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. 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.

***IF YOU ARE SEEING ONE OF OUR BREAST SPECIALISTS PLEASE BRING YOUR FILMS/DISCS FROM ANY IMAGING FACILITY OUTSIDE OF SPARROW (INCLUDING MSU)***

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 at 1200 E Michigan in the Sparrow Professional Building on the 6th floor in Suite 655. The Sparrow Professional Building is located directly across from Sparrow Hospital. 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.

12/18/14
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 ________________

Primary Insurance ____________________________ Secondary Insurance ____________________________

Policy Holders Name ____________________________ Policy Holders Name ____________________________

Address ____________________________ Address ____________________________

Relationship ________________ DOB ________________ Relationship ________________ DOB ________________

*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 ____________________________

7/21/14 VERSION

NEW PT PPWK
# 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: Language: Method of Contact:</td>
<td></td>
</tr>
<tr>
<td>Smoking/Tobacco Use:</td>
<td>Current</td>
</tr>
<tr>
<td>Second Hand Smoke:</td>
<td>Never</td>
</tr>
<tr>
<td>Smoking Cessation Counseling Given:</td>
<td>Yes</td>
</tr>
<tr>
<td>Current Pain Level (1-10)</td>
<td>Where</td>
</tr>
<tr>
<td>Primary Doctor: Reason for Visit Today:</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>
<td></td>
<td></td>
</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
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  Stents  
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:**  
Period started  Duration of Period  
Any problems with periods  
Sexually active  YES or NO  Birth Control  
Has patient been pregnant  YES or NO  
History of sexually transmitted disease  YES or NO  
Vaginal Discharge  YES or NO

**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

**DEVELOPMENTAL HISTORY:**  
Gestational age at birth _____ weeks  
Weight _____ Complications YES or NO  
Intubate  Oxygen  NICU _____ weeks  
Birth Defects  
Developmental Delays

**IMMUNIZATION HISTORY:**  
Immunizations up to date YES or NO  
Has patient had Chickenpox  YES or NO  
Meningococcal Vaccine  YES or NO  
Pneumococcal Vaccine  YES or NO  
Has patient had a TB skin test  YES or NO  
DATE _____ RESULT _____

3/30/15 VERSION  MINOR NEW PT PPWK
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 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>
</tr>
<tr>
<td>Chief Resident</td>
<td>Medical degree in last year of advanced training in surgery</td>
</tr>
<tr>
<td>Resident</td>
<td>Medical degree in 2nd-4th year of advanced training in surgery</td>
</tr>
<tr>
<td>Intern</td>
<td>Medical degree in 1st year of advanced training in surgery</td>
</tr>
<tr>
<td>Medical Student</td>
<td>College degree (enrolled in medical school)</td>
</tr>
<tr>
<td>Pre Medical Student</td>
<td>No college degree (enrolled in college)</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.

_________________________________________ Date
Signature

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.

_________________________________________ Date
Signature

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.

_________________________________________ Date
Signature

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

_________________________________________ Date
Signature

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>

_________________________________________ Date
Signature
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.

Effective Date: February 1, 2005

Revision Date: April 1, 2013