Generations Family Practice

Patient Registration Packet

1) DEMOGRAPHICS

Patient Name (as it appears on the insurance card): _____

DOB: _____Nickname: _____ Gender: _____

SSN: _____ Marital Status_____

Parent / Legal Guardian *(if patient is a minor)*: _____

Relationship to patient: _____

Street Address_____ Apt: _____

City: _____State _____ Zip_____

Email:_____ Employer: _____

Preferred Language_____ Race: _____ Ethnicity: _____

Check preferred phone number:

○ Home:_____ ○ Cell: _____ ○ Work: _____

○ I give Generations Family Practice permission to contact me at the phone numbers listed above. I understand that contact includes automated calls, such as appointment reminders and balance notifications, as well as, calls from staff regarding my healthcare.

○ I would like to receive appointment reminders and other automated notifications by text message to my mobile phone.

Preferred Pharmacy _____ Pharmacy Ph: _____

Pharmacy Address_____

○ I give Generations Family Practice permission to obtain my prescription history through the Medication History Authority so that we may maintain an accurate record of all medications prescribed to you, both within Generations Family Practice, as well as other medical facilities. This will aid our practitioners in prescribing the most beneficial medications based on your history.

○ How did you hear of Generations Family Practice? _____

2) **EMERGENCY CONTACT** *(Health information will only be shared w/ this person if they are listed in #3 below)*

Name: _____ Phone: _____

Relationship to Patient: _____

3) PEOPLE WITH WHOM MY HEALTH INFORMATION CAN BE SHARED *(emergency contact will not be allowed to receive any health information unless listed here)***:**

1. _____ 2. _____

3. _____ 4. _____

What healthcare information can we share with those listed above?

- Financial / Billing
- Laboratory / Blood Test Results
- Diagnosis / Treatment Plans
- Medications, changes and directions for use
- Radiology Results

Patient Signature: _____ Date: _____

4) INSURANCE INFORMATION

Primary Insurance: _____

Subscriber ID: _____ Group: _____

Policy Holder: _____ DOB: _____

Policy Holder Address _____

Relationship to Policy Holder:_____ Co-Pay:_____

Secondary Insurance: _____

Subscriber ID: _____ Group: _____

Policy Holder: _____ DOB: _____

Policy Holder Address _____

Relationship to Policy Holder:_____ Co-Pay:_____

5) SIGNATURES

Authorization to Release Information and Assignment of Benefits

I hereby authorize the designated physician to release any information acquired, in the course of my treatment to my insurance company for completion of claims in consideration of the medical services to be rendered. I agree to pay Generations Family Practice the regular charges for said services. i understand that I am responsible for all charges not paid by insurance. If applicable, I also request payment of government benefits either to myself or the party who accepts assignment. I certify that I have read the above or had it explained to me and agree to all terms and as evidence of this fact, sign my name below.

A returned and unprocessed check will result in a fee of $35.00 charged to the Patient's account.

Signature: _____ Date: _____

Adolescent Care Agreement
(if applicable)

We all realize that this is a special time in your life that involves a lot of physical and emotional changes. Your doctors want to be available to talk about questions you have and want you to know that any information you share with your doctor will be kept private. Your parents and your doctors know that this may include talking about sex, drugs or alcohol abuse, and may also include advice about prescribing birth control methods. We all agree that it is best to talk openly with your parents, but we understand that you may have special needs during your teenage years that require privacy, and we respect that.

Patient Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

Generations Family Practice has permission to provide care to my adolescent child without the presence of a parent / guardian. ○ yes ○ no

○ Permission is indefinite and will expire when patient turns 18
OR
○ Permission will expire 1 year from date of signature.

Parent / Guardian Signature: _____ Date: _____

Generations Family Practice

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Financial Policy

Thank you for choosing Generations Family Practice as your healthcare provider. We are committed to providing you the best quality medical care. We look forward to establishing a lasting relationship and partnership with you. As part of this relationship, we wish to establish our expectation of your financial responsibility.

Self-Pay: Patients without insurance coverage will be required to pay for all services at the time they are rendered. We do offer a discounted rate to self-pay patients.

Insurance Collection: Your medical insurance policy is a contract between you and your insurance carrier and differs from individual to individual, even if from the same insurance carrier. Our providers should not be expected to know your individual insurance benefits or coverage amounts or terms, and you should not take any opinion they may offer as fact. As a courtesy, we will bill your medical insurance carrier for services we provide. We will be diligent in making sure your insurance is filed accurately and promptly. It is your responsibility to ensure we have the most current copy of your insurance card, demographic and contact information. If your insurance cannot be verified at the time of service, you will be responsible for payment at time of service. You are responsible for any balance remaining after your insurance carrier has processed your claim (60-90 days). Should your insurance company reimburse us at a later date, we will gladly refund/reimburse you.

Co-payments, Outstanding Balances and Fees: All co-payments, outstanding balances and fees for services not covered by your insurance policy are due at the time services are rendered. For any questions regarding coverage for any services/treatments, we encourage you to contact your insurance carrier to review costs. As a convenience, we accept all major credit cards, debit cards, checks and cash.

Out of Network/Non-Participating Insurance Carriers: If your insurance carrier considers us 'out of network' or does not participate with us, you are responsible for payment in full at the time of service. We will gladly provide any proof visit/receipts, etc.

Consent Orders: This office is not a party to your child support consent order or divorce decree. The financial responsibility for the minor rests with the accompanying adult.

No Show/Cancellation Policy: Missed appointments represent a cost to us, to you and to other patients who could have been accommodated. Appointments missed or not cancelled at least 24 hours before the appointment time will result in a $75.00 fee. Appointments can only be cancelled by calling during regular business hours. Please help us serve you better by keeping your scheduled appointment.

Form Charges: Starting May 1, 2014, requests for completion of several types of forms and correspondence will incur fees. Fees are strictly based on the amount of time required to fulfill your requests.

Examples include:

- disability forms
- letters /correspondence requested from patients, insurance companies or third parties

Charges for these services will range from $25 for a basic form and vary depending on the amount of time required by the provider to complete the request.

In an effort to provide you with financially viable quality of care, we thank you in advance for understanding the necessity of adding these charges.

Past Due Payments: Just as we make every effort to accommodate you when you are in need of medical care, we expect you to make every effort to pay your bill promptly. If you have financial hardship or you are unable to pay your bill in its entirety, please contact our billing manager to discuss payment options. If your account becomes delinquent (past 30 days) your account will be subject to interest and collection costs.

Returned Checks: A $35.00 fee will be charged on all returned checks. Additionally, we will no longer be able to accept checks from you for yourself or any members of your family.

Transfer of Care: When transferring care to another provider, we will request and require you to close out any balances due. Charges for medical records will be calculated according to the North Carolina General Statutes. Payment is due at the time the records request is made.

Financial Policy Continued

I authorize Generations Family Practice to release all requested information concerning my medical treatment to my insurance carrier. I further authorize my insurance company to pay from the proceeds of benefits of any recovery or insurance payments in my case, directly to the provider(s) of this office, for their professional services rendered.

Generations Family Practice reserves the right to dismiss any patient from the practice who consistently fails to meet this policy or who refuses to sign this agreement.

By signing below, I understand and agree to the terms of this office's Financial Policy.

Signature: _____ Date: _____

PATIENT ACKNOWLEDGMENT AND CONSENT

For New Patients Only

I have been given a copy of Generations Family Practice's Notice of Privacy Practices, version effective September 1, 2013. I consent to the uses and disclosures of my health information as outlined in the Notice.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

_____

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient: _____

_____

_____

FOR GENERATIONS FAMILY PRACTICE'S USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____

_____

_____

GENERATIONS FAMILY PRACTICE
PRIVACY PRACTICES

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

Effective Date: **09 / 01 / 2013**

If you have any questions about this notice, please contact the Generations Family Practice Privacy Officer at (919) 852-3999.

WHO WILL FOLLOW THIS NOTICE

This notice describes the practices of:

- Generations Family Practice, PA.
- Any health care professional authorized to enter information into your medical record maintained by Generations Family Practice, PA.
- Any persons or companies with whom Generations Family Practice, PA. contracts for services to help operate our practice and who have access to your medical information.
- All these persons, entities, sites, and locations follow the terms of this notice. In addition, these persons, entities, sites, and locations may share medical information with each other for treatment, payment, or health care operations purposes and other purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

- We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive from Generations Family Practice, PA. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care and billing for that care that are generated or maintained by Generations Family Practice, whether made by our personnel or other health care providers. Other health care providers may have different policies or notices about confidentiality and disclosure that apply to your medical information that is created in their offices or at locations other than Generations Family Practice, PA.].

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.
We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices at Generations Family Practice, and your legal rights, with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of these categories.

- **For Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, volunteers, or other personnel who are involved in taking care of you at Generations Family Practice. For example, a doctor treating you for a broken hip may need to know if you have diabetes because diabetes may slow the healing process. We also may disclose medical information about you to people outside Generations Family Practice who may be involved in your medical care after you have been treated by Generations Family Practice, such as friends, family members, or employees or medical staff members of any hospital or skilled nursing facility to which you are transferred or subsequently admitted.
- **For Payment**. We may use and disclose medical information about you so that the treatment and services you receive from Generations Family Practice may be billed by Generations Family Practice and payment may be collected from you, an insurance company, or a third party. For example, we may need

to give your health plan information about treatment you received from Generations Family Practice so your health plan will pay us or reimburse you for the treatment. We also may disclose information about you to another health care provider, such as a hospital or skilled nursing facility to which you are admitted, for their payment activities concerning you.

- **For Health Care Operations**. We and our business associates may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run Generations Family Practice and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services Generations Family Practice should offer, and what services are not needed. We may also disclose information to doctors, nurses, technicians, and other personnel affiliated with Generations Family Practice for review and learning purposes. We may also combine the medical information we have with medical information from other health care providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identities of specific patients. We also may disclose information about you to another health care provider for its health care operations purposes if you also have received care from that provider.

- **Treatment Alternatives**. We may use and disclose medical information to tell you about or recommend different ways to treat you.

- **Fundraising Activities**. We may use medical information about you to contact you in an effort to raise money for Generations Family Practice and its operations. Specifically, we may use information about you to target our fundraising efforts. For example, if we are raising money for women's health services, we may focus our fundraising efforts on individuals who have received women's health services from us in the past. We may also disclose medical information to a business partner or a foundation related to Generations Family Practice so that the business partner or the foundation may contact you in raising money for Generations Family Practice. We would release limited information about you, such as your name, address and phone number, age and date of birth, gender, your physician, and the dates you received treatment or services at Generations Family Practice.

  If you do not want Generations Family Practice to contact you for fundraising efforts, you must notify Generations Family Practice's Privacy Officer in writing. If you have not already done so, we must ask you each time we contact you for fundraising efforts if you wish to opt out of all future fundraising communications. If you do opt out of future fundraising communications, we will no longer disclose your information for fundraising purposes. However, in the future you may let us know in writing that you would like to receive these fundraising communications. Your decision whether or not to receive targeted fundraising materials from us will have no impact on your access to health care services or the treatment we provide to you.

  Even if you have opted-out, we may send you non-targeted fundraising materials that are sent out to the general community and are not based on information from your treatment.

- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. Medical information about you that has had identifying information removed may be used for research without your consent. We also may disclose medical information about you to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs), so long as the medical information they review does not leave Generations Family Practice. If the researcher will have information about your mental health treatment that reveals who you are, we will seek your consent before disclosing that information to the researcher. Unless we notify you in advance and you give us written permission, we will not receive any money or other thing of value in connection for using or disclosing your medical information for research purposes except for money to cover the costs of preparing and sending the medical information to the researcher.

- **Individuals Involved in Your Care or Payment for Your Care**. We may release medical information about you to a friend or family member who is involved in your medical care. This would include persons named in any durable health care power of attorney or similar document provided to us. We may also give information to someone who helps pay for some or all of your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. You can object to these releases by telling

us that you do not wish any or all individuals involved in your care to receive this information. If you are not present or cannot agree or object, we will use our professional judgment to decide whether it is in your best interest to release relevant information to someone who is involved in your care or to an entity assisting in a disaster relief effort.

- **As Required or Permitted By Law.** We may disclose medical information about you when required or permitted to do so by federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when it appears necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone who appears able to help prevent the threat and will be limited to the information needed.

SPECIAL SITUATIONS

- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

- **Active Duty Military Personnel and Veterans**. If you are an active duty member of the armed forces or Coast Guard, we must give certain information about you to your commanding officer or other command authority so that your fitness for duty or for a particular mission may be determined. We may also release medical information about foreign military personnel to the appropriate foreign military authority. We may use and disclose to components of the Department of Veterans Affairs medical information about you to determine whether you are eligible for certain benefits.

- **Workers' Compensation.** In accordance with state law, we may release without your consent medical information about your treatment for a work-related injury or illness or for which you claim workers' compensation to your employer, insurer, or care manager paying for that treatment under a workers' compensation program that provides benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose without your consent medical information about you for public health activities. These activities generally include but are not limited to the following:

  - To report, prevent or control disease, injury, or disability;
  - To report births and deaths;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - To report suspected abuse or neglect as required by law.

- **Health Oversight Activities.** We may disclose without your consent medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. The government uses these activities to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we must disclose medical information about you in response to a court or administrative order. We also may disclose medical information about you in response to a subpoena or other lawful process from someone involved in a civil dispute.

- **Law Enforcement**. We may release without your consent medical information to a law enforcement official:

  - In response to a court order, warrant, summons, grand jury demand, or similar process;
  - To comply with mandatory reporting requirements for violent injuries, such as gunshot wounds, stab wounds, and poisonings;
  - In response to a request from law enforcement for certain information to help locate a fugitive, material witness, suspect, or missing person;
  - To report a death or injury we believe may be the result of criminal conduct; and
  - To report suspected criminal conduct committed at Generations Family Practice facilities.

- **Coroners and Medical Examiners**. We may release without your consent medical information to a coroner or medical examiner. This may be done, for example, to identify a deceased person or determine

the cause of death. We also may release medical information about deceased patients of Generations Family Practice to funeral directors to carry out their duties.

- **National Security and Intelligence Activities**. We may release without your consent medical information about you as required by applicable law to authorized federal or state officials for intelligence, counterintelligence, or other governmental activities prescribed by law to protect our national security.

- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

- **Psychotherapy Notes.** Regardless of the other parts of this Notice, psychotherapy notes will not be disclosed outside the Generations Family Practice except as authorized by you in writing or pursuant to a court order, or as required by law. Psychotherapy notes about you will not be disclosed to personnel working within Generations Family Practice, except for training purposes or to defend a legal action brought against Generations Family Practice, unless you have properly authorized such disclosure in writing.

- **Marketing of Health-Related Products and Services.** "Marketing" means a communication for which we receive any sort of payment from a third party that encourages you to use a service or buy a product. Before we may use or disclose your medical information to market a health-related product or service to you, we must obtain your written authorization to do so. The authorization form will let you know that we have been paid to make the communication to you. Marketing does not include: prescription refill reminders or other information that describes a drug you currently are being prescribed, so long as any payment we receive for that communication is to cover the cost of making the communication; face-to-face communications; or gifts of nominal value, such as pens or key chains stamped with our name or the name of a health care product manufacturer. Communications made about your treatment, such as when your physician refers you to another health care provider, generally are not marketing.

- **Sale of Medical Information.** We cannot sell your medical information without first receiving your authorization in writing. Any authorization form you sign agreeing to the sale of your medical information must state that we will receive payment of some kind disclosing your information. However, because a "sale" has a specific definition under the law, it does not include all situations in which payment of some kind is received for the disclosure. For example, a disclosure for which we charge a fee to cover the cost to prepare and transmit the information does not qualify as a "sale" of your information.

- **Inmates.** If you are an inmate of a correctional institution or in the custody of law enforcement, we may release medical information about you to the correctional institution or law enforcement official who has custody of you, if the correctional institution or law enforcement official represents to Generations Family Practice that such medical information is necessary: (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) to protect the safety and security of officers, employees, or others at the correctional institution or involved in transporting you; (4) for law enforcement to maintain safety and good order at the correctional institution; or (5) to obtain payment for services provided to you. If you are in the custody of the North Carolina Department of Corrections ("DOC") and the DOC requests your medical records, we are required to provide the DOC with access to your records.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy**. You have the right to inspect and receive a copy of your medical record unless your attending physician determines that information in that record, if disclosed to you, would be harmful to your mental or physical health. If we deny your request to inspect and receive a copy of your medical information on this basis, you may request that the denial be reviewed. Another licensed health care professional chosen by Generations Family Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will do what this reviewer decides.

  If we have all or any portion of your medical information in an electronic format, you may request an electronic copy of those records or request that we send an electronic copy to any person or entity you designate in writing.

  Your medical information is contained in records that are the property of Generations Family Practice. To inspect or receive a copy of medical information that may be used to make decisions about you, you must

submit your request in writing to Generations Family Practice's Privacy Officer. If you request a copy of the information, **we may charge a fee** for the costs of copying, mailing, or other supplies associated with your request, and we may collect the fee before providing the copy to you. If you agree, we may provide you with a summary of the information instead of providing you with access to it, or with an explanation of the information instead of a copy. Before providing you with such a summary or explanation, we first will obtain your agreement to pay and will collect the fees, if any, for preparing the summary or explanation.

- **Right to Amend**. If you feel that medical information we have about you in your record 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 Generations Family Practice.

  To request an amendment, make your request in writing to Generations Family Practice's Privacy Officer. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for Generations Family Practice;
  - Is not part of the information that you would be permitted to inspect and copy; or
  - Has been determined to be accurate and complete.

  If we deny your request for an amendment, you may submit a written statement of disagreement and ask that it be included in your medical record.

- **Right to an Accounting of Disclosures**. You have the right to request a list of certain disclosures we have made of medical information about you during the past six years.

  To request this list or accounting of disclosures, submit your request in writing to Generations Family Practice's Privacy Officer and state whether you want the list on paper or electronically. Your request must state a time period that may not be longer than six years. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We may collect the fee before providing the list to you.

- **Right to Request Restrictions**. Except where we are required to disclose the information by law, you have the right to request a restriction or limitation on the medical information we use or disclose about you. For example, you could revoke any and all authorizations you previously gave us relating to disclosure of your medical information.

  We are not required to agree to your request, with the exception of restrictions on disclosures to your health plan, as described below**.** If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

  To request restrictions, make your request in writing to Generations Family Practice's Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

  You may request that we not disclose your medical information to your health insurance plan for some or all of the services you receive during a visit to any Generations Family Practice location. If you pay the charges for those services you do not want disclosed ***in full at the time of such service***, we are required to agree to your request. "In full" means the amount we charge for the service, not your co-pay, coinsurance, or deductible responsibility when your insurer pays for your care. Please note that once information about a service has been submitted to your health plan, we cannot agree to your request. If you think you may wish to restrict the disclosure of your medical information for a certain service, please let us know as early in your visit as possible.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, or at another mailing address other than your home address. We will accommodate all reasonable requests. We will not ask you the reason for your request. To request confidential communications, make your request in writing to the Privacy Officer and specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice or any revised notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

  To obtain a paper copy of this notice, request a copy from Generations Family Practice's Privacy Officer in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at Generations Family Practice's office. The notice will contain the effective date on the first page, in the top right-hand corner. If the notice changes, a copy will be available to you upon request.

INVESTIGATIONS OF BREACHES OF PRIVACY

We will investigate any discovered unauthorized use or disclosure of your medical information to determine if it constitutes a breach of the federal privacy or security regulations addressing such information. If we determine that such a breach has occurred, we will provide you with notice of the breach and advise you what we intend to do to mitigate the damage (if any) caused by the breach, and about the steps you should take to protect yourself from potential harm resulting from the breach.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Generations Family Practice or with the Secretary of the United States Department of Health and Human Services. To file a complaint with Generations Family Practice, contact Alan Copland or Jessica DeMaio, Generations Family Practice's Privacy Officers by mail at 110 Preston Executive Drive, Ste 100, Cary, NC 27513. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice may be made only with your written authorization or as required by law. If you authorize us to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. Your revocation will be effective as of the end of the day on which you provide it in writing to Generations Family Practice's Privacy Officer. If you revoke your permission, we will no longer use or disclose medical information about you for the purposes that you previously had authorized in writing. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our record of the care that we provided to you.