CASWELL COUNTY HEALTH DEPARTMENT
PATIENT INFORMATION SHEET

(PLEASE PRINT) ***CDSN #*** _____

NAME: Last _____ First _____ Middle Initial ____Maiden Name: _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** _____

RACE: ☐White ☐Black ☐Amer Indian/Alaskan Native ☐Asian ☐Hawaiian/Pacific Islander **Hispanic/Latin Origin** ☐ Yes ☐ No

GENDER: ☐ Male ☐ Female **MARITAL STATUS:** ☐Single ☐Married ☐Divorced ☐Widowed

Date	Mail Y/No	Address	Primary Number (Include Area Code)	Alternative Number (Include Area Code)
		Mailing Address:	Cell ☐ Home ☐ Work ☐	Cell ☐ Home ☐ Work ☐
		Physical Address: (If different)	County of Physical Address:	
		Address Change		
		Address Change		
		Address Change		
		Address Change		

English Speaking ☐ Yes ☐ No Language_____ Migrant Farm Worker ☐ Yes ☐ No Refugee ☐ Yes ☐ No Seasonal Farm Worker ☐ Yes ☐ No Homeless ☐ Yes ☐ No	Interpreter needed ☐ Yes ☐ No COUNTRY OF ORIGIN: _____

Confidential Contact _____ Phone_____
Name Relationship

Emergency Contact _____ Phone_____
Name Relationship

PLEASE COMPLETE THE FOLLOWING INFORMATION TO DETERMINE IF YOU ARE ELIGIBLE FOR A DISCOUNT BASED ON YOUR INCOME AND FAMILY SIZE. THIS IS REQUIRED FOR THE DISCOUNT.
►►►► YOU WILL BE ASKED TO SHOW PROOF OF ALL INCOME ◄◄◄◄

How Many Adults (age 21 or greater) Live In Your House _____ How Many Children Live In Your House _____
(please include patient)

Date	All Names Of Household Members (Last Name, First Name)	Relationship To Patient	Age	List All Employers Or Sources Of Income	Length Of Employment	Total Income Before Taxes
		Patient				

DO YOU HAVE ANY OF THE FOLLOWING TYPES OF INSURANCE?

Medicaid Yes ☐ No ☐ If You Have Medicaid, Please Provide Your ID Number _____
Medicare Yes ☐ No ☐ If You Have Medicare, Please Provide Your ID Number _____

Please List Below Any Other Insurance You Are Covered By:

Insurance Company _____ ID Number _____
Insurance Company _____ ID Number _____

The Information I Have Given Above Is Correct.
I Understand That The Health Department Has The Right To Check This Information For Accuracy.

Signature _____ Date _____

CASWELL COUNTY HEALTH DEPARTMENT ❖ YANCEYVILLE, NC 27379

PERMISSION TO USE AND DISCLOSE PATIENT HEALTH INFORMATION AND ASSIGNMENT OF BENEFITS

Last Name _____ First Name _____ MI _____

Patient SS# _____ Date of Birth ____/____/____

Acknowledgement Of Receipt Of The Notice Of Privacy Practices

I hereby acknowledge that I have received a copy of the "Notice of Privacy Practices" for the Caswell County Health Department and understand that I may contact the person named therein if I have questions about the content of the notice.

✓ _____ Patient/Parent/Legal Guardian _____ Date

_____ Witness _____ Date

Consent For Use And Disclose Of Health/Medical Information

I give my voluntary consent for the Caswell County Health Department to use and disclose health/medical information regarding _____ for purposes of
Patient's Name
treatment, payment and health care operations as defined in the "Notice of Privacy Practices" mentioned above. I understand that the health/medical information used and disclosed may include information about communicable diseases (such as HIV). I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. I understand that this consent is valid until I revoke it and that if I want to revoke this consent, I must do so in writing.

✓ _____ gnature of Patient _____ Date

_____ Signature of parent, legal guardian, or other legally responsible person (when required) _____ Date

_____ Witness _____ Date

Assignment Of Benefits

I authorize all public and/or private health insurance to pay medical benefits directly to the Caswell County Health Department for services provided by the Caswell County Health Department, unless such payment is prohibited by the health insurance provider. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. I understand that this consent is valid until I revoke it and that if I want to revoke this consent, I must do so in writing.

✓ _____ Signature of Patient _____ Date

_____ Signature of parent, legal guardian, or other legally responsible person (when required) _____ Date

_____ Witness _____ Date

1. Last Name	First Name	MI
2. Patient Number		
3. Date of Birth (MM/DD/YYYY)	Month / Day / Year	
4. Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ White		
5. Ethnic Origin ☐ Hispanic Cuban ☐ Hispanic Mexican American ☐ Hispanic Other ☐ Hispanic Puerto Rican ☐ Not Hispanic/Latino ☐ Unreported		
6. Gender ☐ Female ☐ Male		
7. County of Residence		
8. Home Address:	9. Marital Status:	

CONFIDENTIAL

North Carolina Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section

MALE REPRODUCTIVE HEALTH HISTORY

Date: _____

A. GENERAL INFORMATION (Please complete the following)

1. What is the reason for your visit today? _____
2. Emergency contact: _____
3. May we contact you by mail? ☐ Yes ☐ No By phone? ☐ Yes ☐ No Your phone number is _____
4. Do you have a primary care provider? ☐ Yes ☐ No If yes, who? _____
5. Highest grade completed in school _____
6. Occupation _____
7. Special Needs/Primary Language _____

B. MEDICAL HISTORY, HOSPITALIZATIONS, MEDICATIONS

1. List hospitalizations, surgeries and dates: _____
2. Medications: Do you take any medications (prescription or over the counter), diet or herbal supplements? ☐ Yes ☐ No If yes, what?
   _____
3. Self and Family Medical History: Put an **X** under **SELF** and/or **X** under **FAMILY** (parent, grandparent, brother, sister or your child)

SELF	FAMILY		SELF	FAMILY	
☐	☐	1. Anemia/Sickle Cell Disease or Trait/Blood disorder	☐	☐	9. Hepatitis/Liver problems
☐	☐	2. Heart disease	☐	☐	10. Migraine headaches
☐	☐	3. Diabetes	☐	☐	11. Cancer
☐	☐	4. Hypertension/High cholesterol	☐	☐	12. Blood clots in legs or lungs
☐	☐	5. Thyroid/Endocrine	☐	☐	13. Mental illness/Emotional disorders
☐	☐	6. Pulmonary Disease	☐	☐	14. Transfusions of blood or blood products
☐	☐	7. Kidney Disease	☐	☐	15. Birth defects/Genetic problems
☐	☐	8. Seizure Disorders	☐	☐	16. Tuberculosis

If yes to any of the above, please explain: _____

C. SEXUAL HISTORY (This section lends itself to being a self [patient completed] or a dialogue with the provider)

1. Do you have sex with? ☐ Men only ☐ Women only ☐ Both men and women
2. In the past two months, how many partners have you had sex with? _____
3. In the past 12 months, how many partners have you had sex with? _____
4. Is it possible that any of your sex partners in the past 12 months had sex with someone else while they were still in a sexual relationship with you? ☐ Yes ☐ No
5. What do you do to protect yourself from STDs and HIV? _____
6. What ways do you have sex? ☐ vaginal ☐ oral ☐ anal
7. Do you or your partner use condoms and/or dental dams every time you have vaginal, oral or anal sex? ☐ Yes ☐ No
8. Have you ever had an STD? (i.e., chlamydia, gonorrhea, trichomoniasis, herpes, syphilis, hepatitis B, others) ☐ Yes ☐ No
   If yes, which STD and when? _____
9. Have any of your partners had an STD? ☐ Yes ☐ No
   If yes, which STD and when? _____
10. Have you or any of your partners ever injected drugs? ☐ Yes ☐ No
11. Have you or any of your partners exchanged money or drugs for sex? _____
12. Have you had a HIV test ? ☐ Yes ☐ No If so, when? _____
13. Do you want a HIV test today? ☐ Yes ☐ No

D. SOCIAL HISTORY

1. Do you smoke or use smokeless tobacco? ☐ Yes ☐ No If yes, how much? _____ How long? _____
2. Drink alcohol? ☐ Yes ☐ No If yes, how much? _____ How long? _____
3. Take street drugs? ☐ Yes ☐ No If yes, how much? _____ How long? _____

E. MENTAL HEALTH HISTORY

1. During the past two weeks, have you often been bothered by either of the following two problems?
   a. Feeling down, depressed, irritable or hopeless ☐ Yes ☐ No or
   b. Little interest or pleasure in doing things ☐ Yes ☐ No

F. IMMUNIZATION ASSESSMENT PER CDC ACIP GUIDELINES (UTD = up-to-date; REF = referred, and NA = not applicable)

Td/Tdap ☐ UTD ☐ REF ☐ NA	MMR ☐ UTD ☐ REF ☐ NA	Varicella ☐ UTD ☐ REF ☐ NA	HPV ☐ UTD ☐ REF ☐ NA	Hepatitis A ☐ UTD ☐ REF ☐ NA
Hepatitis B ☐ UTD ☐ REF ☐ NA	Meningococcal ☐ UTD ☐ REF ☐ NA	Pneumonia ☐ UTD ☐ REF ☐ NA	Influenza ☐ UTD ☐ REF ☐ NA	

Source of Information: ☐ NCIR ☐ Patient ☐ Other Written Documentation

Interviewer's Signature: _____ Date: _____

Signature of Interpreter (if used): _____ Date: _____

1. Last Name	First Name	MI
2. Patient Number		
3. Date of Birth (MM/DD/YYYY)	Month / Day / Year	
4. Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ White		
5. Ethnic Origin ☐ Hispanic Cuban ☐ Hispanic Mexican American ☐ Hispanic Other ☐ Hispanic Puerto Rican ☐ Not Hispanic/Latino ☐ Unreported		
6. Gender ☐ Female ☐ Male		
7. County of Residence		
8. Home Address:	9. Marital Status:	

CONFIDENTIAL

North Carolina Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section

FEMALE REPRODUCTIVE HEALTH HISTORY

Date: _____

A. GENERAL INFORMATION (Please complete the following)

1. What is the reason for your visit today? _____
2. Emergency contact: _____
3. May we contact you by mail? ☐ Yes ☐ No By phone? ☐ Yes ☐ No Your phone number is _____
4. Do you have a primary care provider? ☐ Yes ☐ No If yes, who? _____
5. Highest grade completed in school _____
6. Occupation _____
7. Special Needs/Primary Language _____

B. MEDICAL HISTORY, HOSPITALIZATIONS, MEDICATIONS

1. List hospitalizations, surgeries and dates: _____
2. Medications: Do you take a multivitamin with folic acid? ☐ Yes ☐ No Take any medications (prescription or over the counter), diet or herbal supplements? ☐ Yes ☐ No If yes, what? _____
3. Self and Family Medical History: Put an **X** under **SELF** and/or **X** under **FAMILY** (parent, grandparent, brother, sister or your child)

SELF	FAMILY		SELF	FAMILY	
☐	☐	1. Anemia/Sickle Cell Disease or Trait/Blood Disorder	☐	☐	9. Hepatitis/Liver problems
☐	☐	2. Heart disease	☐	☐	10. Migraine headaches
☐	☐	3. Diabetes (if postpartum and had GDM, then repeat screening)	☐	☐	11. Cancer
☐	☐	4. Hypertension/High cholesterol	☐	☐	12. Blood clots in legs or lungs
☐	☐	5. Thyroid/Endocrine	☐	☐	13. Mental illness/Emotional disorders
☐	☐	6. Pulmonary Disease	☐	☐	14. Transfusions of blood or blood products
☐	☐	7. Kidney Disease	☐	☐	15. Birth defects/Genetic problems
☐	☐	8. Seizure Disorders	☐	☐	16. Tuberculosis

If yes to any of the above, please explain: _____

C. GYNECOLOGICAL HISTORY

1. Menstrual history: At what age did you start your period? _____ How often do you have your period? _____
   Any problems? _____
2. Any history of female conditions such as endometriosis, ovarian cysts, chronic pelvic pain, etc.? _____
3. Breast problems such as breast lumps, biopsies, surgeries? _____
4. Mammograms done/date _____
5. Date of last Pap test _____ History of any abnormal Pap tests? ☐ Yes ☐ No If yes, what was done and in what year?

D. OBSTETRICAL HISTORY

1. Total pregnancies _____ # Living _____ # Preterm _____ # Abortion _____ # Miscarriage _____
2. Date of last pregnancy _____
3. ☐ IF POSTPARTUM, advised to delay future pregnancy for 18 months to 5 years.

E. SEXUAL HISTORY (This section lends itself to being a self [patient completed] or a dialogue with the provider)

1. Do you have sex with? ☐ Men only ☐ Women only ☐ Both men and women
2. In the past two months, how many partners have you had sex with? _____
3. In the past 12 months, how many partners have you had sex with? _____
4. Is it possible that any of your sex partners in the past 12 months had sex with someone else while they were still in a sexual relationship with you? ☐ Yes ☐ No
5. What do you do to protect yourself from STDs and HIV? _____
6. What ways do you have sex? ☐ vaginal ☐ oral ☐ anal
7. Do you or your partner use condoms and/or dental dams every time you have vaginal, oral or anal sex? ☐ Yes ☐ No
8. Have you ever had an STD? ☐ Yes ☐ No If yes, which STD and when? _____
9. Have any of your partners had an STD? (i.e., chlamydia, gonorrhea, trichomoniasis, herpes, syphilis, hepatitis B, others) ☐ Yes ☐ No
   If yes, which STD and when? _____
10. Have you or any of your partners ever injected drugs? ☐ Yes ☐ No
11. Have you or any of your partners exchanged money or drugs for sex? _____
12. Have you had a HIV test? ☐ Yes ☐ No If so, when? _____
13. Do you wish to have a HIV test today? ☐ Yes ☐ No

F. SOCIAL HISTORY

1. Do you smoke or use smokeless tobacco? ☐ Yes ☐ No If yes, how much? _____ How long? _____
2. Drink alcohol? ☐ Yes ☐ No If yes, how much? _____ How long? _____
3. Take street drugs? ☐ Yes ☐ No If yes, how much? _____ How long? _____

G. MENTAL HEALTH HISTORY

1. During the past two weeks, have you often been bothered by either of the following two problems?
   a. Feeling down, depressed, irritable or hopeless ☐ Yes ☐ No or
   b. Little interest or pleasure in doing things ☐ Yes ☐ No
2. Are you in a relationship with a person who threatens or physically hurts you? ☐ Yes ☐ No
3. In the past year, have you been slapped, kicked or otherwise physically hurt by someone? ☐ Yes ☐ No

H. IMMUNIZATION ASSESSMENT PER CDC ACIP GUIDELINES (UTD = up-to-date; REF = referred, and NA = not applicable)

Td/Tdap ☐ UTD ☐ REF ☐ NA	MMR ☐ UTD ☐ REF ☐ NA	Varicella ☐ UTD ☐ REF ☐ NA	HPV ☐ UTD ☐ REF ☐ NA	Hepatitis A ☐ UTD ☐ REF ☐ NA
Hepatitis B ☐ UTD ☐ REF ☐ NA	Meningococcal ☐ UTD ☐ REF ☐ NA	Pneumonia ☐ UTD ☐ REF ☐ NA	Influenza ☐ UTD ☐ REF ☐ NA	

Source of Information: ☐ NCIR ☐ Patient ☐ Other Written Documentation

Interviewer's Signature: _____ Date: _____

Signature of Interpreter (if used): _____ Date: _____

CASWELL COUNTY, NORTH CAROLINA ● NOTICE OF PRIVACY PRACTICES

THIS NOTICE IS EFFECTIVE ON APRIL 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

WE ARE REQUIRED BY LAW TO PROTECT MEDICAL INFORMATION ABOUT YOU

We are required by law to protect the privacy of medical information about you and that identifies you. This medical information may be information about health care we provide to you or payment for health care provided to you. It may also be information about your past, present, or future medical condition.

We are also required by law to provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to medical information. We are legally required to follow the terms of this Notice. In other words, we are only allowed to use and disclose medical information in the manner that we have described in this Notice.

We may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for all medical information that we maintain. If we make changes to the Notice, we will:

- Post the new Notice in our waiting area
- Have copies of the new Notice available upon request (you may always contact the Privacy Official to obtain a copy of the current Notice)

The rest of this Notice will:

- Discuss how we may use and disclose medical information about you
- Explain your rights with respect to medical information about you
- Describe how and where you may file a privacy-related complaint

If, at any time, you have questions about information in this Notice or about our privacy policies, procedures or practices, you can contact the Privacy Official.

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU IN SEVERAL CIRCUMSTANCES

We use and disclose medical information about patients everyday. This section of our Notice explains in some detail how we may use and disclose medical information about you in order to provide health care, obtain payment for that health care, and operate our business efficiently. This section then briefly mentions several other circumstances in which we may use or disclose medical information about you. For more information about any of these uses, disclosures, policies, procedures or practices, contact our Privacy Official.

1. Treatment

We may use and disclose medical information about you to provide health care treatment to you. In other words, we may use and disclose medical information about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. It may include transfer of information by radio or telephone to a hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.

We may use and/or disclose medical information about you in order to inform you of or recommend new treatment or different methods for treating a medical condition that you have or to inform you of other health related benefits and services that may be of interest to you. We may use and/or disclose medical information about you to send you reminders about an appointment.

2. Payment

We may use and disclose medical information about you to obtain payment for health care services that you received. This means that we may use medical information about you to arrange for payment (such as preparing bills and managing accounts). We also may disclose medical information about you to others (such as insurers, collection agencies, and consumer reporting agencies). In some instances, we may disclose medical information about you to an insurance plan before you receive certain health care services because, for example, we may want to know whether the insurance plan will pay for a particular service.

3. Health care operations

We may use and disclose medical information about you in performing a variety of business activities that we call "health care operations." These "health care operations" activities allow us to, for example, improve the quality of care we provide and reduce health care costs. For example, we may use or disclose medical information about you in performing the following activities:

- Reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you.
- Providing training programs for students, trainees, health care providers or non-health care professionals to help them practice or improve their skills.
- Cooperating with outside organizations that evaluate, certify or license health care providers, staff or facilities in a particular field or specialty.
- Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients.
- Improving health care and lowering costs for groups of people who have similar health problems and helping manage and coordinate the care for these groups of people.
- Cooperating with outside organizations that assess the quality of the care others and we provide, including government agencies and private organizations.
- Planning for our organization's future operations.
- Resolving grievances within our organization.
- Reviewing our activities and using or disclosing medical information in the event that control of our organization significantly changes.
- Working with others (such as lawyers, accountants and other providers) who assist us to comply with this Notice and other applicable laws.

4. Persons involved in your care

We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. If the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances. For more information on the privacy of minors' information, contact our Privacy Official.

In situations where you are not capable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment, disclose medical information about you to a family member, relative, or friend. We may also use or disclose medical information about you to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition.

You may ask us at any time not to disclose medical information about you to persons involved in your care. We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies) or if the patient is a minor. If the patient is a minor, we may or may not be able to agree to your request.

5. Required by law

We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. For example, state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

6. National priority uses and disclosures

When permitted by law, we may use or disclose medical information about you without your permission for various activities that are recognized as "national priorities." In other words, the government has determined that under certain circumstances (described below), it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. We will only disclose medical information about you in the following circumstances when we are permitted to do so by law. Below are brief descriptions of the "national priority" activities recognized by law. For more information on these types of disclosures, contact our Privacy Official.

- **Threat to health or safety:** We may use or disclose medical information about you if we believe it is necessary to prevent or lessen a serious threat to health or safety.
- **Public health activities:** We may use or disclose medical information about you for public health activities. Public health activities require the use of medical information for various activities, including, but not limited to, activities related to investigating diseases, reporting child abuse and neglect, monitoring drugs or devices regulated by the Food and Drug Administration, and monitoring work-related illnesses or injuries. For example, if you have been exposed to a communicable disease (such as a sexually transmitted disease), we may report it to the State and take other actions to prevent the spread of the disease.
- **Abuse, neglect or domestic violence:** We may disclose medical information about you to a government authority (such as the Department of Social Services) if you are an adult and we reasonably believe that you may be a victim of abuse, neglect or domestic violence.
- **Health oversight activities:** We may disclose medical information about you to a health oversight agency – which is basically an agency responsible for overseeing the health care system or certain government programs. For example, a government agency may request information from us while they are investigating possible insurance fraud.
- **Court proceedings:** We may disclose medical information about you to a court or an officer of the court (such as an attorney). For example, we would

disclose medical information about you to a court if a judge orders us to do so.

- **Law enforcement:** We may disclose medical information about you to a law enforcement official for specific law enforcement purposes. For example, we may disclose limited medical information about you to a police officer if the officer needs the information to help find or identify a missing person.
- **Coroners and others:** We may disclose medical information about you to a coroner, medical examiner, or funeral director or to organizations that help with organ, eye and tissue transplants.
- **Workers' compensation:** We may disclose medical information about you in order to comply with workers' compensation laws.
- **Research organizations:** We may use or disclose medical information about you to research organizations if the organization has satisfied certain conditions about protecting the privacy of medical information.
- **Certain government functions:** We may use or disclose medical information about you for certain government functions, including but not limited to military and veterans' activities and national security and intelligence activities. We may also use or disclose medical information about you to a correctional institution in some circumstances.

7. Authorization

Other than the uses and disclosures described above (#1-6), we will not use or disclose medical information about you without the "authorization" – or signed permission – of you or your personal representative. In some instances, we may wish to use or disclose medical information about you and we may contact you to ask you to sign an authorization form. In other instances, you may contact us to ask us to disclose medical information and we will ask you to sign an authorization form.

If you sign a written authorization allowing us to disclose medical information about you, you may later revoke (or cancel) your authorization in writing (except in very limited circumstances related to obtaining insurance coverage). If you would like to revoke your authorization, you may write us a letter revoking your authorization or fill out an Authorization Revocation Form. Authorization Revocation Forms are available from our Privacy Official. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

You Have Rights With Respect To Medical Information About You

You have several rights with respect to medical information about you. This section of the Notice will briefly mention each of these rights. If you would like to know more about your rights, please contact our Privacy Official.

1. Right to a copy of this Notice

You have a right to have a paper copy of our Notice of Privacy Practices at any time. In addition, a copy of this Notice will always be posted in our waiting area. If you would like to have a copy of our Notice, ask the receptionist for a copy or contact our Privacy Official.

2. Right of access to inspect and copy

You have the right to inspect (which means see or review) and receive a copy of medical information about you that we maintain in certain groups of records. If you would like to inspect or receive a copy of medical information about you, you must provide us with a request in writing. We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. We will also inform you in writing if you have the right to have our decision reviewed by another person.

If you would like a copy of the information, we will charge you a fee to cover the costs of the copy. We may be able to provide you with a summary or explanation of the information. Contact our Privacy Official for more information on these services and any possible additional fees.

3. Right to have medical information amended

You have the right to have us amend (which means correct or supplement) medical information about you that we maintain in certain groups of records. If you believe that we have information that is either inaccurate or incomplete, we may amend the information to indicate the problem and notify others who have copies of the inaccurate or incomplete information. If you would like us to amend information, you must provide us with a request in writing and explain why you would like us to amend the information.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. You will have the opportunity to send us a statement explaining why you disagree with our decision to deny your amendment request and we will share your statement whenever we disclose the information in the future.

4. Right to an accounting of disclosures we have made

You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out an Accounting Request Form, or contact our Privacy Official. Accounting Request Forms are available from our Privacy Official.

The accounting will not include several types of disclosures, including disclosures for treatment, payment or health care operations. It will also not include disclosures made prior to April 14, 2003.

If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

5. Right to request restrictions on uses and disclosures

You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and health care operations. We are not required to agree to your request.

6. Right to request an alternative method of contact

You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address. We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing.

You May File A Complaint About Our Privacy Practices

If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a complaint either with us or with the federal government. We will not take any action against you or change our treatment of you in any way if you file a complaint.

To file a written complaint with Caswell County, you may mail it to the following address:

County Attorney
Caswell County
P.O. Box 98
Yanceyville, NC 27379
(336) 694-4193

To file a complaint with the federal government, you may send your complaint to the following address:

Office of Civil Rights
US Department of Health and Human Services
Attn: Secretary of US DHHS
Atlanta Federal Center, Suite 3B70
61 Forsythe St., S.W.
Atlanta, GA 30303-8909

For Health Dept. Privacy Official Questions:

Health Director
Caswell County Health Department
P.O. Box 1238
Yanceyville, NC 27379
(336) 694-4129

For Social Services Privacy Official Questions:

Director, Department of Social Services
Caswell County D.S.S.
P.O. Box 1538
Yanceyville, NC 27379
(336) 694-4141

For Emergency Medical Services Privacy Official Questions:

Director, EMS
Caswell County EMS
P.O. Box 99
Yanceyville, NC 27379
(336) 694-5177