MemorialCare
Medical Group

Patient Registration

MRN _____

Patient Information

First Name	Last Name	MI	Preferred Name

Address	City	State	Zip

Date of Birth	SSN	Primary Care Physician

Religion	Preferred Language	Interpreter Needed
		Yes ☐ No ☐

Please check Primary phone	Cell Phone ☐	Home Phone ☐	Work Phone ☐

Legal Sex
- ☐ Female
- ☐ Male
- ☐ Nonbinary
- ☐ Unknown
- ☐ X

Gender Identity
- ☐ Choose not to disclose
- ☐ Female
- ☐ Male
- ☐ Nonbinary
- ☐ Other
- ☐ Transgender Female
- ☐ Transgender Male

Sex Assigned at Birth
- ☐ Choose not to disclose
- ☐ Female
- ☐ Male
- ☐ Not recorded on birth certificate
- ☐ Uncertain
- ☐ Unknown

Sexual Orientation
- ☐ Bisexual
- ☐ Choose not to disclose
- ☐ Don't know
- ☐ Gay
- ☐ Lesbian
- ☐ Queer or Pansexual
- ☐ Something else
- ☐ Straight

Ethnicity
- ☐ Cambodian
- ☐ Chinese
- ☐ Cuban
- ☐ Filipino
- ☐ Korean
- ☐ Mexican, Mexican, American, Chicano/a
- ☐ Non-Hispanic
- ☐ Other Hispanic, Latino/a or Spanish Origin
- ☐ Patient Refused/ Unable to Provide
- ☐ Puerto Rican
- ☐ Vietnamese

Race
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ More than one Race
- ☐ Native Hawaiian
- ☐ Other
- ☐ Pacific Islander
- ☐ Patient Refused/ Unable to Provide
- ☐ White

Marital Status
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Domestic Partner

Pronouns
- ☐ He
- ☐ She
- ☐ Other
- ☐ They
- ☐ Unknown

MemorialCare
Medical Group

Communicating with you

MRN ____________________

In order to communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information.

We may communicate with you through mail, email, text, and/or telephone.

Please check all boxes that give MemorialCare permission to use for your communications:

☐ Telephone	Phone Number:
☐ Cell Phone/Text	Phone Number:
☐ Voice Mail Message	Phone Number:
☐ By Email:	
☐ Through Email (MyChart):	
☐ Postal Mail, Address:	

Please list any people you would like to have access to your billing, appointment, or health information, such as your parent, spouse, caretaker or other family member. We will ask for additional consent prior to releasing information related to psychiatric services and/or HIV test results.

Name & Relationship	Phone Number	Options	Emergency Contact	For Pediatric Patients ONLY
		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information	☐ Yes ☐ No	☐ Parent/Guardian ☐ Same household
		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information	☐ Yes ☐ No	☐ Parent/Guardian ☐ Same household
		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information	☐ Yes ☐ No	☐ Parent/Guardian ☐ Same household
		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information	☐ Yes ☐ No	☐ Parent/Guardian ☐ Same household

This request supersedes any prior request for communication of information I may have made.

Signature of Patient/Responsible Party

Date

Name of Patient/Responsible Party (Please Print)

Relationship to Patient

MemorialCare
Medical Group

Assignment of Insurance Benefits/Eligibility Certification

Primary Insurance Plan		
Patient Name	Date of Birth	
Insurance Plan	Group #	Member ID #
Medical Claims Address	Phone #	
Subscriber Name	Relationship to Patient	
Subscriber Social Security #	Subscriber Date of Birth	
Subscriber Phone Number	Employer Phone #	
Subscriber Employer	Employer Address	

For Medicare Patients Only		
Health Insurance Claim #	Part A Effective Date	Part B Effective Date

Other Insurance Coverage for Patient		
Patient Name	Date of Birth	
Insurance Plan	Group #	Member ID #
Medical Claims Address	Phone #	
Subscriber Name	Relationship to Patient	
Subscriber Social Security #	Subscriber Date of Birth	
Subscriber Phone Number	Employer Phone #	
Subscriber Employer	Employer Address	

Responsible Financial Party (For Pediatric Patients ONLY)			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Please check Primary phone	Cell Phone ☐	Home Phone ☐	Work Phone ☐
Relationship to Patient			

MemorialCare
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Agreement of Financial Responsibility

MRN _____

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Proof of payment and photo ID are required for all patients. Providing a copy of your insurance card does not confirm that your coverage is active, that benefits are available, or that the services rendered will be covered by your insurance company. It is your responsibility to provide complete and accurate information regarding all insurance coverage, including primary, secondary, and tertiary insurance plans.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider. Insurance Plan participation does not guarantee coverage or payment for all services rendered.
- We will attempt to confirm your insurance coverage prior to your treatment; however, verification of benefits is not a guarantee of payment. Your insurance company makes the final determination regarding eligibility, benefits, authorization requirements, medical necessity, and payment for services rendered.
- If we have a contract with your insurance company we will bill your insurance company first, less any co-payment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. Claims processing timeframes vary by insurance company and claim circumstances.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you may submit to your insurance company for possible reimbursement according to your plan benefits.
- Any estimate provided before services are rendered is based on information available at the time and is not a guarantee of the final amount owed.
- You are responsible for services that are excluded from your benefits, not covered by your insurance plan, or denied by your insurance company unless otherwise prohibited by law or contractual obligations.
- Some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services under an Out-of-Network benefit, your financial responsibility may be significantly higher than an In-Network benefit due to higher co-payments, co-insurance, deductibles, limited benefits, or reduced reimbursement by your insurance company.
- We do not participate in Sharing Programs, as these are not considered insurance. Patient Share programs are treated as Self-Pay. Payment is due at the time of service, and a Prompt Pay discount may be applied.

MemorialCare Medical Group

Agreement of Financial Responsibility (continued)

MRN _____

- Workman's Compensation injury/illness requires an authorization to treat from your employer. Should your employer fail to provide an authorization, we will work with your health insurance company for reimbursement as outlined below. Your health insurance company may deny coverage if it determines that the injury or illness is work-related. If Workers' Compensation or another responsible party denies liability or payment, you may be financially responsible for services not covered by an insurance carrier.

Assignment of Benefits:

I hereby authorize and request that payment of authorized Medicare/other insurance company benefits be made on my behalf, be paid directly to MemorialCare Medical Foundation for any medical or surgical services rendered by its affiliated medical groups to me or a member of my family. I authorize any holder of medical or other information about me to release to the Social Security Administration, Centers for Medicare & Medicaid Services, its agents or carriers, or the insurance company any information needed for this or a related Medicare/other insurance claim to determine these benefits or the benefits payable for related services. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment.

I have read the financial policy, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that I am financially responsible for applicable co-payments, co-insurance, deductibles, non-covered services, and any amounts determined by my insurance company to be my responsibility under my benefit plan.

Signature of Patient/Responsible Party	Date
Name of Patient/Responsible Party (Please Print)	Relationship to Patient

MemorialCare
Medical Group

Consent for Treatment

MRN _____

I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of the MemorialCare Medical Foundation affiliated medical group to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained herein are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize my MemorialCare Medical Foundation affiliated medical group to release information requested by the insurance company and/or its representatives. I fully understand this agreement and consent will continue until canceled by me in writing.

Signature of Patient/Responsible Party	Date
Name of Patient/Responsible Party (Please Print)	Relationship to Patient

MemorialCare
Medical Group

Acknowledgement of Receipt

MRN _____

For informational purposes only, a link to the federal Centers for Medicare & Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found online at openpaymentsdata.cms.gov.

Your name and signature on this form indicates that you have been notified of the Centers for Medicare & Medicaid Services (CMS) Open Payments Search tool. If you have any questions pertaining to the Open Payments program, submit an email to the Help Desk at openpayments@cms.hhs.gov. For live assistance, call Open Payments Help Desk Support at 1-855-326-8366.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date Received: _____ Time Received: _____

MemorialCare
Medical Group

ACKNOWLEDGEMENT OF RECEIPT

MRN _____

Joint Notice of Privacy Practices

Your name and signature on this form indicates that you have received a copy of MemorialCare's ***Joint Notice of Privacy Practices*** on the date and time indicated below.

If you have any questions regarding the information contained in MemorialCare's ***Joint Notice of Privacy Practices***, please contact MemorialCare's Chief Compliance Officer at (714) 377-3218.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date Received: _____ Time Received: _____

FOR FACILITY USE ONLY

We attempted to obtain written acknowledgement of patient's receipt of our ***Joint Notice of Privacy Practices***, but acknowledgement could not be obtained from the patient for the following reason:

- ☐ Individual Refused to Sign
- ☐ Emergency Situation Prevented Signature
- ☐ Patient Requested Above Individual Sign on His / Her Behalf Other (please specify)
- ☐ _____

Registration Representative Signature: _____ Date: _____

MemorialCare
Medical Group

JOINT NOTICE OF 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.

Who Will Follow This Notice

MemorialCare ("MemorialCare" or "we"), through its affiliated hospitals and facilities ("MemorialCare Facility") and the employees and staff of each MemorialCare Facility, provide healthcare to patients, together with other healthcare providers and other organizations. This Notice applies to the following persons and entities, who have agreed to be bound by this notice:

- Each MemorialCare Facility, as well as all MemorialCare employees, staff and other personnel, who may need to access your information to perform their job functions.
- Members of the medical staff of each MemorialCare Facility, as well as other health care professionals who provide health care services at a MemorialCare Facility.
- Any member of a volunteer group we allow to help you while you are receiving care.

This Notice applies to all of the records related to your health care provided to you in a MemorialCare Facility and generated by the applicable MemorialCare Facility, whether made by MemorialCare personnel or your personal healthcare provider. Your personal healthcare provider may have different policies or notices regarding the use and disclosure of your medical information created or maintained in the healthcare provider's office or clinic. You should review your healthcare provider's notice for information on how your healthcare provider will handle your medical information outside of MemorialCare Facilities.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. Protecting medical information about you is important. We create a record of the care and services you receive while in our care. We need this record to provide you with quality care and to comply with certain regulatory requirements. This Notice will tell you about the ways in which we may use and disclose medical information about you. This Notice also describes your rights, and certain obligations we have regarding the use and disclosure of your medical information. We are required by law to:

- Keep medical information that identifies you private;
- Give you this Notice of our legal duties and privacy practices 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 the categories.

Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to healthcare providers who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing

process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different healthcare professionals within a MemorialCare Facility also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you outside the MemorialCare Facility that treated you to people who may be involved in your medical care after you leave a MemorialCare Facility.

Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to, 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 surgery you received at a MemorialCare Facility so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your insurance will cover the treatment.

Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to run each MemorialCare Facility. 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 disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other facilities 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 knowing the identities of the specific patients. We may disclose your medical information to another health care professional that you have seen so they may improve their quality or costs of care.

Health Information Exchange (HIE). MemorialCare may make your individual medical information available to a local, regional and/or national Health Information Exchange ("HIE") including, but not limited to, the National Health Information Network ("NHIN"). An HIE is a state and/or federal government sponsored initiative that provides a mechanism for healthcare providers in our community to share information electronically, all with a common goal of improving the quality of care for our patients while protecting the privacy and security of your medical information. For example, if you received treatment in a MemorialCare hospital's emergency department over the weekend and you were following up with your regular physician in their office that next week, the physician would be able to access and review your emergency department record during your office visit. This type of access provides your physician with the most current information about your care and treatment.

MemorialCare will only transmit your medical information to an HIE for the purposes of treatment, payment, or healthcare operations, or as required by law. Individual health information that currently by law requires an additional signed authorization for release WILL NOT be transmitted to an HIE without your consent, or as otherwise mandated by law or regulatory requirement.

California Immunization Registry. MemorialCare may share your immunization or tuberculosis (TB) screening test records with the California Immunization Registry (CAIR), a statewide, secure and confidential database of patient immunization information. The CAIR is used by health care professionals, agencies, and schools to keep track of all shots and TB tests you take, and can provide proof about immunizations needed to start child care, school, or a new job. If you do not want your immunization or TB records to be shared with other registry users, please fax or email the "Decline or Start Sharing/Immunization Information Request Form," available on the CAIR website at https://www.cdph.ca.gov/Programs/CID/DCDC/CAIR/Pages/CAIR-records-forms.aspx to the CAIR Help Desk at 1-888-436-8320 or CAIRHelpDesk@cdph.ca.gov.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at a MemorialCare Facility.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Facility Directory. We may include certain limited information about you in the facility directory of a MemorialCare hospital while you are a patient at that hospital. This information may include your name, location in the hospital and your general condition (e.g., fair, good, etc). Unless there is a specific written request from you to the contrary, this directory information may also be released to people who ask for you by name. This information is released so your family and friends can visit you in the hospital and generally know how you are doing. If you wish to "opt out" of the facility directory, please contact the admitting department at the MemorialCare hospital where you are being treated and request that your information not be included in the facility directory.

Individuals Involved in Your Care or Payment for Your Care; Disaster Relief Efforts. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. Unless there is a specific written request from you to the contrary, we may also tell your family or friends about your condition. 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.

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. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we 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 our site. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the MemorialCare Facility.

Business Associates. There are some services provided for our organization through contracts with an outside organization, also known as a business associate. Examples include billing services to submit your claim to the insurance company for payment, transcription services to transcribe dictated reports from the health professionals caring for you in the hospital and copy services for making copies of your health record. When these services are performed by a business associate, we may disclose your information to our business associates so they can perform the job we have asked them to do.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

Averting a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Marketing and Sales. Most uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of medical information, require your authorization.

Fundraising Activities. We may use certain information about you (including demographic information and dates you received service) to contact you in the future in an effort to raise money for a MemorialCare Facility. We may also disclose this same information to our MemorialCare affiliated philanthropic foundations for the same purpose. The money raised will be used to expand and improve the services and programs we provide to the community. If you do not wish to be contacted for our fundraising efforts, you must notify the foundation director or a manager at the MemorialCare Facility where you were treated. Notification may be made in writing, including email, by phone or in person.

Special Situations

Organ and Tissue Donation. 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.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military.

Workers' Compensation. We may release medical information about you for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government 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 may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

- 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;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report the abuse or neglect of children, elders and dependent adults;
- to notify emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal laws.

Law Enforcement. If permitted by applicable law, we may release medical information if asked to do so by a law enforcement official:

in response to a court order, subpoena, warrant, summons or similar process;

- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at the hospital; and
- in emergency circumstances to report a crime, the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

Protective Services for the President, National Security and Intelligence Activities. We may release 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 conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official, if the release 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) for the safety and security of the correctional institution.

Multidisciplinary Personnel Teams. We may disclose health information to a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

Note on Other Restrictions. Please be aware that certain federal or state laws may have more strict requirements on how we use and disclose your medical information. If there are stricter requirements, even for the purposes listed above, we will not disclose your medical information without your written permission, or as otherwise permitted or required by such laws. For example, we will not disclose your HIV test results without obtaining your written permission, except as permitted by state law. We may also be restricted by law to obtain your written permission to use and disclose your information related to treatment for certain conditions such as mental illness, or alcohol or drug abuse.

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 copy the information that we have about you that may be used to make decisions about you and your care, including your medical and billing records. We may deny your request to inspect and copy in certain very limited circumstances. To inspect and copy your information that may be used to make decisions about you, you must submit your request in writing to the Medical Records Department at the MemorialCare Facility where you received health care services. 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.

Right to Amend. If you feel that information we have about you 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 the MemorialCare Facility where you were treated. To request an amendment, your request must be made in writing and submitted to the medical records department of the MemorialCare Facility where you were treated. 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 the MemorialCare Facility where you were treated;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

You also may have the right to ask us to add an addendum to your records, which can be up to 250 words for each item you believe to be incorrect or incomplete. Please submit your request for an addendum to the medical records department of the MemorialCare Facility where you were treated.

Right to an Accounting of Disclosures. You have the right to request an "Accounting of Disclosures." This is a list of the disclosures we made of medical information about you other than disclosures for certain purposes, such as for treatment, payment and health care operations purposes, as those functions are described above, or any disclosures that have been specifically authorized by you. To request this list or accounting of disclosures, you must submit your request in writing to the Medical Records Department of the MemorialCare Facility where you were treated. Your request must state a time period, which may not be longer than six (6) years or three (3) years depending on the MemorialCare Facility's implementation date of an electronic health record (EHR). 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.

In addition, we will notify you as required by law following a breach of your unsecured protected health information.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations purposes. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request, except to the extent that you request us to restrict disclosure to a health plan or insurer for payment or health care operations purposes if you, or someone else on your behalf (other than the health plan or insurer), has paid for the item or service out of pocket in full. Even if you request this special restriction, we can disclose the information to a health plan or insurer for purposes of treating you. If we agree to another special restriction, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the medical records department of the MemorialCare Facility where you were treated. 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.

Right to Request Confidential Communications. You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the medical records department at the

MemorialCare Facility where you seek treatment. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Authorize or Refuse to Authorize Other Uses and Disclosures of Medical Information. Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us your authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

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 receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice at our website (www.memorialcare.org). A paper copy of this Notice is also available in the admitting departments or registration desks of all MemorialCare Facilities.

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 in each MemorialCare Facility, as well as our website (www.memorialcare.org). The Notice will contain on the first page, in the bottom left-hand corner, the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us and with the Secretary of the United States Department of Health and Human Services. For information on filing a complaint with us, contact the MemorialCare Chief Compliance/Privacy Officer at (714) 377-3218 for information on how to file your complaint. All complaints must be submitted in writing. We will take no action against you and you will not be penalized for filing a complaint.

MemorialCare Facilities Covered By This Notice

The list of MemorialCare (MC) Facilities covered by this Notice may be found at www.memorialcare.org or may be obtained by contacting the MC Chief Compliance Officer at the address or phone number below.

MC Chief Compliance/Privacy Officer Contact Information:
Chief Compliance Officer/Privacy Officer
MemorialCare
17360 Brookhurst Avenue
Fountain Valley, CA 92708
(714) 377-3218 Phone
(714) 377-3225 Fax