Tufts Medical Center
Primary Care

OFFICE USE ONLY:

PCP NAME: _____

PT ACCT #: _____

PATIENT REGISTRATION FORM

Patient Demographics

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Would you like to sign up for our Patient Portal? ☐ Yes ☐ No

Race:

☐ Asian ☐ Black/African American ☐ White

☐ Hispanic ☐ Native Hawaiian/Other Pacific ☐ Other: _____

Ethnicity:

☐ Hispanic or Latin American ☐ Non-Hispanic or Latin American ☐ Refuse to Report

Language:

☐ English ☐ Indian (includes Hindi, Tamil)

☐ Spanish ☐ Russian ☐ Other:_____

Insurance

Primary Insurance: _____ Subscriber ID#: _____

Subscriber Name: _____ Relationship to Patient: _____

Secondary Insurance: _____ Subscriber ID#: _____

Subscriber Name: _____ Relationship to Patient: _____

Emergency Contact

Name: _____ Relationship to Patient: _____ Phone: _____

Pharmacy

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____Pharmacy City: _____ Pharmacy State: _____

Tufts Medical Center
Primary Care

Assignment of Benefits

Consent for Treatment, Payment and Health Care Operations

As of March 1, 2014, Tufts Medical Center Primary Care medical billing is processed through Tufts Medical Center Primary Care.

By signing below, I understand that I hereby authorize the practice to disclose my medical information so that the Practice may treat, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations. I understand that I am responsible for payments in full of all charges. I request that payment of authorized Medicare and other insurance benefits be paid directly to Tufts Medical Center Primary Care. I also authorize Tufts Medical Center Primary Care to release all information necessary for the processing of insurance claims to HCFA, its agents or any other insurance company to determine the benefits payable for related services.

Patient Signature: _____Date: _____

Insurance Waiver

This office will make every effort to submit bills for services rendered to you to your insurance and accept insurance rates as payment in full. In some cases, due to specific requirements, such as special contract, lack of referral, or another physician listed as primary care physician the insurance may deny payment. Charges, and payment thereof, will then become the responsibility of the patient.

I understand that, should my insurance not pay for my office visit or procedure, I will be responsible for payment of services.

Patient Signature: _____Date: _____

Tufts Medical Center
Primary Care

Consent Form for ePrescribe Program

ePrescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- Formulary and benefit transactions - Gives the health care provider information about which drugs are covered by your drug benefit plan.
- Fill status notification - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- Medication history transactions - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Tufts Medical Center, Inc. as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. As part of this Consent Form, you specifically consent to the release of medications related to sensitive health information.

Consent

By signing this consent form you are agreeing that your provider at Tufts Medical Center, Inc. may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Tufts Medical Center, Inc. to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Name (Please Print):_____ Date of Birth: _____

Patient Signature: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Tufts Medical Center and the affiliated providers listed in this Notice, and how I may obtain access to and control this information.

_____ _____ _____

Signature of Patient or Personal Representative | Date | Time

_____ _____

Print Name of Patient or Personal Representative | Description of Personal Representative's Authority

Documentation of Good Faith Effort

- ☐ Requested that patient/patient's personal representative acknowledge receipt of Notice of Privacy Practices, but patient/patient's personal representative refused to acknowledge receipt of Notice of Privacy Practices.
- ☐ The Notice of Privacy Practices was mailed to the patient/patient's personal representative at the address of record.
- ☐ Other: _____

_____ _____ _____

Witness | Date | Time

Tufts Medical Center
Primary Care

Consent to Disclose Protective Health Information

Patient Name: _____ DOB: _____

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

Primary Care Provider: _____

By signing below, I hereby authorize Tufts Medical Center Community Care to disclose my protected health information to the following family members and/or friends:

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER

I understand that I may revoke this authorization by notifying the Medical Records Department at any time in writing, but if I do it won't have any effect on actions taken by Tufts Medical Center Community Care before they received the revocation.

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

Patient Signature: _____ Date: _____

Tufts Medical Center
Primary Care

New Patient History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your personal medical record.

PATIENT NAME: _____ **DOB**: _____ **PCP**: _____

LIST ANY MEDICAL PROBLEMS

CURRENT MEDICATIONS

NAME OF MEDICATION	STRENGTH	FREQUENCY TAKEN

ALLERGIES

NAME OF DRUG	REACTION YOU HAD	NAME OF ALLERGEN	REACTION YOU HAD

SURGICAL HISTORY

DATE OF SURGERY	TYPE OF SURGERY	HOSPITAL

HOSPITALIZATION HISTORY

DATE OF ADMISSION	REASON	HOSPITAL

Tufts Medical Center
Primary Care

FAMILY HISTORY

Please check-mark the conditions that apply to your relative's medical history.

Relative:	**CIRCLE ONE**: Alive or Deceased	**AGE** (or age deceased)	**Heart Disease**	**Diabetes**	**Colon/ Rectal Cancer**	**Prostate Cancer**	**Depression**	**Alcohol/ Drug Abuse**	**Thyroid Issue**	**Other:**
Father	Alive Deceased									
Mother	Alive Deceased									
Father's Father	Alive Deceased									
Father's Mother	Alive Deceased									
Mother's Father	Alive Deceased									
Mother's Mother	Alive Deceased									

Preventive/Health Maintenance Questions:

If you are over 50, have you had a colonoscopy?	☐ YES ☐ NO ☐ N/A	Year Done: _____ Hospital/Office: _____ Result if known: _____
Have you had osteoporosis screening for low bone mass? (Bone Density Test)	☐ YES ☐ NO ☐ N/A	Year Done: _____ Hospital/Office: _____ Result if known: _____
If you are over 40, have you had a mammogram?	☐ YES ☐ NO ☐ N/A	Month/Year Done: _____ Hospital/Office: _____ Result if known: _____
If female, have you had a Pap Smear?	☐ YES ☐ NO ☐ N/A	Month/Year Done: _____ Physician/Office: _____ Result if known: _____
If male and over the age of 50, have you had a prostate cancer screening done in the past 2 years?	☐ YES ☐ NO ☐ N/A	Month/Year Done: _____ Physician/Office: _____ Result if known: _____
If diabetic, have you had a diabetic eye exam?	☐ YES ☐ NO ☐ N/A	If yes, Date Done: _____ Physician/Office: _____
Last Flu Vaccine	Date: _____	Where: _____
Last Tetanus Vaccine	Date: _____	Where: _____
If you are over 65, last Pneumonia Vaccine	Date: _____	Where: _____

SCREENINGS PATIENT NAME: _____ DOB: _____ DATE OF VISIT: _____

TOBACCO USAGE

Current Tobacco user?	Yes No	If yes -- What Type of Tobacco: _____
How often do you use tobacco?	**Circle One:**	Every day Some days but not every day
How many cigarettes do you smoke/day?	**Circle One:**	5 or less 6 - 10 11 - 20 21 - 30 31+
How soon after waking up?	**Circle One:**	5 min 6 - 30 min 31 - 60 min after 60 min
Are you interested in quitting?	**Circle One:**	Ready to Thinking about Not ready to
Former Smoker?	Yes No	When did you quit?

DEPRESSION SCREENING

Little interest or pleasure in doing things?	Yes No				
Feeling down, depressed or hopeless?	Yes No				
IF NO TO BOTH, SKIP TO THE MISCELLANEOUS SECTION					
Over the last 2 weeks, how often have you been bothered by any of the following problems?	0 – Not at all 1 – Several Days 2- More than half days 3 – Nearly every day				
Little interest or pleasure in doing things?		0	1	2	3
Feeling down, depressed or hopeless?		0	1	2	3
Trouble falling asleep, staying asleep or sleeping too much?		0	1	2	3
Feeling tired and having little energy?		0	1	2	3
Poor appetite or overeating?		0	1	2	3
Feeling bad about yourself or that you are a failure, or have let yourself or family down?		0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV?		0	1	2	3
Moving or speaking so slowly that other people have noticed – or the opposite – being fidgety or restless?		0	1	2	3
Thoughts that you would be better off dead, or hurting yourself in some way?		0	1	2	3

MISCELLANEOUS

Drink Coffee or Tea (circle one)	Yes No	**How many cups per day?** 1 – 2 2 – 3 3 – 4 4+ **TYPE**: Caffeinated Decaf
Do you Drink Alcohol?	Yes No	Occasional weekends weekly Daily 2x a week 3x a week **TYPE:** Beer Wine Liquor
Do you have a history of substance abuse?	Yes No	Occasional Weekly Daily 2x a week 3x a week
Do you exercise?	Yes No	Occasional Weekly Daily 2x a week 3x a week Bicycling Jogging Walking Swimming
Nutrition: Are you on a special diet?	Yes No	**If yes, circle one:** Vegetarian Diabetic Low cal/low carb Other:_____
Are you sexually active?	Yes No	
Marital Status:	Yes No	Single Married Separated Divorced Widowed
Do you have any children?	Yes No	**How many?**
Housing:	**CIRCLE ONE:**	Homeless Apartment House Shelter
Communication needs?	Yes No	**If yes, specify:** _____
Health Literacy / Education:	**CIRCLE ONE:**	Did not finish high school Finished high school Not finished college Finished college Professional schools/Masters/PhD
Employment Status: Occupation:_____	**CIRCLE ONE:**	Employed Retired Unemployed Part-Time Employed Student Disabled
Family History of mental health or substance abuse:	Yes No	**If yes, specify:**
Have you had any falls in the past year?	Yes No	**If yes, how many times**: _____ **Did you have any injuries with the falls?** (Circle One) Yes No
Diabetic Eye Exam (if Diabetic)	Yes No	**Date of last Eye Exam:** _____ Circle Result: Negative Positive
Do you need a refill on a prescription today?	Yes No	Medications needed to be refilled:

TUFTS MEDICAL CENTER
AND AFFILIATED PROVIDERS*

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003
Revision Date: February 18, 2010
Revision Date: November 18, 2015

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.

Tufts Medical Center provides health care to patients jointly with physicians and other health care providers. This notice applies to Tufts Medical Center and its affiliates listed at the end of this notice.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our hospital and our affiliated health care providers. This notice will tell you about the ways in which we may use and disclose health information about you or your child. We also describe your rights and our duties regarding the use and disclosure of health information.

A copy of our current notice will always be posted in prominent locations, including admitting and registration areas. You will also be able to obtain a copy by accessing the Tufts Medical Center website at www.tuftsmedicalcenter.org, by calling us at 617-636-9229, or asking for one at the time of your next visit.

If you have any questions about this notice or would like further information, please contact the Tufts Medical Center Privacy Officer at 617-636-9229.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

1. **Treatment, Payment and Health Care Operations:** *We may use your health information, make it available to our affiliates, or share it with others in order to treat your condition, obtain payment for that treatment, and run our health care operations. In some cases, we may also disclose your health information for payment activities and certain health care operations of another health care provider or payor. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf. Below are further examples of how your information may be used and disclosed for these purposes.*

   Treatment: We may use and disclose health information about you to provide medical treatment and services. For example, we may disclose health information about you to doctors, nurses, technicians, residents, students, or other hospitals or home health agencies so that they can provide care to you or so that they can coordinate your continuing care.

   Payment: We may use your health information or share it with others so that we may obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after we have treated you, or to determine whether it will cover your treatment. We might also need to inform your health insurance company about your health condition in order to obtain preapproval for your treatment, such as admitting you to the hospital for a particular type of surgery. We, our assignees, and business associates including third-party collection agents may also contact you, including but not limited to via an auto-dialer,

* Affiliated providers are listed on page 7 of this Notice.

at any telephone number that you have provided, including wireless numbers, and may leave answering machine and voice mail messages using pre-recorded / artificial voice related to treatment or payment of your account. Finally, we may share your information with other health care providers and payors for their payment activities.

Health Care Operations: We may use your health information or share it with others in order to conduct our health care operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you. Finally, we may share your health information with other health care providers and payors for certain of their health care operations provided that the information is related to a relationship the provider or payor currently has or previously had with you and the provider or payer is required by federal law to protect the privacy of your health information.

Examples of health care operations include:

- Monitoring the quality of care and making improvements where needed.
- Reviewing medical records for completeness and accuracy.
- Meeting standards set by regulating agencies, such as The Joint Commission.
- Teaching health professionals
- Using outside business services, such as transcription, storage, auditing, legal or other consulting services.
- Storing your health information on computers.
- Managing and analyzing medical information.

Appointment Reminders, Treatment Alternatives, Benefits and Services: In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment or services at our facility. We may also use your health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you or to ask you to participate in a patient survey regarding how to improve the care we provide for you.

Health-Related Services: We may use and disclose health information about you to send you mailings about health-related products and services available at Tufts MC.

Fundraising: To support our business operations, we may use demographic information about you, including information about your age and gender, where you live or work, and the dates that you received treatment, in order to contact you to raise money to help us operate. We may also share this information with a charitable foundation that will contact you to raise money on our behalf. If you do not want to receive fundraising requests in the future, you may contact the Tufts Medical Center Trust at (617) 636-7656. You will also be provided with information on how to opt out of receiving future fundraising requests in any written fundraising communication we send to you.

Business Associates: We may disclose your health information to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company. If we do disclose your health information to a business associate, we will have a written contract with that business associate to ensure that it also protects the privacy of your health information.

2. **Patient Directory/Family and Friends:** *If you do not object,* we will include your name, your location in our facility, your general condition (e.g., fair, stable, critical, etc.) and your religious affiliation in our Patient Directory while you are a patient in the hospital. This directory information, except for your religious affiliation, may be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if he or she doesn't ask for you by name. If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for that care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition here at the hospital, including death if such were to occur. In some cases, we may need to share your information with a disaster relief organization that will help us notify these persons.

3. **Public Need:** We may use your health information, and share it with others, in order to comply with the law or to meet important public needs that are described below:
    - **As Required By Law**
    - **Public Health Activities** - We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling, monitoring, or preventing disease, injury or disability. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits us to do so.
    - **Victims of Abuse, Neglect Or Domestic Violence** - We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence.
    - **Health Oversight Activities** - We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operations of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.
    - **Product Monitoring, Repair And Recall** - We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purposes of reporting or tracking product defects or problems, repairing, replacing, or recalling defective or dangerous products, and monitoring the performance of a product after it has been approved for use by the general public.
    - **Lawsuits And Disputes** - We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.
    - **Law Enforcement** - We may disclose your health information to law enforcement officials for the following reasons:
        - To comply with court orders or laws that we are required to follow;
        - To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;
        - If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your agreement because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
        - If we suspect that your death resulted from criminal conduct;
        - If necessary to report a crime that occurred on our property; or
        - If necessary to report a crime discovered during an offsite medical emergency (for example, by emergency medical technicians at the scene of a crime).
    - **To Avert A Serious And Imminent Threat To Health Or Safety**
    - **National Security And Intelligence Activities Or Protective Services**
    - **Military And Veterans** - If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission.
    - **Inmates And Correctional Institutions** - If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined.
    - **Workers' Compensation**
    - **Coroners, Medical Examiners And Funeral Directors**
    - **Organ And Tissue Donation** - In the unfortunate event of your death, we may disclose your health information to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.
    - **Research** - In most cases, we will ask for your written authorization before using your health information or sharing it with others in order to conduct research. However, under certain circumstances, we may use and disclose your health information without your written authorization, including if we obtain approval through a special process to ensure that research without your written authorization poses minimal risk to your privacy, or for purposes of preparing a future research project.

4. **Completely De-identified Or Partially De-identified Information:** We may use and disclose your health information if we have removed any information that has the potential to identify you so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" health information about you for public health and research purposes, or for health care operations, if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will not contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

5. **Incidental Disclosures:** While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, upon check-in, other patients in the treatment area may hear your name.

WITH YOUR SPECIFIC WRITTEN AUTHORIZATION

Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will only be made with your written permission or authorization. You may also initiate the transfer of your records to another person by completing a written authorization form. If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To obtain or revoke a written authorization, please write to Tufts Medical Center Medical Records Department, 800 Washington St, Box 999, Boston, MA 02111. 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 provide to you.

Health Information Exchange: With your written authorization we may disclose your health information on the secure statewide health information exchange known as the Massachusetts Health Information Highway ("Mass HIway") which enables the electronic movement of health related information among diverse organizations such as physicians' offices, hospitals, laboratories, pharmacies, skilled nursing facilities and insurance companies. Connecting to Mass HIway will enable us to have a more comprehensive understanding of our patients' full medical histories in order to deliver the most comprehensive healthcare to you.

Certain health information: In most cases, we will not be able to disclose the following types of health information without your written authorization or a court order:

- HIV testing and test results
- Genetic testing and test results
- Sensitive information such as sexual assault counseling records or psychotherapy communications between you and a social worker, psychologist, psychiatrist, psychotherapist or licensed mental health nurse clinician
- Records pertaining to venereal diseases, including sexually transmitted diseases (except certain disclosures may be made to public health officials without a court order or your authorization)
- Psychotherapy notes (notes maintained separate from the medical record for the therapist's own use) (However, specific permission is not required for use or sharing of these notes if used by your therapist to treat you, for training programs, for legal defense in an action you bring, or for professional oversight of the therapist.)
- Drug and alcohol abuse treatment

We will also not use or disclose your health information without your written authorization in the event of the following circumstances:

- Uses and disclosures for marketing purposes (except face-to-face communication or promotional gifts of nominal value)
- Uses and disclosures that constitute the sale of health information
- Uses and disclosures not described in this Notice

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

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

1. **Right to Inspect and Copy Records:** You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes the right to obtain an electronic copy of your health information maintained in our electronic health record. To inspect or obtain a copy of your health information, please submit your request in writing to Tufts Medical Center Medical Records Department, 800 Washington St., Box 999, Boston, MA 02111. If you request a paper copy of the information, we may charge a fee for the costs of labor, copying, mailing or other supplies we use to fulfill your request. If you request an electronic copy, we may charge a fee for our labor costs in fulfilling your request, as well as the cost of supplies for electronic media if you request the electronic copy on portable media.

   We will ordinarily respond to your request within 30 days. If we need additional time to respond, we will notify you within the 30 days to explain the reason for the delay and when you can expect to have a final answer to your request.

   Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we deny part or all of your request, we will provide a written denial notice that explains our reasons for doing so, and a complete description of your rights to have that decision reviewed and how you can exercise those rights. The notice will also include information on how to file a complaint about these issues with us or with the United States Department of Health and Human Services. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect or copy.

2. **Right To Amend Records:** If you believe that the health 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 in our records. To request an amendment, please write to the Tufts Medical Center Privacy Officer, 800 Washington St., Box 5100, Boston, MA 02111. Your request should include the reasons why you think we should make the amendment. Ordinarily we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.
   If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement which we will include in your records. We will also include information on how to file a complaint with us or with the United States Department of Health and Human Services. These procedures will be explained in more detail in any written denial notice we send you.

3. **Right To An Accounting Of Disclosures:.** You have a right to request an "accounting of disclosures" which identifies certain other persons or organizations to whom we have disclosed your health information in accordance with applicable law and the protections afforded in this Notice of Privacy Practices. An accounting of disclosures does not include health information that has been shared within and between Tufts Medical Center and its affiliates, as long as all other protections described in this Notice of Privacy Practices have been followed.

   An accounting of disclosures also does not include information about disclosures made: to you or your personal representative; pursuant to your written authorization; for treatment, payment or health care operations (unless such disclosures were made from our electronic health record in the three years prior to your request for an accounting, and beginning on the date we are required to provide an accounting of such disclosures); from the patient directory; to family and friends involved in your care or payment for your care; incidental to permissible uses and disclosures of your health information; for purposes of research, public health or our health care operations of partially de-identified health information that does not directly identify you; to federal officials for national security and intelligence activities; with respect to inmates, to correctional institutions or law enforcement officers; before April 14, 2003.

To request an accounting of disclosures, please write to Tufts Medical Center Medical Records Department, 800 Washington St. Box 999, Boston, MA 02111. Your request must state a time period within the past six years for the disclosures you want us to include. For example, you may request a list of the disclosures that we made between January 1, 2012 and January 1, 2013. You have a right to receive one accounting within every 12 month period for free. However, we may charge you for the cost of providing any additional accounting in that same 12 month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred.

Ordinarily we will respond to your request for an accounting within 60 days. If we need additional time to prepare the accounting you have requested, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting. In rare cases, we may have to delay providing you with the accounting without notifying you because a law enforcement official or government agency has asked us to do so.

4. **Right to Request Additional Privacy Protections:** You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, or run our health care operations. You may also request that we limit how we disclose information about you to family or friends involved in your care. To request restrictions, please write to the Tufts Medical Center Privacy Officer at 800 Washington St. Box # 5100, Boston, MA 02111. Your request should include (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others, or both; and (3) to whom you want the limits to apply.

   Except for the situations noted below*, we are not required to agree to your request for a restriction*, and in some cases the restriction you request may not be permitted under law. However, if we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment or comply with the law.

   Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction.

   You have the right to request a restriction on the use and disclosure of your health information, and we will agree to the request, where: except as otherwise required by law, the disclosure by Tufts Medical Center is to a health plan for the purposes of carrying out payment or health care operations, and the health information to be restricted pertains solely to a health care item or service for which Tufts Medical Center has been paid out of pocket in full.

5. **Right to Request Means of Confidential Communications:** You have the right to request that we communicate with you about your medical matters in a confidential way by requesting that we communicate with you by alternative means or at alternative locations. For example, you may ask that we contact you at home instead of at work, or you may ask that we send certain communications, such as appointment reminders or patient survey requests, by means other than e-mail. To request confidential communications, please write to the Tufts Medical Center Privacy Officer at 800 Washington St. Box 5100, Boston, MA 02111. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests. Please specify in your request how or where you wish to be contacted, and how payment for your health care will be handled if we communicate with you through this alternative method or location.

6. **Right to Receive Notification of a Privacy or Security Breach:** We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. You have the right to be notified of a breach that compromises the security or privacy of your health information maintained by us to the extent you are affected by such breach.

   How to Obtain a Copy of This Notice and Revised Notices: You have the right to a paper copy of this notice. You may request a paper copy at any time, even if you have previously agreed to receive this notice electronically. To do so, please call the Tufts Medical Center Privacy Officer at 617-636-9229. You may also obtain a copy of this notice from the Tufts Medical Center website at www.tuftsmedicalcenter.org or by requesting a copy at your next visit. We may change our privacy practices from time to time. If we do, the revised notice will apply to all of your health information. We will post any revised notice in prominent locations in the hospital and at our affiliate locations. You will also be able to obtain your own copy of the revised notice by accessing the Tufts Medical Center website at

www.tuftsmedicalcenter.org, calling our office at 617-636-9229 or asking for one at the time of your next visit. The effective date of the notice will always be noted in the top right corner of the first page. We are required to abide by the terms of the notice that is currently in effect.

7. **Right to File A Complaint:** If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact the Tufts Medical Center Privacy Officer at 617-636-9229 or call the anonymous hotline at 844-550-0008. No one will retaliate or take action against you for filing a complaint.

This Notice of Privacy Practices applies to Tufts Medical Center and the following providers or groups affiliated with Tufts Medical Center, as such may change from time to time:

Tufts Medical Center Community Care

Tufts Medical Center Physicians Organization, Inc.

Pratt Otolaryngology – Head & Neck Surgery Associates, Inc.

New England Medical Center Group Practice, Inc. (d/b/a Pratt Neurosurgery Associates)

Pratt Anesthesiology Associates, Inc.

Pratt Medical Group, Inc.

Pratt Medical & Surgical Dermatology Associates, Inc.

Pratt Neurology Associates, Inc.

Pratt OB/GYN Associates, Inc.

Pratt Ophthalmology Associates, Inc.

Pratt Orthopedic Associates, Inc.

Organized Health Care Arrangements

New England Quality Care Alliance and affiliated Physicians and Physician Groups

Pratt Radiation Oncology Associates of Rhode Island Inc.

Pratt Pathology Associates, Inc.

Pratt Pediatric Associates, Inc.

Pratt Psychiatric Associates, Inc.

Pratt Radiation Oncology Associates, Inc.

Pratt Radiology Associates, Inc.

Pratt Rehabilitation Medicine Associates, Inc.

Pratt Surgical Associates, Inc.

Pratt Urology Associates, Inc.

Pratt Radiation Oncology Associates of Rhode Island, Inc.

Certain inquiries or requests directed to the Tufts Medical Center Privacy Officer or Medical Records Department under this Notice may be forwarded to the Privacy Officer of one of the above-listed affiliates for a response, as appropriate, or you may be directed to contact that person directly.

Tufts Medical Center
Primary Care

85 Worcester Road
Framingham, MA 01701
T: 508 532-0223
F: 508 875-0049

65 Walnut Street, Suite 201
Wellesley Hills, MA 02481
T: 781 237-3395
F: 781 489-2265

7 Alfred Street, Suite 370
Woburn, MA 01801
T: 781 528-6720
F: 781 528-6719

tuftsmedicalcenter.org

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Patient Address: _____

I request and authorize: _____

To release/obtain healthcare information to/from:

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ Other: _____

If the information described above includes information in any category below, *I specifically authorize the use or disclosure of such information.*

☐ Yes ☐ No STD results or HIV/AIDS testing, whether negative or positive
☐ Yes ☐ No Genetic Testing/Results
☐ Yes ☐ No Any records regarding drug, alcohol, or mental health treatment

This authorization will remain in effect:

☐ Until Tufts Medical Center Community Care fulfills this request
☐ Until I revoke this authorization in writing
☐ From the date of this authorization until the following date: _____
☐ Other: _____

I understand that I may revoke this authorization by notifying the Medical Records Department at any time in writing, but if I do it won't have any effect on actions taken by the Tufts Medical Center Community Care before they received the revocation.

I may refuse to sign this authorization. My health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form (Except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party). I have a right to receive a copy of this form after I have signed it.

By signing this authorization form, I authorize the use or disclosure of my protected health information as described above. I understand that information used of disclosed pursuant to this authorization may be disclosed by the recipient and my no longer be protected by federal or state law.

PLEASE NOTE: A charge will apply when releasing records directly to patient. Please see separate sheet for fees.

I have read this form and all my questions about this form have been answered. By Signing below, I acknowledge that I have read and accept all of the above.

Patient Signature: _____ **Date Signed:** _____