WELCOME TO MICHIGAN STATE UNIVERSITY
DEPARTMENT OF SURGERY

You are scheduled with ________________________ on _______ at _______

Please arrive at ____________________________

Please arrive 30 minutes prior to your appointment time with the enclosed paperwork completed and any relevant films related to your visit. We have access to both MSU and Sparrow Diagnostics films and reports. For testing done elsewhere (x-rays, mammograms, ultrasounds, CT scans, etc.) please bring the actual films or a disc to your appointment for physician review. IT IS VERY IMPORTANT THAT YOU HAND CARRY ANY FILMS AND/OR DISCS, ANY TESTING REPORTS YOU HAVE HAD DONE OUTSIDE OF MSU OR SPARROW PERTINENT TO YOUR VISIT. THIS INCLUDES THYROID ULTRASOUND OR SCANS, MAMMOGRAMS, BREAST ULTRASOUNDS AND CT SCANS. IT ENABLES THE PHYSICIANS TO DO A MORE THOROUGH EVALUATION. YOUR APPOINTMENT COULD BE RESCHEDULED IF YOU DO NOT HAVE THESE ITEMS WITH YOU.

Please bring insurance card(s) and a picture ID to the appointment along with any insurance authorization if required. If scheduled due to an auto or work related injury, please have claim numbers and pertinent information required for billing.

Our office is located in the Edye Building at 4660 S Hagadorn Rd Suite 600 East Lansing, MI 48823. Parking is free. If you have any questions prior to your appointment time, please feel free to contact us at 517-267-2460 or toll free 888-451-2909.

Thank you for choosing MSU Department of Surgery. We look forward to taking care of all your surgical needs.

12/16/15

NEW PT PPWK
MICHIGAN STATE UNIVERSITY
DEPARTMENT OF SURGERY
New Patient Registration

Name (Last, First, Middle) ____________________________ Date of Birth ____________
Social Security# ____________________________ Sex M / F Marital Status M / S / D / W
Race ____________ Ethnicity ____________ Preferred Language ____________
Address ____________________________ Home Phone ____________
City, State, Zip Code ____________________________ Cell Phone ____________
Employer ____________________________ Work Phone ____________
Email Address ____________________________
Primary Care Dr ____________________________ Referring Dr ____________________________
Address ____________________________ Address ____________________________
Phone ____________ Fax ____________ Phone ____________ Fax ____________

Are you here as a result of an injury? Y / N If yes, Date of Injury ____________________________
Type of Injury (Please Circle) WORK AUTO OTHER ____________________________
Is this visit a follow-up from a recent surgery? Y / N Date of Surgery ____________________________

<table>
<thead>
<tr>
<th>Primary Insurance</th>
<th>Secondary Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Holders Name ____________________________</td>
<td>Policy Holders Name ____________________________</td>
</tr>
<tr>
<td>Address ____________________________</td>
<td>Address ____________________________</td>
</tr>
<tr>
<td>Relationship ____________ DOB ____________</td>
<td>Relationship ____________ DOB ____________</td>
</tr>
</tbody>
</table>

*Co-pay amount or percentage per office visit ____________________________

Emergency Contact:
Name ____________________________ Relationship ____________________________ Phone ____________________________

If patient is a minor, please fill out the following:
Mother’s Name ____________________________ Father’s Name ____________________________
Address ____________________________ Address ____________________________
Phone ____________ DOB ____________ Phone ____________ DOB ____________
Patient resides with: Both parents Mother Father Other ____________________________
### MSU DEPARTMENT OF SURGERY
### PATIENT PROFILE

<table>
<thead>
<tr>
<th>Legal Name:</th>
<th>Name You Prefer:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birthdate:</td>
<td>Age: Ht: Wt: Occupation:</td>
</tr>
<tr>
<td>Race:</td>
<td>Language: Method of Contact:</td>
</tr>
<tr>
<td>Smoking/Tobacco Use:</td>
<td>Current Quit Never</td>
</tr>
<tr>
<td>Second Hand Smoke:</td>
<td>Never Current Past</td>
</tr>
<tr>
<td>Smoking Cessation Counseling Given:</td>
<td>Yes No Deferred</td>
</tr>
<tr>
<td>Current Pain Level (1-10):</td>
<td>Where Referring Doctor:</td>
</tr>
<tr>
<td>Primary Doctor:</td>
<td></td>
</tr>
</tbody>
</table>

**PLEASE LIST ANY ALLERGIES OR SENSITIVITIES TO MEDICATIONS/FOOD/LATEX/OTHER:**

**PLEASE LIST ANY PREVIOUS SURGERIES OR HOSPITALIZATIONS (INCLUDE DATES):**

**PLEASE CIRCLE ANY OF THE FOLLOWING DIAGNOSES THAT APPLY:**

<table>
<thead>
<tr>
<th>Anemia</th>
<th>CVA/Stroke</th>
<th>Emphysema</th>
<th>Myocardial Infarction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia Complications</td>
<td>Coronary Heart Disease</td>
<td>GERD</td>
<td>Mitral Valve Prolapse</td>
</tr>
<tr>
<td>Antibiotic use prior to procedures</td>
<td>Chronic Renal Failure</td>
<td>Hepatitis A B C</td>
<td>Osteo/Rheumatoid Arthritis</td>
</tr>
<tr>
<td>Asthma</td>
<td>Cirrhosis</td>
<td>High Cholesterol</td>
<td>Osteoporosis</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>Colon Cancer</td>
<td>High Blood Pressure</td>
<td>Pancreatitis</td>
</tr>
<tr>
<td>Blood Transfusions</td>
<td>Crohn’s Disease</td>
<td>Hypothyroidism</td>
<td>Peripheral Vascular Disease</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>Deep Vein Thrombosis</td>
<td>Hyperthyroidism</td>
<td>Pulmonary Embolism</td>
</tr>
<tr>
<td>Breast Disease</td>
<td>Depression</td>
<td>IBS</td>
<td>Seizure Disorder</td>
</tr>
<tr>
<td>COPD</td>
<td>Diabetes-Type I</td>
<td>Kidney Disease</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Diabetes Type-II</td>
<td>Kidney Stone</td>
<td>Valvular Heart Disease</td>
<td>Varicose Veins/Phlebitis</td>
</tr>
<tr>
<td>Diverticulitis</td>
<td>Morbid Obesity</td>
<td>MRSA</td>
<td>VRE</td>
</tr>
<tr>
<td>Type of Cancer(s):</td>
<td></td>
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</tr>
</tbody>
</table>

**PLEASE LIST ALL MEDICATIONS YOU ARE TAKING INCLUDING BIRTH CONTROL AND “OVER THE COUNTER” MEDICATIONS OF ASPIRIN, TYLENOL, VITAMINS, ETC. (INCLUDE DOSAGE):**

Family History (Blood Relatives only)
CANCER: Breast, Cervical, Colon, Liver, Lung, Ovarian, Pancreatic, Prostate, Skin, Melanoma Coronary, Heart Disease, Colon Polyps, Thyroid Disease

7/21/14 VERSION

NEW PT PPWK
PLEASE CIRCLE ANY CONDITIONS THAT APPLY TODAY OR ON AN ON GOING BASIS

GENERAL: No concerns
Fever Fatigue Anemia Weight loss
Loss of Appetite

HEAD/EYE/EAR/NOSE/THROAT: No concerns
Decreased hearing Sore throat Neck swelling
Thyroid problems Mandibular/jaw fracture
Goiter Nasal fracture Dentures Seizures
Frequent headaches Glaucoma Cataracts
Blurred vision Eye injury

STOMACH/DIGESTION: No concerns
Abdominal pain Nausea Vomiting
Diarrhea Constipation Recent weight loss
Change in bowel habits Black tarry stools
Blood in stools Hepatitis Gas/Bloating
Indigestion/Heartburn Difficulty swallowing
Painful swallowing

BREAST: No concerns
Left breast lump Right breast lump
Nipple discharge Bloody nipple discharge
Breast pain Abnormal mammogram
Breast enlargement Nipple inversion

HEART/CIRCULATION: No concerns
Chest pain Irregular heart beat
Fainting/Blackout spells Heart surgery
Swelling of arms or legs Use of oxygen
History of heart attack

PULMONARY/LUNGS: No concerns
Cough Shortness of breath Blood in sputum
Wheezing Pain with breathing Use of oxygen
COPD Asthma

URINARY: No concerns
Incontinence Painful urination Blood in urine
Urinary frequency Urinary hesitancy Nocturia

FEMALE ONLY: No concerns
Vaginal discharge Abnormal vaginal bleeding
Pelvic pain Pregnancy Menopause HRT
# of pregnancies # of live births
Last menstrual period

MALE ONLY: No concerns
Abnormal discharge Erectile dysfunction

WOUND: No concerns
Redness Discharge Pain
Opening of wound Purulent discharge
Bleeding from wound

SKIN: No concerns
Suspicious lesions New skin lesions Rash
Changing moles History of Cancer Itching

NEUROLOGICAL: No concerns
Paralysis Parathesias Seizures
Dizziness Frequent headaches Head injury
History of Alzheimer’s History of stroke

PSYCHOLOGICAL: No concerns
Depression Anxiety Memory loss
Thoughts of suicide Hallucinations Claustrophobia

ENDOCRINE: No concerns
Heat intolerance Cold intolerance
Unusual weight change Exposure to radiation
Hair loss

HEMATOLOGY: No concerns
Abnormal bruising or bleeding Anemia
Enlarged lymph nodes Anticoagulation
Transfusion

MUSCULOSKELETAL: No concerns
Back pain Sciatica Arthritis

OTHER: No concerns
Stoma: Redness Pain Discharge
Vascular access: Redness Pain Discharge

SOCIAL HISTORY
Tobacco use: Current Quit Never
Year started: ___________________________
How much per day: ____________________
Second hand smoke: YES NO
Alcohol use: YES NO
Use of cocaine, marijuana, heroin, steroids: YES NO
History of treatment for substance abuse: YES NO
Hit, Slapped, or Kicked with in the past year: YES NO
Sexually abused within the past year: YES NO
Religious beliefs affecting care: YES NO

7/21/14 VERSION NEW PT PPWK
Patient Name: __________________________ Date of Birth: __________________________

What breast concerns are you being seen for today? ____________________________________________
Describe: ________________________________________________________________________________

**FAMILY BREAST CANCER HISTORY**

A: Is there a history of breast cancer in your blood related family? (If yes, complete section below)  

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>ONE BREAST</th>
<th>BOTH BREASTS</th>
<th>AGE AT DIAGNOSIS</th>
<th>TREATMENT RECEIVED</th>
<th>CIRCLE ONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grandmother(s)</td>
<td></td>
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</tr>
<tr>
<td>Mother</td>
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<tr>
<td>Sister(s)</td>
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<tr>
<td>Daughter(s)</td>
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<tr>
<td>Aunt(s)</td>
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<tr>
<td>Father</td>
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<tr>
<td>Brother(s)</td>
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<tr>
<td>Son(s)</td>
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</tr>
<tr>
<td>Uncle(s)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Grandfather(s)</td>
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</tr>
</tbody>
</table>

**PAST BREAST HISTORY**

A. Do you have any history of non-cancerous breast problems? (i.e. fibrocystic changes, mastitis) 

If yes, describe: __________________________________________________________________________

B. Have you had any procedures/operations or needle biopsies on your breast(s)? (If yes, please complete)  

<table>
<thead>
<tr>
<th>PROCEDURE DATE</th>
<th>BREAST</th>
<th>TYPE OF OPERATION</th>
<th>HOSPITAL CITY/STATE</th>
<th>SURGEON</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R / L</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>R / L</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>R / L</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. Have ever been diagnosed with breast cancer? (If yes, check ALL treatments below that apply)  

   ____ Mastectomy (surgical removal of breast) ____ Radiation (treatment to breast)
   ____ Lumpectomy or Wide Excision (removal of lump from breast only) ____ Radiation (treatment to chest wall)
   ____ Chemotherapy ____ Hormone Therapy (i.e. Tamoxifen)
   ____ Other __________________________________________________________________________

D. Have you ever received radiation (cobalt) treatments to face, tonsils, skin, thymus, chest for cancer?  

If yes, How much? _________________________________________________________________________ How long? ______________

**GYNECOLOGICAL HISTORY**

A. Age you began menstruating? _______ Stopped? _______ Naturally? ____ Due to surgery? ________
B. Have you had surgery to remove your uterus (womb)? YES NO
C. Any surgery to remove your ovaries? YES NO
D. Number of pregnancies _____ Number of completed deliveries _____ Age at first delivery _____
E. Have you ever taken estrogens, progesterone or hormonal pills? ___________ How long? _____
F. Have you taken any birth control? _______ What type? ___________ How long? ______

**CONCERNS ABOUT BREAST CANCER**

Please use the back of this form to tell us anything not covered above that could help us with your care.

Patient Signature: __________________________ Dr/Nurse Signature: __________________________ Date: __________________________
We are pleased to offer you a wide range of services to meet your surgical needs. Our team of surgeons, residents, nurses and staff provide exceptional health care in a comfortable and caring environment. We are committed to providing you the highest quality of compassionate surgical care. If you choose to have a procedure, we will work with your schedule to make arrangements. If your introduction to us is for an emergency or acute problem we are available every day and night of the year. Our team is dedicated to working with you, your family and your personal physician to personally and professionally provide your surgical care.

As our patient, you will have access to our clinical expertise. Our surgeons are faculty of Michigan State University College of Human Medicine and belong to the MSU Health Team, a large group of primary care and specialist physicians. Through collaboration with our colleagues, community physicians and our affiliation with area teaching hospitals, our surgeons provide a comprehensive approach to meet your health care needs. Our commitment to you includes the following:

- Our team will work together and we will offer consultation among our surgeons so you may benefit from our group’s expertise.
- Patient education is an important part of our practice. As experienced teachers, we are committed to providing you truthful information and the support you need to make informed decisions about your health care.
- As educators of the next generation of surgeons, it is our obligation and commitment to you to apply the most advanced scientific knowledge and surgical standards available for your benefit.

If we can be of any further assistance to you, please contact our office at (517) 267-2460. We are available Monday through Friday 8:00am to 4:45pm. Thank you for choosing MSU Surgery for your surgical care.
Your surgical team has many health care providers involved in your care. Your **Attending Surgeon**, as leader of the team, will discuss your medical and surgical concerns, options and recommended plan. Each surgeon in our Department is Board Certified or Board Eligible. This Board certification is another assurance that you are receiving care from the most qualified individuals. As faculty of MSU, our surgeons are actively involved in the education of surgical residents and medical students. **Surgical Residents** are licensed physicians who have a college degree and a medical degree. They have completed advanced education from an accredited medical school and are studying to become surgeons. **Medical Students** are individuals who have completed college, are enrolled in medical school and are training to become physicians. Both residents and students provide aspects of your care, but always under direction of your attending surgeon.

The information below should help to clarify medical titles and level of education.

<table>
<thead>
<tr>
<th>TITLE</th>
<th>TRAINING</th>
<th>LEVEL OF PHYSICIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending Physician</td>
<td>Medical degree with completion of advanced training in surgery</td>
<td></td>
</tr>
<tr>
<td>Chief Resident</td>
<td>Medical degree in last year of advanced training in surgery</td>
<td></td>
</tr>
<tr>
<td>Resident</td>
<td>Medical degree in 2(^{nd})-4(^{th}) year of advanced training in surgery</td>
<td></td>
</tr>
<tr>
<td>Intern</td>
<td>Medical degree in 1(^{st}) year of advanced training in surgery</td>
<td></td>
</tr>
<tr>
<td>Medical Student</td>
<td>College degree (enrolled in medical school)</td>
<td></td>
</tr>
<tr>
<td>Pre Medical Student</td>
<td>No college degree (enrolled in college)</td>
<td></td>
</tr>
</tbody>
</table>
Patient Name: ___________________________ Date of Birth __________

(Please Print - Last Name, First Name, Middle Initial)

PAYMENT
I acknowledge it is my responsibility to pay for any services I receive from the MSU HealthTeam.

Signature ___________________________________________ Date __________

IF I HAVE INSURANCE, I acknowledge Michigan State University HealthTeam will disclose protected health information to my insurance carrier or other third party responsible for my bill as required in order to receive reimbursement for services provided. This information may include mental health treatment, genetic testing, and information about serious communicable diseases, such as STDs, hepatitis, HIV and AIDS.

I authorize and request assignment of benefits to be paid directly to Michigan State University. I acknowledge and agree to pay any unpaid balances not covered by my insurance policy, including deductibles, co-payments, and unauthorized or out of network services.

Signature ___________________________________________ Date __________

MEDICARE PATIENTS ONLY
I authorize and request that payment of authorized Medicare benefits be made to the MSU HealthTeam on my behalf for any services furnished to me by a provider of the MSU HealthTeam.

Signature ___________________________________________ Date __________

MSU HEALTHTEAM NOTICE OF PRIVACY PRACTICE
I acknowledge that I have been offered the MSU HealthTeam Notice of Privacy Practices

Signature ___________________________________________ Date __________

COMMUNICATION OF YOUR PROTECTED HEALTH INFORMATION
If you want us to speak with another individual about your care, please list their name, relationship to you, and phone number:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature ___________________________________________ Date __________
E-MAIL CONSENT FORM FOR NON-SECURE E-MAIL

Patient Name: ___________________________ Date of Birth: ___________________

Patient E-mail Address: ____________________________________________________

- MSU HealthTeam cannot guarantee the security and confidentiality of an e-mail transmission. Employers and on-line services have the right to access and archive e-mail transmitted through their systems. If your e-mail is a family address, other family members may see your messages, therefore, please be aware that you e-mail at your own risk. Because of the many internet and e-mail factors beyond our control, we cannot be responsible for misaddressed, misdelivered or interrupted e-mail. Your health care provider is not liable for breaches of confidentiality caused by yourself or a third party.

- E-mail is best suited for routine matters and simple questions. You should not send us e-mail for urgent or emergency situations or for matters requiring an immediate response. Your provider will attempt to read and respond promptly to e-mail but cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Time sensitive issues should be taken care of by telephone.

- Please do not use e-mail for communications regarding sensitive health information, such as sexually transmitted diseases, AIDS/HIV, mental health or substance abuse.

- Please include your full name, birthdate and telephone number in all e-mails. List the subject of your e-mail in the “Subject” line of your message.

- All e-mails between you and your provider regarding diagnosis or treatment will be printed and made part of your permanent health information.

- Your provider may forward your e-mail to other staff members as necessary for response. However, your e-mail will not be forwarded outside the HealthTeam without your authorization.

- In order to prevent the introduction of computer viruses into our system, do not send attachments to us in your e-mail.

- You are responsible for protecting your password or other means of access to e-mail.

Signature of Patient: ___________________________ Date: ___________________

Witness: ___________________________ Date: ___________________
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

The Michigan State University HealthTeam is a multi-specialty medical practice which is comprised of teaching faculty from MSU's College of Human Medicine, College of Osteopathic Medicine, and the College of Nursing. All of the HealthTeam clinics located in the greater Lansing area share a common electronic health record (EHR).

We are required by law to maintain the privacy of your protected health information and to provide you with information that describes our privacy practices. This Notice of Privacy Practices describes how the MSU HealthTeam will use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are required or permitted by federal, state, and local law. This Notice also contains information about your rights to access and control your protected health information.

Uses and Disclosures of Protected Health Information for Treatment, Payment, or Health Care Operations

Federal privacy rules permit the MSU HealthTeam to use and disclose your protected health information without your written authorization for the purposes of treatment, payment, or health care operations.

Treatment: Your protected health information will be used and disclosed to provide, coordinate, or manage your health care and any related services. This includes the coordination and/or management of your health care with another health care provider for treatment purposes. The MSU HealthTeam participates in certain health information exchanges to facilitate the secure exchange of your health information electronically between health care providers and health care entities for your treatment, payment, or other healthcare operations purposes. This means that we may share information we obtain or create about you with outside entities (such as hospitals, doctor’s offices, and pharmacies) or we may receive information they create or obtain about you so that each of us can provide better treatment and coordinate your health care services.

Examples: The MSU HealthTeam may disclose protected health information to other health care providers, such as your primary care physician or when we refer you to a specialist who will participate in your treatment. We may disclose your protected health information to a pharmacy in order to fill your prescription, or to coordinate referrals for other health care services such as radiology or physical therapy.

Payment: Your protected health information will be used and disclosed to obtain payment for the services we provide to you. This includes communicating with your insurance carrier about your insurance benefits.

Examples: The MSU HealthTeam will disclose protected health information to your insurance carrier in order to receive payment for our services. We may disclose protected health information in order to determine if you are eligible for specialized services, the range of services that can be provided, and to obtain prior approval, if needed, for those services.

Health Care Operations: Your protected health information will be used and disclosed in order to operate our practice. Health care operations include activities such as quality assessment and improvement; providing educational training programs for medical, nursing, and other allied health and non-health care professionals; accreditation, certification, and licensing activities; and general administrative, legal, and auditing activities.

Examples: The MSU HealthTeam may use protected health information in the training of health professions students who are working in our clinics. We may use protected health information to evaluate the quality of care that you receive from us, or to conduct cost-management and business planning activities. We may disclose protected health information to a business associate who performs a function or activity on our behalf, such as a typing services or collection services.

Certain Other Uses and Disclosures: Your protected health information may be used to remind you of appointments, medication refills, treatment alternatives, and/or other health-related benefits and services that may be of interest to you. We may disclose limited protected health information to a family member or close personal friend that you designate as being involved in your care.

Uses and Disclosures of Protected Health Information That Are Required or Permitted by Law

Public Health Activities: We will use and disclose your protected health information for the following public health activities and purposes as required or permitted by law:

- To prevent, control, or report disease, injury, or disability.
- To report suspected child abuse or neglect.
- To conduct public health surveillance, investigations, and interventions.
- To collect or report adverse events and product defects; enable product recalls, repairs, or replacements to FDA-regulated products or activities; and to track FDA-regulated products or conduct post-marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.
- To report to an employer about an individual who is a member of the workforce if there is a work-related injury or illness or to conduct an evaluation relating to medical surveillance of the workplace.
- To report proof of immunizations to a school about an individual who is a student or prospective student of the school.

To Report Suspected Abuse, Neglect, or Domestic Violence: We will use and disclose your protected health information to notify government authorities as required by law if we believe you are the victim of abuse, neglect, or domestic violence. If we make such a disclosure, we will inform you unless we believe that this will place you at risk of serious harm.

Health Oversight Activities: We will disclose your protected health information to a health oversight agency for activities authorized by law including audits; civil, administrative, or criminal investigations, proceedings or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight.
JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We will use and disclose your protected health information in the course of a judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. We may disclose your protected health information in response to a subpoena to the extent authorized by law.

LAW ENFORCEMENT: We will disclose your protected health information to a law enforcement official for law enforcement purposes as follows:
- As required by law for reporting certain types of wounds or other physical injuries.
- Pursuant to a court order, court-ordered warrant, subpoena, summons, or similar process authorized under law.
- For the purposes of identifying or locating a suspect, fugitive, material witness, or missing person.
- Under certain circumstances when there is a crime on our premises.
- In an emergency, to report a crime.

CORONERS, FUNERAL DIRECTORS, AND ORGAN DONATION: We may disclose your protected health information to a coroner or medical examiner for identification purposes, to determine cause of death, or to perform other duties authorized by law. We may disclose your protected health information to a funeral director in order for them to carry out their duties. We may disclose your protected health information if you are an organ donor for organ, eye, or tissue donation purposes.

RESEARCH: We may use and disclose your protected health information for research purposes when our institutional review board or privacy board waives the requirement to obtain an individual authorization.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY: We may disclose your protected health information when necessary to prevent or lessen a serious and imminent threat to your health or safety, or the health and safety of the public.

SPECIALIZED GOVERNMENT FUNCTION: We may use and disclose your protected health information to facilitate specific government functions relating to military and veterans activities, national security and intelligence activities, protective services to the President and others, medical suitability determinations, public benefit programs, correctional institutions and law enforcement custodial situations.

WORKERS’ COMPENSATION: We may use and disclose your protected health information to comply with laws related to workers’ compensation or similar programs established by law to provide benefits for work-related illnesses or injuries.

OTHER AS REQUIRED BY LAW: We will use and disclose your protected health information to the extent that such use or disclosure is required by laws not listed above.

Other than as stated in the previous paragraphs, we will not disclose your PHI without your written authorization. We are specifically required to obtain your written authorization for all treatment and health care communications (except face to face) if the HealthTeam receives financial remuneration from a third party whose product or service is being marketed in exchange for making the communication. In addition, most uses and disclosures psychotherapy notes will only be made with your written authorization. You may revoke your written authorization at anytime, except to the extent that action has been taken in reliance on the authorization.

YOUR RIGHTS UNDER THE PRIVACY RULE:

- The right to inspect and request a copy of your protected health information, to the extent allowed by law. You may inspect and obtain a copy (paper or electronic) of the protected health information that is contained in your designated record set for as long as we maintain the protected health information. The designated record set contains both medical records and billing records. A fee may be charged to cover the copying, supplies, and postage costs incurred in complying with your request.
- The right to request communication of your protected health information by an alternative means or at an alternative location. You may request that we communicate with you in certain ways and we will accommodate reasonable requests. We will not require you to provide an explanation for your request.
- The right to request a restriction on the use and disclosure of your protected health information for treatment, payment, or health care operations purposes. With one exception, we are not required to agree to a restriction and will notify you if we deny the request. If we do agree, your protected health information will not be used or disclosed in violation of the restriction unless it is needed to provide you with emergency treatment. We are required to agree to the restriction if you pay 100% out of pocket for items or service and request that we do not disclose this to your health plan.
- The right to request amendments to your protected health information. This request must be in writing and you must provide a reason to support the requested amendment. In certain cases, we may deny your request. If we do, you have the right to file a statement of disagreement with us. If we prepare a rebuttal to your statement of disagreement, we will provide you with a copy.
- The right to receive an accounting of certain disclosures. You have the right to receive an accounting of certain disclosures of your protected health information by the MSU HealthTeam. Your request for an accounting must be in writing and you are permitted one free accounting during any 12-month period but subsequent requests for an accounting will incur a fee.
- The right to be notified of a breach of your protected health information. The HealthTeam must notify you as soon as possible and no later than 60 days following discovery of the breach.
- The right to obtain a paper copy of this Notice. You may ask for a copy of this Notice at any time. You may also access the Notice on our website at www.healthteam.msu.edu.

If you are interested in pursuing any of these rights, please discuss them with your health care provider or contact the MSU HealthTeam Privacy Officer at (517) 355-1822.

CHANGES TO THIS NOTICE:
We reserve the right to revise, change, or amend our Notice of Privacy Practices. Any revisions or amendments to this notice will be effective for all of the protected health information that we already have as well as any protected health information that we may create, receive, or maintain in the future. The MSU HealthTeam will post a copy of our current Notice in prominent locations within our clinics and you may request a current Notice during any visit to our organization or by calling the MSU HealthTeam Privacy Officer at (517) 355-1822. In addition, you will find our current Notice on our website at www.healthteam.msu.edu.

COMPLAINTS:
If you believe your privacy rights have been violated, you may file a complaint with the Michigan State University Privacy Officer or with the Secretary of the Department of Health and Human Services. Complaints must be submitted in writing. You will not be penalized for filing a complaint.
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