STANISLAUS SURGICAL HOSPITAL
1421 OAKDALE ROAD MODESTO, CA 95355 | 209.572.2700

**Registration Packet Instructions**

Please complete the below in addition to the highlighted areas in the attached documents. By providing an e-mail address, the patient will have access to view their medical record online.

E-mail: _____ Social Security Number: __ __ __ - __ __ - __ __ __ __

Primary Physician: _____ Employer: _____

Disclosure of Physician Ownership and Disclosure of Emergency Response

This is a non-emergency facility owned by a group of shareholders. In the event of an emergency, the physician would take care of immediate medical needs and then transfer the patient to a local hospital.

Conditions of Admission

This allows the physician to perform the procedure and allows the hospital to bill your insurance. Sections #7 and #9 will be discussed with an Admitting Representative.

Notice of Privacy Practices (HIPAA)

This explains how patient information is used and disclosed. The hospital strives to keep patient medical information private.

Authorization for Release of Health Information (*endoscopy patients only*)

This authorizes the nurse to go over the Discharge Instructions with the person that is designated to take the patient home.

Rights to Receive Visitors (*inpatients only*)

This explains the right to receive two (2) visitors, after the procedure, when the patient is roomed. *No visitor under the age of 13 will be permitted.*

**Please have identification card, insurance card, and form of payment readily available when called.**

*This page to be shredded after use*

STANISLAUS SURGICAL HOSPITAL
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# Patient Post Procedure Contact Information

Today's contact person: _____

Relationship to patient: _____

Will they be waiting for the patient? ☐ Yes ☐ No

**Contact:**

Cell Phone (  ) _____

Home Phone (  ) _____

Work Phone (  ) _____

Name _____ Identification# _____

Date of Birth _____ Date of Surgery _____

Physician _____

version5-5-08

# COVID-19 Screening Questionnaire

Visitor/Ride/Vendor Name: _____

Patient Name: _____ DOS: _____

**Please circle YES or NO to the following questions:**

1. In the past, have you been diagnosed with/or had a positive COVID-19 lab test? If yes, when? _____*(If >4 weeks it is appropriate to proceed)*

   Yes No

2. In the last 14 days, have you had close contact with someone diagnosed with COVID-19?

   Yes No

3. Within the last **7** days have you experienced any of the following *new or worsening symptoms*? Circle all that apply. Yes No

| | | |
|---|---|---|
| Fever | Headache | Sore throat |
| Chills | Nausea | Runny nose |
| Cough | Vomiting | Congestion |
| Body aches | Diarrhea | Breathing problems |
| Loss of taste or smell | | |

**A "yes" answer to any of these questions it is considered a "Hard Stop". The individual is directed to wait and notify one of the following:**

- Lisa Hinds, IP ext. 2602 or 559-799-7926
- Dawn Giles ext. 2502
- Tanya Beard ext. 2518
- Pre-op ext. 2598

_____

_____

_____

_____

Completed by: _____ Date: _____

*SHEMS Revised 12.16.2022*

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Name: _____ DOB _____ Age ____
Acct.# _____ MR # _____ Gender __ Stay Type: __ Svc Code: ___
Admitting Physician _____ Admission Date: _____ Surgery Date: _____

## Conditions of Admission

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES** The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment services, and which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or hospital services rendered the patient under the general and special instruction of the patient's physician or surgeon.

   ☐ By checking this box, the undersigned acknowledges receipt of the hospital's Patients' Rights.

2. **NURSING CARE** This hospital provides only general duty nursing care unless, upon orders of the patient's physician, the patient is provided more intensive nursing care. If the patient's condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged by the patient or his/her legal representative. The hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

3. **LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIAN** All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist and the like, are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered the patient under the general and special instructions of the physician.

4. **INFORMATION PRIVACY** I acknowledge receipt of Stanislaus Surgical Hospital's notice of Privacy and Information Practices. We (and or Medical Staff) will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. I am automatically included in the Facility Directory that allows Stanislaus Surgical Hospital to relay my location and general condition if asked for by name. If I do not want to be included in this directory, I will designate that below. If I opt out of this directory, I understand that if my family members, my clergy, neighbors, or friends inquire about me while I am a patient, my presence here will not be disclosed, and that mail or flowers addressed to me will be returned.

   ☐ I understand placing an "X" in this field signifies that I do NOT want to be part of the facility directory and my presence here will be kept confidential to the fullest extent of the hospital's ability to comply with my request.

5. **HEALTH CARE SERVICE PLAN OBLIGATION** This hospital maintains a list of the health care service plan with which it has contracted. A list of such plans is available upon request from the financial office. The hospital has no contract, express of implies, with any plan that does not appear on the list.

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Name: _____ DOB _____ Age ____
Acct.# _____ MR # _____ Gender __ Stay Type: __ Svc Code: ___
Admitting Physician _____ Admission Date: _____ Surgery Date: _____

## Conditions of Admission

6. **FINANCIAL AGREEMENT** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she individually obligates himself/herself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. Court costs including the court filing fee, service fee and e-file fee for summons & complaints, garnishments and transcripts in addition to reasonable attorney fees will be the responsibility of the adult person(s) named on the account. A collection agency fee of 25 percent will also be added to all balances if turned to collections. All delinquent accounts shall bear interest at the legal rate. In the event there is any excess proceeds or monies remaining or credited to my account after the payment in full of the charges for the services rendered for this hospitalization, then, in that event, I hereby authorize Stanislaus Surgical Hospital to apply said excess to any outstanding accounts I have with Stanislaus Surgical Hospital for services rendered of whatever nature or whenever incurred.

7. **PLEASE READ AND RESPOND TO THE STATEMENTS REGARDING ADVANCE DIRECTIVES (I.E. DURABLE POWER OF ATTORNEY FOR HEALTH CARE OR DECLARATION TO PHYSICIAN.)**

   O Yes O No I have received the information about "Your Right to Make Decisions about Medical Treatment" and the information about "What is an Advanced Directive".

   O Yes O No Do you have an advance directive for health care (i.e. Durable Power of Attorney for Health Care or Declaration?)

   O Yes O No Has SSH received a current copy of your advance directive this admission?
   If "No", I understand it is my responsibility to present a current copy of my advance directive on each admission.

8. **ASSIGNMENT OF INSURANCE BENEFITS** The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the hospital and/or anesthesiologist/physician of any insurance benefits otherwise payable to or on behalf of the undersigned for this hospitalization or for these patient services, including emergency services if rendered, at a rate not to exceed the hospital's regular charges. It is agreed that payment to the hospital, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood that he/she is financially responsible for charges not covered by this assignment.

9. **PERSONAL VALUABLES** It is understood that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, furs, fur coats and fur garments or other articles of unusual value and small size, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The liability of the hospital for loss of any personal property which is deposited with the hospital for safekeeping is limited by statue of five hundred dollars ($500.00) unless written receipt for a greater amount has been obtained from the hospital by the patient.

   I have explained this personal valuables policy to the patient _____ Clerk.

   INITIALS

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Name: _____ DOB _____ Age ____
Acct.# _____ MR # _____ Gender __ Stay Type: __ Svc Code: ___
Admitting Physician _____ Admission Date: _____ Surgery Date: _____

## Conditions of Admission

I do not wish to deposit any items for safekeeping Patient/Patient's Representative.
INITIALS

Valuables may only be retrieved Monday through Friday from 8:00 am to 4:30 pm (Not on holidays)

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, RECEIVED A COPY THEREOF, AND IS THE PATIENT, THE PATIENT'S LEGAL REPRESENTATIVE, OR IS DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.

**DATE:** _____ **TIME:** _____

**SIGNATURE:**
(PATIENT/PARENT/GUARDIAN/CONSERVATOR)

**RELATIONSHIP TO PATIENT** _____

**WITNESS:** _____

STANISLAUS SURGICAL HOSPITAL
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# NOTICE TO PATIENTS

As a prospective patient of **Stanislaus Surgical Hospital**, we are pleased to inform you of the following:

## DISCLOSURE OF PHYSICIAN OWNERSHIP

1. **Stanislaus Surgical Hospital** is partly owned by physicians and meets the federal definition of a physician owned hospital as specified in 42 CFR 489.3. A list of the Hospital's physician owners and the names of any immediate family members of a physician who have any ownership or investment interest in the Hospital is posted in the lobby or available upon request.
2. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than **Stanislaus Surgical Hospital.**
3. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

## DISCLOSURE OF EMERGENCY RESPONSE PLAN

1. Stanislaus Surgical Hospital has arranged for one or more physicians to be available to respond to medical emergencies during all hours of operation. However, we cannot guarantee that a physician will be present at the Hospital at all times. The Hospital has taken certain measures to ensure that qualified and properly trained medical personnel are available to respond to any medical emergency that may arise when a physician is not present at the Hospital.
2. In the event of a medical emergency, we notify your physician and provide all necessary medical care:
   Should your physician determine that you should be transferred to another hospital, he will explain to you and your family the reason for the transfer. Stanislaus Surgical Hospital will coordinate the transfer to a nearby hospital.
   Stanislaus Surgical Hospital has a Transfer Agreement in place with Sutter Gould Memorial Hospital Modesto, Doctors Medical Center Modesto, and Emanuel Hospital in Turlock.
   A full report of your medical condition will be communicated to the receiving hospital staff, along with copies of your electronic health record (EHR).
3. If you would like additional information about Stanislaus Surgical Hospital's capabilities for handling medical emergencies, please call 209-232-2502.
4. **If you have any questions regarding the information contained in this Notice to Patients, please feel free to ask your physician or a representative of Stanislaus Surgical Hospital. We welcome you as a patient and value our relationship with you.**

_____ _____

*Please Check*: ☐ **Patient** ☐ **Patient Representative Signature** **Date**

_____ _____

**Witness** **Date**

# Notice of Privacy Practices

## ACKNOWLEDGMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Stanislaus Surgical Hospital. Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by: contacting our organization at 209-572-2700.

If you have any questions about our *Notice of Privacy,* please contact our Privacy Officer at the number above.

I acknowledge receipt of the *Notice of Privacy Practices* of Stanislaus Surgical Hospital:

**Date:** _____ **Time:** ____

**Signature:**
(Patient of Legal Representative)

If singed by someone other than patient, list relationship _____

**Legal Representative:** _____

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Name: _____ DOB _____ Age ____
Acct.# _____ MR # _____ Gender __ Stay Type: __ Svc Code: ___
Admitting Physician _____ Date of Service: _____



## INABILITY TO OBTAIN ACKNOWLEDGMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's *Acknowledgment,* describe the good faith efforts made to obtain their *Acknowledgment,* and the reasons why the Acknowledgment was not obtained.

**Patient Name** _____

Reasons why the acknowledgment was not obtained:

☐ Patient refused to sign this Acknowledgment even though the patient was asked to do so and the patient was given the Notice of Privacy Practices

Other: _____

**Date:** _____ **Time:** ____

**Signature:**

(Provider Representative)

**Provider Representative Name:** _____

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Name: _____ DOB _____ Age ____
Acct.# _____ MR # _____ Gender __ Stay Type: __ Svc Code: ___
Admitting Physician _____ Date of Service: _____

## HIPAA Notice of Privacy Practices
## (Effective Date: January 2018)

### WHO WILL FOLLOW THIS NOTICE

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

**If you have any questions about this notice, please contact the Privacy Officer at 209-572-2700**

* Any health care professional authorized to enter information into your hospital chart.
* All departments and units of the hospital.
* Any member of a volunteer group we allow to help you while you are in the hospital.
* All employees, staff and other hospital personnel.

### 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 at the hospital. 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 generated by the hospital, whether made by hospital personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.
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 medical information.

We are required by law to:

* Make sure that medical information that identifies you is kept private (with certain exceptions);
* Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
* 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 the categories.

#### DISCLOSURE AT YOUR REQUEST

We may disclose information when requested by you. This disclosure at your request may require a written authorization by you.

#### 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, health care students, or other hospital personnel who are involved in taking care of you at the hospital. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietician if you have diabetes so that we can arrange for appropriate meals. Different departments of the hospital also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the hospital who may be involved in your medical care after you leave the hospital, such as skilled nursing facilities, home health agencies, and physicians or other practitioners. For example, we may give your physician access to your health information to assist your physician in treating you.

#### FOR PAYMENT

We may use and disclose medical information about you so that the treatment and services you receive at the hospital be billed to 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 surgery you received at the hospital so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

We may also provide basic information about you and your health plan, insurance company or other source of payment to practitioner outside the hospital who are involved in your care, to assist them in obtaining payment for services they provide to you.

**FOR HEALTH CARE OPERATIONS**
We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the hospital 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 hospital patients to decide what additional services the hospital should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other hospital personnel for review and learning purposes. We may also combine the medical information we have with medical information from other hospitals 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 who the the specific patients are.

***Appointment Reminders***
We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the hospital.

***Treatment Alternatives***
We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that me be of interest to you.

***Health-Related Products and Services***
We may use and disclose medical information to tell you about our health-related products or services that may be of interest to you.

***Fundraising Activities***
We may use medical information about you, or disclose such information to a foundation related to the hospital, to contact you in an effort to raise money for the hospital and its operations. We only would release contact information, such as your name, address and phone number and the dates you received treatment or services at the hospital. If you do not want the hospital to contact you for fundraising efforts, you must notify the Privacy Officer in writing.

***Business Associates***
There are some services provided in our organization through contracts with business associates. Examples include transcribing your medical record, surveying for patient satisfaction, and a copy service we use when making copies of your health record. When services are provided by contracted business associates, we may disclose the appropriate portions of your health information to them so they can perform the job we have asked them to do. However, our business associates are also required by law to safeguard your information.

***Hospital Directory***
We may include certain limited information about you in the hospital directory while you are a patient at the hospital. This information may include your name, location in the hospital, your general condition (e.g. good, fair, etc.) and your religious affiliation. Unless there is a specific written request from you to the contrary, this directory information, except for your religious affiliation, may also be released to people who ask you by name. Your 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. This information is released so your family, friends and clergy can visit you in the hospital and generally know how you are doing.

***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. We may also give information to someone who helps pay for your care. Unless there is a specific written request from you to the contrary, we may also tell your family or friends your condition and that you are in the hospital.

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.

***Research***
Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, as long as the medical information they review does not leave the hospital.

***As Required By Law***
We will disclose medical information about you when required 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 necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

## SPECIAL SITUATIONS

***Organ and Tissue Donation***
We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation to an organ donation bank, as necessary to facilitate organ and tissue donation and transplantation.

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

***Workers' Compensation***
We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

***Public Health Activities***
We may disclose medical information about you for public health activities. These activities generally include the following:

* To prevent or control disease, injury or disability;
* To report births and deaths;
* To report regarding the abuse or neglect of children, elders and dependent adults;
* 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 notify the appropriate government authority if we believe a patient has been a victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
* To notify emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal laws.

***Health Oversight Activities***
We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government 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 may disclose medical information about you in a response to a court or administrative order. We may also disclose medical information about you in a response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

***Law Enforcement***
We may release medical information if asked to do so by a law enforcement official:

* In response to a court order, subpoena, warrant, summons or similar process;
* To identify or locate a suspect, fugitive, material witness, or missing person;
* About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
* About a death we believe may be the result of criminal conduct;
* About criminal conduct at the hospital; and
* In emergency circumstances to report a crime; the location of the crime or victims; or the identity description or location of the person who committed the crime.

***Coroners, Medical Examiners and Funeral Directors***
We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

***National Security and Intelligence Activities***
We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

***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 conduct special investigations.

***Inmates***
If you are an inmate of a correctional institution, or under the custody of a law enforcement official, we may disclose medical information about you to the correctional institution or law enforcement official. This disclosure would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

***Multidisciplinary Personnel Teams***
We may disclose health information to a multidisciplinary personnel team relevant to prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

***Special Categories of Information***
In some circumstances, your health information may be subject to restrictions that may limit or prelude some uses or disclosures described in this notice. For example, there are special restrictions on the use or disclosure of certain categories of information - e.g., tests for HIV or treatment for mental health conditions or alcohol and drug abuse. Government health benefit programs, such as Medi-Cal, may also limit the disclosure of beneficiary information for purposes unrelated to the program.

## 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 copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but may not include some mental health information.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Stanislaus Surgical Hospital, 1421 Oakdale Road, Modesto, CA 95355, ATTN: Health Information Manager. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

***Right to Amend***
If you feel that medical information we have about you 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 the hospital.

To request an amendment, your request must be made in writing and submitted to the Health Information Management Department.

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 if you ask us to amend information that:

* Was not created by Stanislaus Surgical Hospital, 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 the hospital;
* Is not part of the information which you would be permitted to inspect and copy; or
* Is accurate and complete in the record.

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

***Right to an Accounting of Disclosures***
You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment and health care operations, (as those functions are described above) and with other exceptions pursuant to the law. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). 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.

***Right to Request Restrictions***
You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit or use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

***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.

To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must 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. 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 paper copy of this notice, contact the Health Information Management Department at 209-572-2700.

## 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 in the hospital. The notice will contain the effective date on the first page, in the top right-hand corner. In addition, each time you register at or are admitted to the hospital for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect. **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the Department of Health and Human Services. To file a complaint with the hospital, contact the Privacy Officer at 209-572-2700. *You will not be penalized for filling a complaint.*

## OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us we will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, this will stop any further use or disclosure of your medical information for the purposes covered by your written authorization, except if we have already acted in reliance on your permission. 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.