained by Docu Family Medicine Center.
- Any persons or companies with whom Docu Family Medicine Center does business, i.e., "Business Associates."
- All these persons, entities, sites, and locations follow the terms of this notice. In addition, these persons, entities, sites, and locations may share medical information with each other for treatment, payment, or health care operations purposes and other purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive from Docu Family Medicine Center. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care and billing for that care that are generated or maintained by Docu Family Medicine Center, whether made by Docu Family Medicine Center personnel or other health care providers. Other health care providers may have different policies or notices about confidentiality and disclosure that apply to your medical information that is created in their offices or at locations other than Docu Family Medicine Center.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices of Docu Family Medicine Center, and your legal rights, with respect to medical information about you
- Follow the terms of the notice that is currently in effect

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of these categories.

- **For Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, volunteers, or other personnel who are involved in taking care of you at Docu Family Medicine Center. For example, a doctor treating you for a broken hip may need to know if you have diabetes because diabetes may slow the healing process. We also may disclose medical information about you to people outside Docu Family Medicine Center who may be involved in your medical care after you have been treated by Docu Family Medicine Center, such as friends, family members, or employees or medical staff members of any hospital or skilled nursing facility to which you are transferred or subsequently admitted.
- **For Payment**. We may use and disclose medical information about you so that the treatment and services you receive from Docu Family Medicine Center may be billed by Docu Family Medicine Center and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about treatment you received from Docu Family Medicine Center so your health plan will pay us or reimburse you for the treatment. We also may disclose information about you to another health care provider, such as a hospital or skilled nursing facility to which you are admitted, for their billing activities concerning you.
- **For Health Care Operations**. We and our business associates may use and disclose medical information about you for health care operations. These uses, and disclosure are necessary to operate Docu Family Medicine Center and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services Docu Family Medicine Center should offer, and what services are not needed. We may also disclose information to doctors, nurses, technicians, and other personnel affiliated with Docu Family Medicine Center for review and learning purposes. We may also combine the medical information we have with medical information from other health care providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information, so others may use it to study health care and health care delivery without learning the identities of specific patients.

- **Treatment Alternatives**. We may use and disclose medical information to tell you about or recommend different ways to treat you.
- **Individuals Involved in Your Care or Payment for Your Care**. We may release medical information about you to a friend or family member who is involved in your medical care. This would include persons named in any durable health care power of attorney or similar document provided to us. We may also give information to someone who helps pay for some or all of your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. You can object to these releases by telling us that you do not wish any or all individuals involved in your care to receive this information. If you are not present or cannot agree or object, we will use our professional judgment to decide whether it is in your best interest to release relevant information to someone who is involved in your care or to an entity assisting in a disaster relief effort.
- **As Required or Permitted by Law**. We may disclose medical information about you when required or permitted to do so by federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you when it appears necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone who appears able to help prevent the threat and will be limited to the information needed.

SPECIAL SITUATIONS

- **Organ and Tissue Donation**. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.
- **Active Duty Military Personnel and Veterans**. If you are an active duty member of the armed forces or Coast Guard, we must give certain information about you to your commanding officer or other command authority so that your fitness for duty or for a particular mission may be determined. We may also release medical information about foreign military personnel to the appropriate foreign military authority. We may use and disclose to components of the Department of Veterans Affairs medical information about you to determine whether you are eligible for certain benefits.
- **Workers' Compensation**. In accordance with state law, we may release without your consent medical information about your treatment for a work-related injury or illness or for which you claim workers' compensation through your employer, insurer, or care manager paying for that treatment under a workers' compensation program that provides benefits for work-related injuries or illness.
- **Public Health Risks**. We may disclose, without your consent, medical information about you for public health activities. These activities generally include but are not limited to the following:
  - To report, prevent, or control disease, injury, or disability
  - To report births and deaths
  - To report reactions to medications or problems with products
  - To notify people of recalls of products they may be using
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
  - To report suspected abuse or neglect as required by law
- **Health Oversight Activities**. We may disclose, without your consent, medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. The government uses these activities to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we must disclose medical information about you in response to a court or administrative order. We also may disclose medical information about you in response to a subpoena or other lawful process from someone involved in a civil dispute.
- **Law Enforcement**. We may release, without your consent, medical information to a law enforcement official:
  - In response to a court order, warrant, summons, grand jury demand, or similar process
  - To comply with mandatory reporting requirements for violent injuries, such as gunshot wounds, stab wounds, and poisonings
  - In response to a request from law enforcement for certain information to help locate a fugitive, material witness, suspect, or missing person
  - To report a death or injury we believe may be the result of criminal conduct
  - To report suspected criminal conduct committed at Docu Family Medicine Center facilities
- **Coroners and Medical Examiners**. We may release, without your consent, medical information to a coroner or medical examiner. This may be done, for example, to identify a deceased person or determine the cause of death. We may also release medical information about deceased patients of Docu Family Medicine Center to funeral directors to carry out their duties.
- **National Security and Intelligence Activities**. We may release, without your consent, medical information about you as required by applicable law to authorized federal or state officials for intelligence, counterintelligence, or other governmental activities prescribed by law to protect our national security.

- **Protective Services for the President and Others**. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.
- **Psychotherapy Notes**. Regardless of the other parts of this Notice, psychotherapy notes will not be disclosed outside Docu Family Medicine Center except as authorized by you in writing or pursuant to a court order, or as required by law. Psychotherapy notes about you will not be disclosed to personnel working within Docu Family Medicine Center, except for training purposes or to defend a legal action brought against Docu Family Medicine Center, unless you have properly authorized such disclosure in writing.
- **Inmates**. If you are an inmate of a correctional institution or in the custody of law enforcement, we may release medical information about you to the correctional institution or law enforcement official who has custody of you, if the correctional institution or law enforcement official represents to Docu Family Medicine Center that such medical information is necessary: (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) to protect the safety and security of officers, employees, or others at the correctional institution or involved in transporting you; (4) for law enforcement to maintain safety and good order at the correctional institution; or (5) to obtain payment for services provided to you. If you are in the custody of the Georgia Department of Corrections (DOC) and the DOC requests your medical records, we are required to provide the DOC with access to your records.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy**. You have the right to inspect and receive a copy of your medical records, unless your attending physician determines that information in those records, if disclosed to you, would be harmful to your mental or physical health. If we deny your request to inspect and receive a copy of your medical information on this basis, you may request that the denial be reviewed. Another licensed health care professional chosen by Docu Family Medicine Center will review your request and the denial. The person conducting the review will not be the person who denied your request. We will do what this reviewer decides. Your medical information is contained in records that are the property of Docu Family Medicine Center. To inspect or receive a copy of medical information that may be used to make decisions about you, you must submit your request in writing to Docu Family Medicine Center's Privacy Officer. If you request the copy of the information, **we may charge a fee** for the costs of copying, mailing, or other supplies associated with your request, and we may collect the fee before providing the copy to you. If you agree, we may provide you with a summary of the information instead of providing you with access to it, or with an explanation of the information instead of a copy. Before providing you with such a summary or explanation, we first will obtain your agreement to pay and will collect the fees, if any, for preparing the summary or explanation.
- **Right to Amend**. If you feel that medical information we have about you in your record is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Docu Family Medicine Center.

To request an amendment, make your request in writing to Docu Family Medicine Center's Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request for amendment of information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the medical information created or maintained by Docu Family Medicine Center
- Is not part of the information that you would be permitted to inspect and copy
- Has been determined to be accurate and complete

If we deny your request for an amendment, you may submit a written statement of disagreement and ask that it be included in your medical record.

- **Right to an Accounting of Disclosures**. You have the right to request a list of certain disclosures we have made of medical information about you during the past six years.

To request this list or accounting of disclosures, submit your request in writing to Docu Family Medicine Center's Privacy Officer and state whether you want the list delivered on paper or electronically. Your requested time period may not be longer than six years. 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 at that time before any costs are incurred. We may collect the fee before providing the list to you.

- **Right to Request Restrictions**. Except where we are required to disclose the information by law, you have the right to request a restriction or limitation on the medical information we use or disclose about you. For example, you could revoke any and all authorizations you previously gave us relating to disclosure of your medical information.

We are not required to agree to your request, with the exception of restrictions on disclosures to your health plan, as described below. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions, make your request in writing to Docu Family Medicine Center's Privacy Officer. In your request, you must tell us

(1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

You may request that we do not disclose your medical information to your health insurance plan for some or all of the services you receive during a visit to any Docu Family Medicine Center location. If you pay the charges for those services you do not want disclosed **in full at the time of such service**, we are required to agree to your request. "In full" means the amount we charge for the service, not your copay, coinsurance, or deductible responsibility when your insurer pays for your care. Please note that once information about a service has been submitted to your health plan, we cannot agree to your request. If you think you may wish to restrict the disclosure of your medical information for a certain service, please let us know as early in your visit as possible.

- **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, or at another mailing address other than your home address. We will accommodate all reasonable requests. We will not ask you the reason for your request. To request confidential communications, make your request in writing to the Privacy Officer and specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice or any revised notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a copy of this notice, request a copy from Docu Family Medicine Center's Privacy Officer in writing.

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 medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at Docu Family Medicine Center's office. The notice will contain the effective date on the first page, in the top right-hand corner. If the notice changes, a copy will be available to you upon request.

INVESTIGATIONS OF BREACH OF PRIVACY

We will investigate any discovered unauthorized use or disclosure of your medical information to determine if it constitutes a breach of the federal privacy or security regulations addressing such information. If we determine that such a breach has occurred, we will provide you with notice of the breach and advise you what we intend to do to mitigate the damage (if any) caused by the breach, and about the steps you should take to protect yourself from potential harm resulting from the breach.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Docu Family Medicine Center or with the Secretary of the United Stated Department of Health and Human Services. To file a complaint with Docu Family Medicine Center, contact the Privacy Officer by mail at 4849 Paulsen St. Ste 314, Savannah, GA 31405. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice may be made only with your written authorization or as required by law. If you authorize us to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. Your revocation will be effective as of the end of the day on which you provide it in writing to Docu Family Medicine Center's Privacy Officer. If you revoke your permission, we will no longer use or disclose medical information about you for the purposes that you previously had authorized in writing. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.