MARION COUNTY PUBLIC HEALTH DEPARTMENT
Prevent. Promote. Protect.

CLIENT REGISTRATION FORM

Please complete this form so we can provide the best care possible. The information you share with us is part of your **confidential** medical record. Some infectious diseases must be reported to the Indiana State Department of Health in accordance with Indiana state law (IC 16-41-2-1).

PLACE LABEL HERE

PLEASE PRINT

Birth Date: _____ / _____/_____ Social Security Number: _____-_____-_____
MM DD YYYY

Legal Name: _____
First Middle Last

Other names used: _____ Maiden: _____

Address: _____
Street address City State Zip Code

Home phone: (_____) _____ Work phone: (_____) _____ Cell phone: (_____) _____

Email address: _____

Sex/Gender:
☐ Male ☐ Female ☐ Trans (choose one) ☐ male → female ☐ female → male

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Language:
☐ English ☐ Spanish ☐ Other: _____

Is the patient of a multiple birth? (twin, triplet, etc.) Check the box if the answer is Yes. ☐

Please answer both questions: Please select all that apply. *(This information is for statistical use only)*

1. What is this person's race?
☐ African American or Black
☐ American Indian or Alaskan Native - Specify tribe: _____
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Hawaiian Native
☐ Japanese
☐ Korean
☐ Other Asian: _____
☐ Other Pacific Islander: _____
☐ Other Race: _____
☐ Samoan
☐ Vietnamese
☐ White

2. Is this client Hispanic/Latino?
☐ No, not Spanish/ Hispanic/Latino
☐ Yes, Mexican, Mexican Am., Chicano
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Spanish/ Hispanic/Latino - Specify: _____

Country of birth:
_____

Insurance Information
Medicaid
ID# _____
Medicare
ID # _____

Smoking Status (Select one if over the age of 12) ❒ Current Smoker ❒ Former Smoker ❒ Never Smoked

Parent or guardian information (if under age 18)

Name: _____ Date of birth: _____ / _____ / _____ Relationship: _____
MM DD YYYY

Address: _____ Phone Number: (_____) _____

In case of emergency, who should be contacted?

Name: _____ Phone Number: (_____) _____

Acknowledgement of receipt of Notice of Privacy

I have received a copy of this office's Notice of Privacy Practices. *(You may refuse to sign this acknowledgement)*

Patient/Parent/Guardian signature: _____ **Date:** _____

Authorization for Services

I hereby authorize the Marion County Public Health Department to examine, test or provide services to the patient listed above. Test results and treatment will be explained to me as part of my visit today. If follow-up is needed or any test/exam results or appointment reminders, I will be contacted by a staff member.

Patient/Parent/Guardian signature: _____ **Date:** _____

HIPAA Refusal: Please complete if client refuses to sign the acknowledgement section. We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

❒ Individual refused to sign ❒ Communication barriers prohibited obtaining the acknowledgement

❒ An emergency situation prevented us from obtaining acknowledgement ❒ Other (please specify)

_____ _____
Authorized Employee Name (Print) Title (Print)

_____ _____
Employee Signature Date

REGISTRATION FORM - PAGE 2

Birth Date: ____/____ / ____
MM DD YYYY

Name: _____
First Middle Last

School Name:_____

Grade: _____

Please list everyone that lives with you

Name	Birthdate	Relationship	Gender	School	(Staff Use) MCPHD#

PATIENT CONTACT AUTHORIZATION

The Marion County Public Health Department allows you to request to receive communications regarding appointments, lab results, treatment and/or other health information. ***Please check all that apply:***

☐ I do not want any contact made.

Telephone Communication

Home Phone _____
☐ OK to leave a detailed voicemail message ☐ Leave message with call back number only ☐ Do not leave a message

Cell Phone _____
☐ OK to leave a detailed voicemail message ☐ Leave message with call back number only ☐ Do not leave a message

Work Phone _____
☐ OK to leave a detailed voicemail message ☐ Leave message with call back number only ☐ Do not leave a message

Other _____
☐ OK to leave a detailed voicemail message ☐ Leave message with call back number only ☐ Do not leave a message

☐ OK to leave a detailed message with: _____ _____
Name Relationship

Written Communication

☐ You may contact me by mail using my home address
☐ You may contact me by mail using my work/office address
☐ If you have any other special request, please list:_____

_____ _____
Patient Signature Date

If you change your mind after completing this authorization, you must submit a written cancellation of the authorization. This will not affect or undo any disclosure prior to this notification.

For Staff Use Only

Date	Additional Addresses	Zip Code	Home Phone	Other Phone

Other Hospital Patient Number: _____ Medicaid Caseworker: _____

MARION COUNTY PUBLIC HEALTH DEPARTMENT
Prevent. Promote. Protect.

Lead Poisoning Prevention Program
3901 Meadows Dr.
Indianapolis, IN 46205
317-221-2155
marionhealth.org

CONSENT TO BLOOD LEAD SCREENING AND AUTHORIZATION TO SHARE INFORMATION FORM

Patient's Information

Please print

Patient's name _____ _____ _____
First Middle Last

Date of birth _____/_____/____
MM DD YYYY

Blood Lead Screening

I understand that a blood screening is necessary because lead poisoning can occur without symptoms. Screening requires a blood sample obtained by a fingerstick or venipuncture.

With a fingerstick, blood is taken from the finger. With a venipuncture, blood is taken from the arm.

If the fingerstick indicates that a *child*'s blood level is elevated, a representative from the Marion County Lead Poison Prevention Program will contact me to schedule a confirmatory test.

Sharing Information

I understand that my/my child's test results are confidential medical information. Under Indiana law, the results of a blood lead test will be shared with other public agencies in a confidential manner. The agencies will take care to protect privacy. Sharing information will help if lead poisoning is identified.

I understand Indiana Code 16-41 -39.4-3 requires the laboratory that analyzes the blood to report the test result and all demographic information to the Indiana State Department of Health (ISDH)

I understand that lead-poisoned children need immediate medical attention. In order to provide this help, ISDH will share this information with other public agencies, which work to prevent and treat lead poisoning. The agencies include the Family and Social Services Administration, the Department of Health and Human Services, the Department of Housing and Urban Development and other housing agencies at the local, state and federal level.

Signature of Verification

By signing below I agree that I have read, understand and authorize the sharing of information regarding my/my child's blood lead screening and test results.

Patient or Parent/Legal guardian (Please print name) _____

Patient or Parent/Legal guardian signature: _____ Date: ____/____/____
MM DD YYYY

For Staff Use Only

Surveyor: _____ Date drawn: ____/____/____
MM DD YYYY

DISCLOSURES REQUIRED OR PERMITTED BY LAW

Your permission is not required for the following:

1. As Required by Law: Under certain circumstances, HHC/MCPHD will disclose your PHI when required to do so by federal, state or local law or by regulation. For example, we may disclose your PHI when a law requires that we report information about suspected abuse, neglect, domestic violence, information related to suspected criminal activity, or in response to a court or agency order, subpoena, discovery request or other legal process. Although required to disclose your PHI under any one of these scenarios, HHC/MCPHD will do everything possible to minimize the risk of unauthorized disclosures of your PHI. HHC/MCPHD will only disclose the minimum necessary information to comply with the request. We must also disclose PHI to authorities that monitor compliance with these privacy requirements.

2. Public Health Activities: We may disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to the public health authority, such as reports of tuberculosis cases or births and deaths.

3. Health Oversight Activities: We may disclose your PHI to health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions.

4. Disclosures for Law Enforcement Purposes: We may disclose your PHI to law enforcement officials for these purposes:

(a) If a crime is committed at a HHC/MCPHD facility;
(b) In response to a court, grand jury or administrative warrant, order or subpoena;
(c) To identify or locate a missing person;
(d) About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement;
(e) To avert a serious threat or event or to warn a victim or victims of intended harm; or
(f) To report a death if we suspect the death may have resulted from criminal activity

5. Disclosures to Coroners, Medical Examiners and Funeral Directors: We may disclose your PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death. We may also disclose medical information to funeral directors so that they can carry out their duties.

6. Special Government Functions: We may disclose the PHI of military personnel and veterans in certain situations; to correctional facilities in certain situations; and for national security and intelligence reasons, such as protection of the President.

7. Inmates and Persons in Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release 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.

Other Uses of Medical Information

Other uses and disclosures of PHI, not covered by this notice or required by law, will only be made with your written permission or authorization. This includes, but is not limited to, certain uses and disclosures of psychotherapy notes and the sale or use of PHI for marketing purposes. If you provide us permission to use or disclose medical information, you may revoke that permission, in writing, at any time to the Privacy Officer. If you revoke your permission, HHC/MCPHD will no longer use or disclose medical information about you for the reasons covered by your written authorization. HHC/MCPHD will be unable to retract information, used or disclosed or retained in our records of the care we provided to you, prior to your written request.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding your PHI.
All requests must be in writing.

1. Right to Request Restrictions/Alternative Means of Confidential Communications

Under certain circumstances, you have the right to request, in writing, that HHC/MCPHD restrict the uses and disclosures of your PHI. For example, you could ask that HHC/MCPHD not disclose your PHI to a specific family member.

You should explain: (a) what information you want to limit; (b) whether you want to limit use or disclosure or both; and, (c) to whom you want the limits to apply. Additionally, you may request restriction of disclosures to your health plan if it pertains to an item or service paid out of pocket in full and HHC/MCPHD must agree to the requested restriction.

HHC/MCPHD is not required to agree to any requested restriction. However, if HHC/MCPHD does agree, we must follow the restriction unless the information is needed to provide emergency treatment. The restriction will remain in effect for one (1) year from the date restriction is requested, unless otherwise specified.

2. Right to Access, Inspect and Copy

With a few limited exceptions, you have the right to inspect and obtain a copy of your PHI. This includes but is not limited to medical records, laboratory test reports and billing information. To request inspection or copies of your PHI, you must complete, an HHC/MCPHD Authorization for Release of Information form. If electronic health records are maintained by HHC/MCPHD, you may request your PHI in electronic format. Your request should state specifically what PHI you want to inspect or copy. Direct the Authorization to: Marion County Public Health Department, Attention Central Records Department, 3838 N. Rural Street, Room 250, Indianapolis, IN 46205-2930. We will respond to your request within thirty (30) days. If your request is granted, HHC/MCPHD may charge a fee for the costs of copying and mailing. If HHC/MCPHD denies your request, HHC/MCPHD will explain the denial in writing and inform you of any additional rights you may have.

3. Right to Amend

With some exceptions, you also have the right to ask HHC/MCPHD to amend your medical records if you believe they are incomplete or inaccurate. You have this right for as long as HHC/MCPHD maintains your PHI. To request an amendment, you must contact the appropriate service delivery site in writing using the amendment form designated by HHC/MCPHD. Your request must state the amendment(s) desired and provide a detailed reason for the amendment(s). If your request is granted, HHC/MCPHD will add the appropriate amendment(s) and inform others, as needed or required. If HHC denies your request, HHC/MCPHD will explain the denial in writing and inform you of any additional rights you may have.

4. Right to an Accounting of Disclosures

You have a right to request an accounting of disclosures, which is a list of disclosures of your PHI made by HHC/MCPHD for purposes other than treatment, payment or health care operations. Your request can relate to disclosures going as far back as six (6) years. This list will not include those disclosures made to correctional institutions, law enforcement, or national security or intelligence agencies.

To request an accounting of disclosures, your request must be in writing and must state a beginning and ending date for the time period in question. We will respond to your request within 60 days of receiving it.

5. Rights With Respect to Your Insurance

Even if you have insurance, you have the right to pay for services yourself and avoid having any information about these services sent to your insurance company. Also, any genetic information may not be used by your insurance company to make premium rates and coverage decisions about you. HHC/MCPHD will not share the results of any genetic testing with your insurance company.

HHC/MCPHD RESPONSIBILITIES

HHC/MCPHD is required by law to maintain the privacy of your protected health information; notify you promptly if a breach of unsecured PHI occurs that may have compromised the privacy or security of your information; abide by the terms of this Notice or any Notice that is currently in effect; and provide you with a copy of this Notice an our legal duties.

CHANGES TO THIS NOTICE

While HHC/MCPHD reserves the right to change its Notice of Privacy Practices, federal law requires HHC/MCPHD to notify you of any and all changes to that Notice. A copy of our current Notice of Privacy Practices will be posted and made available on the HHC/MCPHD website at www.hhcorp.org and at the HHC/MCPHD headquarters at Health and Hospital Corporation of Marion County, 3838 N. Rural Street, Indianapolis, IN 46205.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with HHC/MCPHD and with the United States Secretary of Health and Human Services. To file a complaint with HHC/MCPHD, send your written complaint to the HHC/MCPHD contact listed below. Your complaint must contain a detailed explanation of the reason(s) for your complaint. To file a complaint with the United States Secretary of Health and Human Services, send your written complaint to: the U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201.

We will not retaliate against you or penalize you for filing a complaint.

CONTACT INFORMATION

To contact the HHC/MCPHD for any reason, please send written correspondence to:

HIPAA Privacy Officer
Health and Hospital Corporation of Marion County
3838 N. Rural Street, Suite 820, Indianapolis, IN 46205
317-221-2005

The Health & Hospital Corporation of Marion County complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

HEALTH& HOSPITAL CORPORATION

MARION COUNTY PUBLIC HEALTH DEPARTMENT

Prevent. Promote. Protect.

NOTICE OF PRIVACY PRACTICES FOR PATIENT MEDICAL INFORMATION SUMMARY

Effective: October 17, 2016

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.

The Health & Hospital Corporation of Marion County/ Marion County Public Health Department (HHC/ MCPHD) will protect the confidentiality and security of the patient health information it collects about you. Your protected health information (PHI) includes medical information that specifically identifies you as the patient.

THE NOTICE OF PRIVACY PRACTICES FOR PATIENT MEDICAL INFORMATION DESCRIBES:

1. Your rights relative to your protected health information:

- You have the right to keep your PHI confidential.
- You have the right, with some restrictions, to prohibit or restrict the use of your PHI.
- You have the right, with some restrictions, to access, inspect and to obtain copies of your PHI.
- You have the right to amend your PHI for as long as HHC/MCPHD maintains your PHI.
- You have the right to an accounting of your PHI disclosures
- You have the right to pay for services out of pocket and not have any information about those services sent to your insurance company.
- You have the right to submit a complaint if you feel your privacy rights have been violated.

2. HHC/MCPHD's commitment and pledge to protect your rights:

- Your PHI will be protected from disclosure and/or usage as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Additionally, any specific restrictions that you request and are approved will be enforced.

3. How and when your PHI may be used or disclosed by HHC/MCPHD:

- To provide, coordinate or manage your health care by HHC/MCPHD, other health care providers such as doctors, nurses, hospitals, school-based health clinics, and other health facilities, which become involved in your health care.
- For payment of your treatment, services and items you may receive.
- For the explicit use by HHC/MCPHD or our business associates for business operations.
- For specific disclosures required or permitted by law. HHC/MCPHD will only disclose the minimum necessary to comply with the request.
- For health research purposes.
- To provide your PHI to individuals, authorized by you, involved with your care or payment of your care.
- To provide your PHI to a correctional institution or law enforcement official if you are in their custody.
- To provide your PHI, to the extent necessary, to comply with workers' compensation and similar laws providing benefits for work-related injuries or illness.

NOTICE OF PRIVACY PRACTICES FOR PATIENT MEDICAL INFORMATION - *Effective: October 17, 2016*

OUR PLEDGE REGARDING MEDICAL INFORMATION

The Health & Hospital Corporation of Marion County/Marion County Health Department (HHC/MCPHD) is committed to protecting the confidentiality of protected health information (PHI) that HHC/MCPHD collects about you. PHI means any individually identifiable health information which relates to your past, present, or future health treatment or payment for health care services, or for which there is a reasonable basis to believe the information can be used to identify you. This Notice of Privacy Practices (Notice) will tell you how HHC/MCPHD may use and disclose your PHI. This Notice will also tell you about your rights and our duties with respect to your PHI, as well as, how to complain to us if you believe HHC/MCPHD has violated your PHI privacy rights.

WHO IS BOUND BY THIS NOTICE?

This Notice of Privacy Practices describes the practices of HHC/MCPHD as well as that of the following when services are provided at a HHC/MCPHD facility:

- Any health care professional authorized to access or create medical information about you at HHC/MCPHD;
- All divisions, departments and units of HHC/MCPHD;
- All members of a volunteer group whom we allow to assist while you are in a HHC/MCPHD facility;
- All employees, staff, contractors, students, trainees and other personnel working with HHC/MCPHD;
- Medical practitioners and health care professionals of, and faculty practice plans organized under, Indiana University School of Medicine, the Indiana University Medical Group-Primary Care, the Indiana University Medical Group-Specialty Care and the Indiana University Schools of Nursing and Dentistry.
- All health care professionals authorized to provide care on behalf of Eskenazi Health Services, including Eskenazi Hospital, Midtown Mental Health Center, all community health centers and at any other location where Eskenazi Health Services provides services.

All of the above named entities, sites and locations have agreed to follow the terms and conditions of this Notice of Privacy of Practices. In addition, these entities, sites and locations may share your PHI with each other and with HHC/MCPHD for treatment, payment and HHC/MCPHD health care operations as described in this Notice of Privacy Practices.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose your PHI. Not every use or disclosure is listed; however, all of the ways we are permitted to use and disclose PHI fall within one of these categories listed below.

1. Treatment

HHC/MCPHD may use and disclose your PHI to provide, coordinate or manage your health care and related services offered by HHC/MCPHD and other health care providers. HHC/MCPHD may disclose medical information about you to doctors, nurses, hospitals, other health facilities that become involved in your care, and school-based clinics or other school officials involved in a child's care coordination, or continuity of care, when necessary. HHC/MCPHD may consult with other health care providers concerning you, and as part of the consultation, share your PHI with them. Similarly, HHC/MCPHD may refer you to another health care provider and as part of that referral, share medical information about you with that provider. For example, HHC/MCPHD may conclude you need to receive services from a physician with a particular specialty. When HHC/MCPHD refers you to that physician, HHC/MCPHD will provide the medical information requested and deemed necessary for your treatment by that physician.

HHC may participate in various local, regional, state and/or federal Health Information Exchanges ("HIEs") to make certain patient information available electronically to participating hospitals, doctors and others participating in the HIE for purposes of coordinating treatment of care.

2. Payment

HHC/MCPHD may use and disclose your PHI in order to receive payment for the treatment, services and items you may receive. This can include billing you, an insurance company, or a third-party payor. For example, HHC/MCPHD may need to verify that you received certain treatment(s). Also, HHC/MCPHD may be required to provide details regarding your treatment(s) to determine if your benefits will cover or pay for your treatment(s). HHC/MCPHD may work with government programs, such as Medicare or Medicaid, and provide them with information about your medical condition to determine if that program covers you. HHC/MCPHD may also disclose your PHI to obtain payment from third parties that may be responsible for certain costs. HHC/MCPHD may also contact your health plan about a treatment you are going to receive to obtain prior approval for treatment coverage.

3. Health Care Operations

HHC/MCPHD may use and disclose medical information about you for its own business operations. HHC/MCPHD may use and disclose your PHI to evaluate and maintain quality health care services for you. HHC/MCPHD may also use your PHI to study ways to more efficiently manage our organization and provide more cost-efficient services to HHC/MCPHD clients. For example, HHC/MCPHD may disclose your PHI to outside auditing organizations to evaluate the services provided and ensure compliance with the highest industry standards. Whenever possible, we will use medical information that does not identify you.

4. Health-Related Benefits and Services

HHC/MCPHD may use and disclose medical information to keep you informed of health-related benefits or services. For example, HHC/MCPHD may have a new program, treatment alternative or class, which would benefit you. You may write to our HIPAA Privacy Officer at 3838 North Rural Street, Suite 820, Indianapolis, IN 46205, if you do not wish to be contacted for this purpose.

5. Community Service Activities.

HHC/MCPHD may use and disclose your PHI in an effort to provide or refer you to health-related community service activities. We may disclose PHI to members of a business or volunteer group assisting in your receipt of services from HHC/MCPHD. You must write to the Privacy Officer listed in this notice if you do not want to be contacted for community service activities.

6. Business Associates

Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as physicians, copy service companies, record storage facilities, or, etc. At times it may be necessary for us to provide certain health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information. Business Associates are also required by law to protect your confidentiality and privacy and they sign a contract to this effect.

7. Research

Under certain circumstances, HHC/MCPHD may use and disclose your PHI for research purposes, such as research projects involving patients with specific health problems or taking specific medications. Generally, we will ask you for your specific permission if the researcher will have access to your name, address and other PHI or will be involved in your care. Any research conducted without your expressed permission will have been authorized by a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with clients' need for privacy of their medical information. We may also disclose PHI about a client to people preparing to conduct a research project.

8. HHC/MCPHD Registry

HHC/MCPHD may include your name, general condition (good, fair, serious, critical) and your location in our facility in the HHC/MCPHD site-based registry or sign-in sheet. HHC/MCPHD may disclose this information to people who ask for you by name unless you have previously informed the site/clinic that you do not want this information maintained and/or released.

9. Individuals Involved in Your Care

HHC/MCPHD may use and disclose to a family member, other relative, a close personal friend, or any other person identified and authorized by you, your PHI that is directly relevant to that person's involvement with your care or payment related to your care. HHC/MCPHD also may use or disclose medical information about you to notify those authorized persons of your location, general condition, or death. You have the right to request, in writing, that disclosure of your medical information be prohibited to individuals of your choosing, for example, a family member, other relative, or close personal friend.

10. Disaster Relief

We may use or disclose your PHI to authorized public or private entities to assist with disaster relief efforts or to notify family and friends of your location, condition or death in the event of a disaster.

11. Workers Compensation

HHC/MCPHD may use and disclose PHI about you to the extent necessary to comply with workers' compensation and similar laws that provide benefits for work-related injuries or illness.

12. Fundraising

HHC may contact you to raise money for HHC and its divisions, unless you tell us in writing not to contact you for this purpose. You may write to our HIPAA privacy officer listed in this Notice, if you do not want to be contacted for fundraising.

13. 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.

14. How HHC Will Contact You

HHC/MCPHD may contact you by telephone or mail at your home or your job in order to remind you of health care appointments, prescription refills, or to reschedule missed or cancelled appointments. HHC/MCPHD may leave messages for you on an answering machine or a voice mail system. You have the right to request, in writing, that HHC/MCPHD communicates your PHI only in a certain way or at a certain location. If reasonable, HHC/MCPHD will accommodate your request. Your request must state specifically how and/or where you wish to be contacted.