Center for Orthopaedic Injuries & Disorders

Theodore P. Vlahos M.D., P.A.

Certified, American Board of Orthopaedic Surgery

Please bring to your initial visit all x-rays, MRIs and diagnostic studies that have been done since your injury if available. If these items are not available, new x-rays may have to be done in order to provide the most thorough evaluation possible.

In order to avoid delays, please complete all attached paperwork as thoroughly as possible prior to your appointment. Please complete the questionnaire thoroughly, making sure to leave no questions blank.

Please also remember to bring a photo ID and all insurance cards.

Thank you.

31581 U.S. 19 North • Palm Harbor, Florida 34684

Tel: (727) 772-0819 • Fax: (727) 772-8430

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Theodore P. Vlahos, M.D.

Please Let Us Know the Best Way To Contact You

Name: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Cell Carrier: _____

E-Mail: _____

Cancellation Policy

I, _____ agree to call at least 24 hours before my appointment date to cancel or reschedule my appointment. I understand that non-compliance of this agreement will result in $120.00 fee.

_____ _____

Signature Date

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Fall Prevention Balance and Dizziness Survey

Patient Name: _____ Age: _____ Date: _____

To help determine if you may be headed for a fall or have a balance disorder, take the Balance Self Test below. If you answer yes to one or more of the questions, you could be at risk. The best way to determine if you have a problem is to share with the doctor any fears or concerns you have regarding falling, dizziness or vertigo, so that he or she may help determine the cause of your symptoms.

	Please read each question and check the box that most describes your answer.	**Yes or Often**	**Some-times**	**No or Never**
1.	Do you ever lose your balance or feel dizzy or unsteady?			
2.	Have you continued to experience dizziness after an injury or accident?			
3.	Do you feel unsteady when you are walking or climbing stairs?			
4.	Do you feel dizzy while sitting down or rising from a seated or lying position?			
5.	Does walking down the isle of a supermarket or stopping next to moving traffic make you dizzy?			
6.	Does moving your head quickly make you dizzy or cause you to feel nauseous?			
7.	Are you dizzy or unsteady when you first get up in the morning?			
8.	Do you ever fall or feel like you are about to fall for no apparent reason?			
9.	Do you use a walker, cane, or any other form of assistance for your mobility?			
10.	Have you had a recent loss of, or decrease in, your vision or hearing?			
11.	Do you fear falling?			
12.	Have you experienced dizziness, vertigo, or serious imbalance in the past six months?			
13.	Has your balance problem caused problems in your social life?			
14.	Have you fallen more than once in the past year without an obvious cause?			
15.	Does dizziness or imbalance interfere with your job or your household responsibilities?			

Please fill out the top with your name and date, sign the survey at the bottom and provide this to your physician during your visit.

_____ _____

Patient Signature Date

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NEW PATIENT INFORMATION

NAME OF PATIENT: _____ AGE:_____ DATE OF BIRTH:_____
SEX: M _____ F _____ MARITAL STATUS :(circle) S M D W SS#:_____
HOME PHONE: _____ WORK PHONE: _____
CELL PHONE: _____ E-MAIL:_____
IF PATIENT IS A MINOR, PARENT'S NAME: _____ PARENT SS #:_____
HOME ADDRESS: _____ CITY _____ ST ____ ZIP _____
MEDICAL INSURANCE: _____ ID NUMBER: _____
SECONDARY INSURANCE: _____ ID NUMBER: _____
OCCUPATION: _____
EMERGENCY CONTACT:_____ PHONE:_____
WHO IS YOUR PRIMARY PHYSICIAN: _____ PHONE: _____
WHAT OTHER DOCTORS DO YOU SEE:_____
WHAT INJURY OR PROBLEM ARE YOU HERE FOR TODAY: _____
_____
IS THIS A WORK RELATED INJURY: YES _____ NO _____ DATE OF INJURY: _____
DURATION OF PROBLEM:_____

CURRENT MEDICAL PROBLEMS OR CONDITIONS: _____
_____
_____
HISTORY OF MAJOR MEDICAL PROBLEMS (such as cancer, etc.): _____
_____
PAST OPERATIONS (include year):_____
_____

CURRENT MEDICATIONS: _____

ALLERGIES TO MEDICATIONS:_____

WHAT DISEASES RUN IN YOUR FAMILY:_____

DO YOU SMOKE:____ HOW MUCH:_____ DRINK ALCOHOL:____ HOW MUCH:_____
ANY PAST HISTORY OF TRAUMA, WORK ACCIDENT OR AUTO ACCIDENT (please describe and give year):_____

HEIGHT: _____ WEIGHT: _____

I authorize the release of any medical or other information necessary to process this claim and payment of medical benefits for services described . I also release medical and other information necessary for the benefit of my medical care to other physicians and providers of medical services.

Signature: _____ Date:_____

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REVIEW OF SYSTEMS

DO YOU CURRENTLY HAVE ANY PROBLEM IN THE CATEGORIES BELOW? PLEASE DESCRIBE IN DETAIL.

Constitutional: Fevers, chills, weight loss or gain, etc… _____

Eyes: _____

Ears, nose, mouth, throat: _____

Cardiovascular: Heart or blood vessels, high blood pressure, etc… _____

_____

Respiratory: Breathing problems, asthma, emphysema, etc… _____

_____

Gastrointestinal: Stomach, intestines, colon, liver problems. Includes ulcers, heartburn, hepatitis, etc…_____

Genitourinary: Problems with the kidneys, bladder, prostate, sexual organs, etc. _____

_____

Musculoskeletal: Problems before this current injury with your bones, muscles, tendons, etc… Include things like fibromyalgia, osteoporosis, arthritis (diagnosed by a doctor) etc…_____

Skin or breast problems such as tumors, growths, etc…_____

Neurologic: Seizures, brain disorders, nerve problems or damage, carpal tunnel, etc.

_____

Psychiatric: _____

Endocrine: Problems with the thyroid, parathyroid, adrenals, hormone problems, pancreas, diabetes, etc…_____

_____

Hematologic/Lymphatic: Problems with your blood cells, anemia, polycythemia, sickle cell, thallasemia, lymph nodes or system, i.e. lymphoma, leukemia, etc…_____

_____

Allergic/Immunologic: Lupus, rheumatoid arthritis, immune problems, etc…_____

_____

Other problems not mentioned: _____

COORDINATION OF BENEFIT FORM

Dear Patient:
Your Insurance contract provides for benefits to be coordinated with other medical insurance by which you may be covered. Your primary carrier pays first when there is more than one insurance company or health care provider. Please complete Sections 1 and 2 of this form and fill in Section 3 only if applicable.

IN ORDER TO EXPEDITE YOUR CLAIM PROCESS, THE FOLLOWING INFORMATION MUST BE COMPLETED:
Patient ID#: _____ Group Name and #: _____
Patient's Name: _____ Subscriber's Name: _____

SECTION 1
Name of Specialist you are seeing: _____
Date of visit: _____ Referred by: _____
Is the reason for your visit due to an injury caused by an accident? _____
Auto_____ Home_____ School_____ Work_____ Other_____
Date of Accident or Injury: _____
How and where did accident happen? _____
_____
If not an Accident, please explain problem: _____
_____ Where did problem start: _____
Was a third party responsible for your injury? _____
If so, please provide the following information:
Name of individual or company: _____
Name and address of Attorney representing third party: _____
_____

SECTION 2
(INFORMATION TO BE FILLED OUT IF AUTO ACCIDENT)
Were you in your own vehicle or someone else's? _____
Name of Insurance Company: _____
Were you the driver or passenger? _____
Were you wearing a seat belt? _____

SECTION 3
Full name of your Spouse _____ SS# _____
Spouse's Birth Date: _____ Spouse's Employer: _____
Is your Spouse covered by any Health Insurance Company? _____ If so, please provide name of Insurance Carrier: _____

SECTION 4
Is your problem covered by any other Insurance? _____ Yes _____ No
If yes, Name of Insurance: _____

To the best of my knowledge the statements above are true. Unanswered questions indicate they do not apply. My signature authorizes _____ Insurance to receive any and all information concerning claims filed by me or on my behalf to another insurance carrier.

SIGNATURE: _____ DATE: _____

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Theodore P. Vlahos, M.D.

COMMERCIAL INSURANCE

I hereby authorize release of medical information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO **Theodore P. Vlahos, M.D.**

I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature of patient or guardian _____ Date _____

MEDICARE INSURANCE

BENEFICIARY _____ Medicare Number_____

I request that payment of authorized Medicare benefits be made on may behalf to **Theodore P. Vlahos, M.D.** for any services furnished to me by that provider. I authorize any custodian of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Beneficiary Signature _____ Date _____

MEDICARE SUPPLEMENTAL INSURANCE

BENEFICIARY _____ Supplement Insurance Number_____

I hereby give **Theodore P. Vlahos, M.D.** permission to bill for Medicare Supplemental Insurance payments for my medical care.

I understand that _____(<Supplemental Ins. Name) needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to _____. (< Supplemental Ins. Name)

I request that payment of authorized Medicare Supplemental benefits be made to **Theodore P. Vlahos, M.D.** for any services furnished me by the physician. I authorize any holder of medical information abourt me to release to _____(<Supplemental Ins. Name) any information required to determine and pay these benefits.

Beneficiary Signture _____ Date _____

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AUTHORIZATION TO RELEASE INFORMATION

I do hereby authorize **The Center For Orthopaedic Injuries & Disorders,** its health care providers and employees to release copies of my medical records including all office notes, medical information forms, radiology or laboratory reports and radiology studies to the following:

1) My insurance carrier or its representative.
2) My primary care physician or referring health care professional.
3) My attorney in the case that the injuries being treated are the result of an accident which may be the subject of litigation.
4) Medical consultants involved in the care of my medical conditions or injuries.

In addition, I authorize release of an itemized statement of services rendered to me with regard to my accident or injury in order to process any claim for that I may have in connection with such accident or injury and to pay charges incurred by me as a result of the professional services that I have received. Furthermore, by my signature below, I hereby release **The Center For Orthopaedic Injuries & Disorders**, its providers and employees of any consequences thereof.

AUTHORIZATION FOR INFORMATION

I do hereby authorize all physicians, hospitals, ancillary service centers, other health care providers, attorneys, etc… to release to **The Center For Orthopaedic Injuries & Disorders**, copies of my complete medical records including office notes, reports, consultations, laboratory and radiology reports and studies. I understand that this is to assist in the treatment of my orthopaedic injuries or conditions and that privacy will be respected to the fullest extent possible.

I have read and fully understand the above:

_____ _____

Signature Date

_____

Printed Name

Center for Orthopaedic Injuries & Disorders

Theodore P. Vlahos M.D., P.A.

Certified, American Board of Orthopaedic Surgery

CENTER FOR ORTHOPAEDIC INJURIES AND DISORDERS

AUTHORIZATIONS:

Authorization to pay benefits to provider: I hereby authorize payment directly to The Center For Orthopaedic Injuries & Disorders. If payment is sent directly to me (the patient), I will promptly submit the same to The Center For Orthopaedic Injuries & Disorders.

Authorization to release information: I hereby authorize The Center For Orthopaedic Injuries & Disorders to release any information acquired in the course of my examination or treatment.

Authorization to photocopies: I herby authorize photocopies of this form to be as the original.

One Time Authorization: I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.(Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

I hereby acknowledge I am personally responsible for payment for any and all treatments rendered not covered by a medical insurance plan.

_____ _____

Patient's Signature Date

_____ _____

Signature of Parent (if minor) Date

_____ _____

Witness Date

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review does not leave the Clinic's offices. 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.

Public Health and Safety: We may use or disclose your PHI for public health activities, including but not limited to the reporting of disease, injury, vital events, conducting of public health surveillance, investigation and intervention, child abuse or neglect, and for activities related to quality and safety of FDA-regulated products or activities. We may use or disclose your PHI to prevent or lessen a serious threat to the health or safety of another person or to the public, or for national security and intelligence activities authorized by law.

Workers' Compensation: We may disclose your PHI as authorized by laws relating to Workers' Compensation or similar programs.

Notification of Family and Friends: With your written permission, we may disclose your PHI to family members, other relatives, or other person(s) you identify, when the PHI is directly relevant to that person's involvement with your care. We may disclose your PHI to others who may be involved in your health care, to notify a family member, or another person responsible for your care of your location, general condition or death. If you are unable to agree or object to such a disclosure, we may disclose such information, as necessary, if we determine that it is in your best interest based on our professional judgment. We also may disclose your PHI to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts. We may disclose such information, as necessary, based on our professional judgment to respond to the emergency circumstances.

Appointment Reminders: We may use or disclose your protected health information, as necessary, to contact you to provide appointment reminders or to reschedule your appointment. We may leave brief messages about your appointments on your answering machine or voice mail.

Alternative Treatment Information: The Clinic is always interested in improving health care and lowering costs for groups of people who have similar health problems, and to help manage and coordinate the care for these groups of people. We may use your PHI to identify groups of people with similar health problems, to provide them with information about treatment alternatives or other health-related benefits and services that we believe may be of interest to them. We may also use and disclose your PHI for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, or we may send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer in writing to request that these materials not be sent to you.

ANY OTHER USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ABOUT YOU REQUIRES YOUR WRITTEN AUTHORIZATION

We will not use or disclose your health information for any other purpose without your written authorization. Once you give written authorization, you may cancel your authorization in writing at any time. If you cancel your authorization we will not disclose protected health information about you after we receive your cancellation, except for disclosures made or processed, before we received your cancellation.

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Palm Harbor, Florida 34684

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Fax: (727) 772-0122

CENTER FOR ORTHOPAEDIC INJURIES & DISORDERS

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.

CENTER FOR ORTHOPAEDIC INJURIES & DISORDERS is required by federal and Florida law to maintain a record of the care and services you receive at the Clinic. We understand that this information about you and your health is personal, and we are committed to protecting the privacy and security of your health information.

This Notice of Privacy Practices (the "Notice") describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, as well as other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information"(or "PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. This Notice applies to all your PHI maintained by the Clinic, whether the PHI is created by your treating Clinic physician, by your referring physician, by a nurse, or by others working at or with the Clinic.

The Clinic is required by law to abide by the terms of this Notice. In this regard, we are required by law to:

- make sure that your PHI is kept private;
- give you this Notice of our legal duties and privacy practices with respect to your PHI; and
- follow the terms of this Notice as currently in effect.

REVISION OF NOTICE OF PRIVACY PRACTICES

We reserve the right to change the terms of this Notice at any time, and we reserve the right to make the changed Notice effective for all health information that we maintain at the time of the revision. If we revise the terms of this Notice, we will post a revised notice at all Clinic offices. We also will make paper copies of the revised Notice available upon request.

HOW TO CONTACT THE CLINIC

If you would like further information regarding your rights or regarding the uses and disclosures of your health information, you may contact our Privacy Officer at 727-772-0819

THIS NOTICE IS EFFECTIVE AS OF April 14, 2003.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION:

You have the following rights with respect to your protected health information:

Right to Request Restrictions: You may request that we restrict or limit the protected health information we use or disclose about you for treatment, payment, or health care operations, or you may request a limit on the PHI we disclose to others who are involved in your care (i.e., a non-Clinic physician, a laboratory) or in the payment for your care. We are not required to agree to your request; but if we do, we will honor it. Even if we agree to your request, your restrictions might not be applied in certain situations. For example, in an emergency, we may use or disclose the PHI, without any restriction, to provide emergency treatment to you. To request a restriction or limitation, your request must be made in writing and submitted to the Medical Records Department.

Right to Request Confidential Communications: You have the right to receive communications from us in a confidential manner, and you may request that we com...

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PATIENT ACKNOWLEDGMENT FORM

By signing this form I acknowledge that I have received a copy of the office's Privacy Notice.

_____
Print Name

_____
Signature

_____
Date

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Theodore P. Vlahos, M.D.

GENERAL PATIENT/PHYSICIAN AGREEMENT

Please read the following paragraphs and initial below each paragraph that you have read, understand and agree to the same.

In any effort to provide the most efficient and effective healthcare, your treating physician will diagnose your illness according to your complaints, symptoms, test results and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method and/or any physician that can assist with the care of the patient, as long as confidentiality is kept at the physicians level. I have read, understand and agree with the above.

Patient/Guardian Initials: _____

The patient understands that he/she is not required to use treating physician or any other physician employed by or under the direction of this facility or practice for general healthcare and/or surgery. The patient understands medicine is not an exact science and there is risk involved in any medical procedure. The patient understands he/she is being treated at their own risk. It is further understood, that in the event of any controversy or dispute which might arise between the patient and the physician, regardless of whether the dispute concerns the medical care rendered by the treating physician or any manner whatsoever, then the patient agrees that the controversy or dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682 & 684 Florida Statutes. This arbitration shall be binding and shall be in lieu of and instead of any trial by judge or jury. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. Each party shall be entitled to the discovery provided for under rules 1.280-1.390 Florida Rules of Civil Procedure. The panel or arbitrators shall hear and decide the controversy and the decision shall be binding on all parties and may be enforced by a court of competent jurisdiction. I have read, understand and agree with the above. Patient/Guardian Initials: _____

"Physician Orders" are meant to improve and/or resolve the patient's medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician's care and/or facility, thus releasing treating physician and/or facility from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can include but is not limited to missing, postponing or refusal of additional tests to rule out, confirm or discover illnesses. I have read, understand and agree with the above. Patient/Guardian Initials: _____

I _____, as patient/guardian, have read and understand all paragraphs above by initialing below each paragraph. I have read and agreed to abide by their content by signing below.

In witness whereof, I have set my hand this date _____.

_____ _____

Print Patient's Name Patient's Signature

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(e.g., only by mail, only on your cell phone) or at a certain location (e.g., only at work, only at home). Your request for confidential communications must be made in writing to the Medical Records Department and must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to Inspect and Copy: Generally, you may review and obtain a copy your PHI in a designated record set. This right is subject to certain specific exceptions. Your request must be made in writing to the Medical Records Department. We may charge a reasonable fee to cover our copying, mailing, and any other supplies associated with your request. We will notify you of the fee and you may choose to withdraw or modify your request at that time, before any costs are incurred. We reserve the right to withhold the requested information until payment of the reasonable fee is received.

Right to Amend: You may ask us to amend your PHI if you believe that any of the information is incorrect or incomplete. You have the right to request an amendment for as long as the PHI is maintained by the Clinic. We may deny your request for certain specific reasons. For example, we may deny your request if you ask us to amend information that: was not created by us; is not part of the PHI maintained by the Clinic; is not the type of PHI that you would be permitted to inspect and copy; if we determine that the information is correct and complete, or if you fail to explain the reason(s) for your request in writing. Your request to amend your PHI must be made in writing to the Medical Records Department and must specify the reason(s) that support your request. If we deny your request, we will provide you with a written explanation for the denial and information regarding appeal rights you may have at that point.

Right to an Accounting of Disclosures: You have the right to request a written list of certain disclosures of your PHI made by the Clinic. We are not required to account for disclosures made for treatment, payment, or healthcare operations (as described on the following page), disclosures that you authorized, and certain other specific disclosure types. Your request must state the time period which the accounting is to cover. This period may not be longer than six (6) years and may not include dates before April 14, 2003. Your request for an accounting of disclosures must be made in writing to the Medical Records Department. The first accounting you request within a twelve (12) month period will be free. For additional accounting requests during that twelve-month period, we may charge a reasonable fee to cover our costs of providing the accounting. We will notify you of the fee and you may choose to withdraw or modify your request at that time, before any costs are incurred. We reserve the right to withhold the requested accounting until payment of the reasonable fee is received.

Right to a Copy of this Notice: You may request a paper copy of this Notice of Privacy Practices at any time.

Complaints: You have the right to complain to us, and to the Secretary of the U.S. Department of Health and Human Services, if you believe that your privacy rights have been violated. If you choose to file a complaint, you will not be retaliated against in any way. You must submit all complaints in writing to:

31581 U.S. 19 North Palm Harbor, Florida 34684

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose protected health information. Your PHI may be used and disclosed by your physician, by nurses, technicians, or health care team members, by our office staff, and by others outside of our office that are involved in your care and treatment. When required, we will obtain your authorization before disclosing any of your PHI, and we will use reasonable efforts to share only minimally necessary PHI with others.

Treatment: We may use and disclose your PHI to provide, coordinate, and manage your health care and any related services. For example:

- Your protected health information may be provided to a physician to whom you have been referred, to other physicians who may be treating you, or to a hospital that is involved in your care, to ensure that the physician or hospital has the necessary information to diagnose or treat you.
- We may disclose your PHI from time to time to another physician or health care provider (e.g., a specialist, imaging center or laboratory) who, at the request of your attending physician, becomes involved in your care by providing assistance with your health care diagnosis or plan of treatment.
- We may disclose your protected health information to a pharmacy when calling in a prescription.

Payment: Your PHI may be used and disclosed by the business office to process your payment for the health care services provided to you. For example:

- Before you receive scheduled services, we may share information with your health plan in order to verify eligibility, to ask whether coverage is provided by your plan or policy, to obtain required pre-certification, or to obtain prior approval of payment.
- After you receive services, we may share information with your health plan to support our claim for payment , to review services provided to you for medical necessity, and for utilization review activities.

Health care operations: We may use or disclose, as needed, your PHI in order to support the business activities and operations of the Clinic. These activities include, but are not limited to, reviewing the quality of the care you received, quality assessment activities, employee review activities, training of healthcare students, licensing, and marketing activities, compliance with applicable laws, and conducting or arranging for other business activities. For example:

- We review the quality, efficiency and cost of care that we provide to you and our other patients in order to find more efficient and effective ways to provide service, to develop ways to assist our health care providers and staff in deciding what additional services the Clinic should offer, and to evaluate whether new treatments are effective.
- We may share your PHI with third party "business associates" who perform various activities for the Clinic (e.g., accountants, lawyers, transcription, copy, billing, and collection services). Whenever an arrangement between the Clinic and a business associate involves the use or disclosure of your PHI, we will have a written contract with the business associate that contains terms that will protect the privacy of your PHI.

Disclosure to Department of Health and Human Services We may disclose your PHI when required by the U.S. Department of Health and Human Services, the Florida Department of Health or Agency for Health Care Administration, or their agents, as part of an investigation or determination of our compliance with relevant laws.

Health Oversight Activities: We may disclose your PHI to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.

Abuse or Neglect: We may disclose your PHI, in accordance with applicable federal, state, and local law, when it concerns abuse, neglect, or violence to you.

Law Enforcement and Legal Proceedings: As required by law, we may disclose your PHI for law enforcement purposes or other specialized government functions. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We also may disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts, as required by law, have been made to tell you about the request or to obtain an order protecting the requested information.

Coroners, Medical Examiners and Funeral Directors: We may disclose your health information to a coroner, medical examiner or a funeral director.

Organ Donation: We may disclose your health information to an organ donation and procurement organization.

Research: Under certain circumstances, we may use and disclose your PHI 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 health information, trying to balance the research needs with patients' need for privacy of their PHI. Before we use or disclose PHI for research, the project will have been approved through this research approval process. We also may disclose your PHI to people preparing to conduct a research project. For example, we may help potential researchers look for patients with specific health needs, as long as the health information they