Alaska Children's EYE and Strabismus DATE:___________________

Robin Grendahl, M.D. * R. Kevin Winkle, M.D., * Robert Arnold, M.D. • Kyle Smith, O.D.

PLEASE COMPLETE AND RETURN TO OUR OFFICE (fax 563-5373 or info@AlaskaChildrensEye.com)

Each Individual patient -→ page 2. Several Children → page 3

PATIENT NAME:____________________________ SOCIAL SECURITY:__________________

ADDRESS:____ SEX: ☐ (M) ☐ (F)

CITY:___________________________STATE:_______ Date of Birth________________Age______

ZIP CODE:_______________________ PHONE (home):________________cell_________________

Referred by:______________________ Pediatrician/Primary doctor:_________________________

Medical Provider(s):______________________,_________________,________________

If patient is a child: (see page 3 for multiple children)

MOTHER'S NAME:__________________________ FATHER'S NAME:__________________________

MOTHER'S WK PHONE:____________________ GUARDIAN'S NAME:_______________________

FATHER'S WK PHONE:___________________ E mail ________________________

LOCAL CONTACT NUMBER (IF FROM OUTSIDE ANCHORAGE):________________________

EMERGENCY CONTACT____

Who is financially responsible?: __________________________________

As a courtesy we will bill your medical insurance. You will be responsible for whatever your insurance does not pay. We are a medical provider and therefore we do not accept vision insurance. We are not currently considered "Preferred Providers" with any insurance group. Please call us in advance if you have further questions.

WE WILL ALSO NEED A COPY OF YOUR INSURANCE CARD(s). If different insurance for each child- see page 3**. If Satellite Clinic or you cannot give us copy of the insurance card(s)- Please fill out:**

PRIMARY:

INSURANCE COMPANY:____

INS. CO. ADDRESS:____

ID NUMBER:________________________________GROUP NUMBER:_________________

FULL NAME, DATE OF BIRTH AND SOCIAL SECURITY NUMBER OF THE INSURED:

____

SECONDARY:

INSURANCE COMPANY:____

INS. CO. ADDRESS:____

ID NUMBER:________________________________GROUP NUMBER:_________________

FULL NAME, DATE OF BIRTH AND SOCIAL SECURITY NUMBER OF THE INSURED:

____

*** If Tricare or Alaska Native Health Service insures you, provide a letter of pre-authorization **BEFORE** you are seen.

PREFERRED PHARMACY____

Alaska Children's EYE and Strabismus

DATE:__________________

Robin Grendahl, M.D. * R. Kevin Winkle, M.D., * Robert Arnold, M.D. • Kyle Smith, O.D.

Page 2: **Each Patient**: → Bring to exam or RETURN TO OUR OFFICE (fax 563-5373 or info@AlaskaChildrensEye.com)

PATIENT First NAME:______________________________ Last NAME:____________________________

SOCIAL SECURITY:____________________ e-mail ___________________________

SEX: ☐ (M) ☐ (F) Date of Birth__________________ Age______

Referred by:_________________________ Pediatrician/Primary doctor:____________________________

Medical Provider(s):_________________________,___________________,__________________

DOES the Patient WEAR GLASSES? ☐ NO ☐ YES How old are glasses?_______

Which school does / did the patient attend? ______________________________

List Special doctors and therapist who should know about this exam:_________________________

Patient's MEDICAL HISTORY

☑ *Check if present* *Describe / Comment*

- ☐ Birth Difficulties
- ☐ SPECIAL NEEDS / autism
- ☐ Strabismus (ie crossed eyes)
- ☐ A.D.H.D
- ☐ DIABETES
- ☐ THYROID DISEASE
- ☐ HIV/ HEPATITIS
- ☐ DEAFNESS
- ☐ **Syndrome**:
- ☐ Prematurity
- ☐ CATARACTS
- ☐ AMBLYOPIA
- ☐ ASTHMA
- ☐ ARTHRITIS
- ☐ HEART DISEASE
- ☐ TUBERCULOSIS
- ☐ SINUS PROBLEMS

____

☐ Serious Anesthesia problem: _____________________________________

☐ Eye Injury?: ____

☐ Eye Surgery? ____

Please describe below. Use back of page if needed:

ALLERGIES:________________________ MEDICATIONS:________________________

*It often takes **2 hours** for a new patient or complete eye exam.* If you are a new patient or here for your yearly eye exam, **your eyes may be dilated**.

PLEASE SILENCE YOUR PHONE WHILE IN THE EXAM ROOM.
We encourage you to review aspects of Pediatric eyes and strabismus on www.AlaskaChildrensEye.com on our FREE Patient WiFi. (password "eyeseeyou")

Robin Grendahl, M.D. * R. Kevin Winkle, M.D., * Robert Arnold, M.D. • Kyle Smith, O.D.

Page 3: **Family Members**: → Bring to exam or RETURN TO OUR OFFICE (fax 563-5373 or info@AlaskaChildrensEye.com)

Father:________________________________ Mother:________________________________

Each Child by Columns:

Name:	____________	____________	____________
	____________	____________	____________
Birth Date:	____/____/____	____/____/____	____/____/____
Gender:	☐M / ☐F	☐M / ☐F	☐M / ☐F
Social Security#	____________	____________	____________
Attends which School?	____________	____________	____________
Allergies:	☐ ____________	☐ ____________	☐ ____________
	____________	____________	____________
Medications:	☐ ____________	☐ ____________	☐ ____________
	____________	____________	____________
Does Child wear Glasses?	☐Y ☐ N	☐Y ☐ N	☐ Y ☐ N
Check ☑ only if child has condition: *Then comment below.*			
Birth Difficulties	☐ ____________	☐ ____________	☐ ____________
Prematurity	☐ ____________	☐ ____________	☐ ____________
Special Needs / Autism	☐ ____________	☐ ____________	☐ ____________
Cataracts	☐ ____________	☐ ____________	☐ ____________
Strabismus (ie crossed eyes)	☐ ____________	☐ ____________	☐ ____________
Amblyopia	☐ ____________	☐ ____________	☐ ____________
A.D.H.D.	☐ ____________	☐ ____________	☐ ____________
Asthma	☐ ____________	☐ ____________	☐ ____________
Diabetes	☐ ____________	☐ ____________	☐ ____________
Arthritis:	☐ ____________	☐ ____________	☐ ____________
Thyroid Disease	☐ ____________	☐ ____________	☐ ____________
Heart Disease	☐ ____________	☐ ____________	☐ ____________
Seizures	☐ ____________	☐ ____________	☐ ____________
HIV / Hepatitis	☐ ____________	☐ ____________	☐ ____________
Tuberculosis	☐ ____________	☐ ____________	☐ ____________
Deafness	☐ ____________	☐ ____________	☐ ____________
Sinus Problems	☐ ____________	☐ ____________	☐ ____________
Serious Anesthesia Problem	☐ ____________	☐ ____________	☐ ____________
Eye Injury:	☐ ____________	☐ ____________	☐ ____________
Eye Surgery:	☐ ____________	☐ ____________	☐ ____________
Syndrome (describe)	☐ ____________	☐ ____________	☐ ____________
Comments:			
	____________	____________	____________
	____________	____________	____________
	____________	____________	____________
	____________	____________	____________
Need more room? Write on back	____________	____________	____________
	____________	____________	____________
Different Insurance on this child?	☐ ____________	☐ ____________	☐ ____________

Dear Patient:

Your privacy is important to us. We may need your permission to speak to anyone regarding your care and medications. Please list below any family members or healthcare providers who may contact us about your current medications or care. We will also need your signature at the bottom of this form giving us written permission to communicate with the individuals listed below.

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

I,____, give Alaska Children's Eye and Strabismus permission to discuss my current care and medications with the individuals or organizations listed above.

Witness:_________________________________ Date:_____________________________

EXCLUSIONS: Please do NOT share information with the following without my permission:

_____________________________________ aka (alias) _______________________________

_____________________________________ aka (alias) _______________________________

Family's NAME_______________________________

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to ALASKA CHILDREN'S EYE AND STRABISMUS, for services furnished me by ALASKA CHILDREN'S EYE AND STRABISMUS. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. ALASKA CHILDREN'S EYE AND STRABISMUS accepts the charge determination of the Medicare carrier as full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2.MEDIGAP: I understand that if Medigap policy or other health insurance in item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to ALASKA CHILDREN'S EYE AND STRABISMUS, if possible or otherwise to me.

3. RELEASE OF INFORMATION: ALASKA CHILDREN'S EYE AND STRABISMUS may disclose all or any part of my medical record and/financial ledger information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to ALASKA CHILDREN'S EYE AND STRABISMUS, for reimbursement for services rendered, and (2) any health care provider for continued patient care. ALASKA CHILDREN'S EYE AND STRABISMUS may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. OTHER INSURANCE- I understand that ALASKA CHILDREN'S EYE AND STRABISMUS maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that ALASKA CHILDREN'S EYE AND STRABISMUS has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by ALASKA CHILDREN'S EYE AND STRABISMUS if I belong to a plan that does not appear on the above mentioned list.

5.NON-COVERED SERVICES- I understand that ALASKA CHILDREN'S EYE AND STRABISMUS contracts with health care service plans (i.e. HMO's PPO's) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with ALASKA CHILDREN'S EYE AND STRABISMUS to obtain necessary health care service plan authorizations.

6. FINANCIAL AGREEMENT: I agree in return for the services provided to the patient by ALASKA CHILDREN'S EYE AND STRABISMUS I will pay my account at the time service is rendered or will make financial arrangements satisfactory to ALASKA CHILDREN'S EYE AND STRABISMUS for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to ALASKA CHILDREN'S EYE AND STRABISMUS, if copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to ALASKA CHILDREN'S EYE AND STRABISMUS. However, it is understood that the undersigned and or the patient are primarily responsible for the payment of my bill.

_______________________________________ ________________________

Signature or Authorized Party Date

Alaska Children's Eye & Strabismus QR code:

Alaska Children's Eye & Strabismus Facebook Page QR code:

"Meaningful Use"

Patient Name:______________________________ Date: ____________

Alaska Children's EYE & Strabismus (ACES) uses an electronic medical record (EMR). The information requested on this form is Federally mandated for "Meaningful Use." ACES understands if you do not wish to disclose this information. Please select "Decline to Provide" option; otherwise please select the option best suited to the patient.

Payment Method: ☐ Cash ☐ Check ☐ Credit Card

Preferred Language: ______________________________ Decline to Provide: ___

Gender: ☐ Male ☐ Female ☐ Non-Declared

Race:
☐ American Indian
☐ Alaska Native
☐ Asian
☐ Black / African American
☐ Pacific Islander. ☐ Native Hawaiian
☐ White
☐ Decline to Provide

Ethnicity:
☐ Hispanic or Latino
☐ Non-Hispanic or non-Latino
☐ Decline to Provide

Preferred means of communication with Alaska Children's EYE & Strabismus
☐ Phone: ☐ Letter ☐ email

Please provide e-mail address: __________________________________

Concerning your option / privilege to receive communication from Alaska Children's EYE & Strabismus's EMR (S.R.S. Communicator), a secure patient portal, using the email provided above:

☐ I consent to receive this information.
☐ I decline to receive communication regarding pertinent information in the ACES EMR.

Our electronic Medical Record can "pull" your medication list from your preferred pharmacy if you like:
☐ I consent link pharmacy information with ACES EMR (This helps avoid bad drug interactions)
☐ I decline to link my medication information.
My Preferred Pharmacy: _______________________________

Signature: ____

NOTICE OF PRIVACY PRACTICES (HIPAA)

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

OUR COMMITMENT TO YOUR PRIVACY
We at Alaska Children's EYE & Strabismus are required by law to maintain the privacy of Protected Health Information (PHI) and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information.

Effective Date: _April 13, 2003__ This Notice was revised on: __September 2, 2015__

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR COMPLIANCE OFFICER:

Compliance Officer: Wayne Earle
Telephone: 907-561-1917
Fax: 907-563-5373

How We May Use and Disclose Your Protected Health Information
We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose, treat you, or provide you with a service.
- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and to collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you; such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.
- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.
- **Appointment Reminders/Treatment Alternatives.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.
- **Minors.** We may use and disclose Protected Health Information of minor children to their parents or guardians unless such disclosure in otherwise prohibited by law.
- **As Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety; or to the health and safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.
- **Workers' Compensation.** We may use and disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1)a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety, or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury, or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medication or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting for spreading a disease or condition.
- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example; audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Data Breach Notification Purposes.** We may use and disclose Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We may also disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute; but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.
- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.
- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities' or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is 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) the safety and security of the correction institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosure of your Protected Health Information will be made only with your written authorization:

Uses and disclosure of Protected Health Information for marketing purposes.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Compliance Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decision about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the out of the review.
- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been proved to you, so long as you agree to this alternative form and pay the associated fees.
- **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record "EMR" or electronic health record "EHR"), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in that format. If the information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the EMR.
- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Compliance Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases we may deny your request for an amendment. If we deny your request you have the right to file a statement of disagreement with us and we may prepare rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures", which is a list of the disclosure we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Notice. It excludes disclosure we may have made to you, *for a resident directory*, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic medical records. The first accounting of disclosures you request within a 12-month period will be free. For additional requests within the same period we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. To request a restriction, you must submit a written request to the Compliance Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.
- **Out-of-Pocket Payments.** If you paid out-of-pocket in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not de disclosed to a health plan for purposes of payment or health care operations and we will honor that request.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at you work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receiver this Notice electronically. You may request a copy of the Notice at any time.

How to Exercise Your Rights

To exercise the rights described in this Notice send your request, in writing, to our Compliance Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this notice, contact our Compliance Officer by phone or mail.

Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Compliance Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail your written complaint to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775)) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.