WHITMAN-WALKER HEALTH

Mailing Address:
Whitman-Walker Health 1525
1525 14th St., NW
Washington, DC 20005

Welcome to Whitman-Walker Health! We look forward to you joining our healthcare family.

Established in 1978, Whitman-Walker Health is a nonprofit community health center focused on removing barriers to accessing care in the Washington, DC, metropolitan area. Whitman-Walker works to provide stigma-free healthcare and support services to the gay, lesbian, bisexual, transgender and non-binary communities of greater Washington, and people living with or affected by HIV. Through multiple locations in the district, Whitman-Walker serves 18,000 individuals with medical and dental care, mental health and addiction services, legal services, youth programming and more. We extend affirmation, dignity and respect to everyone we provide care to.

This packet includes the following:

- Patient Registration
- Consents and Acknowledgement
- E-Communications Opt-Out Form
- Patient Acknowledgement of Financial Obligation
- Authorization to Release Health Information
- Authorization to Permit Release of Health Information
- Patient Rights and Responsibilities Statement
- Notice of Privacy Practices

You might be wondering why it's important for you to completely fill out your registration form. Here's why:

- The information you provide helps us learn about you and better serve you. This information includes your preferred name and gender pronouns.
- It also helps us comply with grants we apply for and provide services through. To keep receiving grant funding and serve you affordable care, we need for you to answer all questions on the form, including information about your annual income, family size, and housing.

This information will become a part of your health record. It is kept confidential. It is protected by law just like all of your health information.

Thank you for choosing Whitman-Walker Health for your healthcare needs and for taking time to complete these forms. We appreciate you!

Sincerely,

Sara Henn, MD
Chief Health Officer

WHITMAN-WALKER HEALTH

Patient Registration Form

Welcome to Whitman-Walker Health! We are happy you have chosen us for your care. To register, please complete this form. Several of the items below help us ensure that we are meeting the needs of the population we serve, so please be as thorough as you can. Let us know if you have any questions or if you need help in completing this form.

HOW CAN WE HELP YOU?

- ☐ Primary Medical Care
- ☐ HIV Medical Care/Red Carpet
- ☐ HIV Testing
- ☐ STI Testing
- ☐ Post-Exposure Prophylaxis (PEP) *(I believe I was exposed to HIV)*
- ☐ Gender-Affirming Care
- ☐ Pre-Exposure Prophylaxis (PrEP)
- ☐ Substance Abuse Services
- ☐ Support Groups
- ☐ Dental
- ☐ Legal Services
- ☐ Aesthetics

Wellness services available for existing eligible patients:

- ☐ Acupuncture
- ☐ Diabetes Education
- ☐ Massage Therapy
- ☐ Mental Health Counseling
- ☐ Nutrition
- ☐ Reiki
- ☐ Psychiatry
- ☐ Smoking Cessation
- ☐ Yoga

First Name: | **Middle Initial:** | **Last Name:**

Preferred Name:

Date of Birth: *Month:* / *Day:* / *Year:* | **Social Security Number:** ___ ___ ___–___ ___ –___ ___ ___ ___

Street Address: | **Apt. No.:** | **D.C. Ward:**

City: | **State:** | **Zip:**

Whitman-Walker will send you mail to the listed address. We believe it important to communicate with you, and at times, we do mail information.

Is your housing: ☐ Stable ☐ Unstable ☐ Temporary

Phone Numbers:

Cell Number:_____

Home Number:_____

Work Number:_____

Patient Portal:

The most secure way to communicate with us is via our patient portal. Please show us your identification and provide your email address.

Email Address:_____

Gender Identity:

- ☐ Man
- ☐ Woman
- ☐ Trans Man
- ☐ Trans Woman
- ☐ Genderqueer/Non-binary
- ☐ _____

Sex Assigned at Birth:

- ☐ Male
- ☐ Female
- ☐ Intersex
- ☐ _____

Do you identify as transgender?

☐ Yes ☐ No

Gender Pronouns:

- ☐ He/Him/His
- ☐ She/Her/Hers
- ☐ They/Them/Theirs
- ☐ _____

Sexual Orientation:

- ☐ Lesbian, Gay, Homosexual
- ☐ Straight, Heterosexual
- ☐ Bisexual
- ☐ _____

Annual Family Income:

$_____

Family Size:

_____

(includes spouse, dependent children, or other people dependent on you)

To comply with Federal law, we are required to collect information about family income and family size from all patients to determine the patient's income by the Federal Poverty Level.

Ethnicity:

- ☐ Non-Hispanic/ Non-Latino

Hispanic/Latino *(please specify)*

- ☐ Mexican Mexican American Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Another Hispanic Latino/a Spanish Origin

Race:

- ☐ African American/Black *(including Africa, Caribbean)*
- ☐ Caucasian/White *(including Middle Eastern)*
- ☐ American Indian or Alaska Native *(including all Original Peoples of the Americas)*

Asian *(please specify)*

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian/Pacific Islander *(please specify)*

- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Guamanian or Chamorro
- ☐ Other Pacific Islander

Patient Registration Form (continued)

Language:	**Deaf or hard of hearing:**	**Do you have an advanced health care directive?**
☐ English ☐ Spanish ☐ _____ ☐ I request language translation services.	☐ Yes ☐ No **Preference:** ☐ Live interpreter ☐ Video remote interpreter	☐ Yes *(please bring a copy for your WWH health record)* ☐ No If no, would you like more information? ☐ Yes ☐ No

Emergency Contact Information

First Name:	**Last Name:**		**Relationship:**	
Street Address:	**Apt.:**	**City:**	**State:**	**Zip:**
Cell Number:		**Work Number:**		
Home Number:		**Email Address:**		

Payment and Insurance Information

PLEASE PROVIDE YOUR INSURANCE CARD AT THE TIME OF REGISTRATION.
A list of insurance we accept is available on our website. Our registration staff can also assist you.

Are you insured? ☐ Yes ☐ No	*If you do not have insurance, you must meet with the Public Benefits and Insurance Navigators. You may be eligible for insurance or our sliding fee schedule for your services. In order to determine your eligibility, you must provide income, family size, and residency documentation. Until we receive your documentation, you will be responsible for the full fee for your services.*	
Insurances we do not accept:	*If we do not take your insurance OR you have an HMO, we encourage you to select a provider who takes your insurance. Choosing to get your care with us will mean being charged for the full fee of your care and seeking reimbursement from your insurer.*	
Insurance Information:	**Company:**	**Identification Number:**
	Group Number:	**Contact Number** *(on back of card):*
	In whose name is your insurance? ☐ Self ☐ Other	**If private/commercial insurance:** ☐ Employer-Paid ☐ Individual-Paid ☐ Other:_____
	Is the responsible party a Whitman-Walker patient? ☐ Yes ☐ No	
Secondary Insurance Information:	**Company:**	**Identification Number:**
	Contact Number *(on back of card):*	
Sex/Gender Marker with Insurance Company:	WWH recognizes your gender identity. For insurance billing purposes, what sex/gender marker is on file with your insurance company? ☐ Male ☐ Female	Is your legal name on your insurance card? ☐ Yes ☐ No, it's listed as _____

☐ For HIV+ patients: I understand that I may be eligible for savings on my health care if I incur a certain level of health care expenses. For more information, I will call the Public Benefits and Insurance line at 202.745.6151.

Acknowledgement of Responsibility for Payment for Services and Assignment of Benefits

- I understand that I am responsible for all charges and fees for my care, except any that might be covered by insurance accepted by WWH.
- I understand that payment, including co-insurance, co-pays and self-pay / sliding fee payments, is due at the time of service.
- For uninsured or underinsured clients: I understand that if my income, family size, or residency changes, I will bring in documentation of those changes to the Public Benefits and Insurance Navigators. Navigators will re-assess my eligibility for insurance on the sliding fee scale and/or grant-supported care.

Signature:	**Date:**

Give completed form to Reception; fax to 202.332.1049; mail to Client Services, 1342 Florida Ave., NW, Washington, DC 20009-4808

WHITMAN-WALKER HEALTH

Consents and Acknowledgements

In order for you to become a patient, we need your consent to provide you with care. We also need you to acknowledge that we have provided you with certain important information and documents. If you have any questions about any of this information or need help completing this form, please do not hesitate to ask a member of our staff. It is important to us that you feel comfortable with all of this information. By signing, you are indicating that you understand the information, have been given a chance to ask questions, and are giving your consent.

GENERAL CONSENT TO TREAT

I voluntarily agree to receive services from WWH, and authorize the providers of WWH to provide such care, treatment, or services as are considered necessary and advisable for me. I understand that I should participate in the planning for my care and that I have a right to refuse interventions, treatment, care, services or medications at any time to the extent the law allows. I know that the care I will receive may include tests, injections, and other medications, etc., that are based on established medical criteria, but not free of risk. Finally, I know that WWH sometimes has students/residents being trained as doctors, nurses, therapists and other health care providers who might be helping to care for me. These individuals are under the supervision of licensed providers. I understand that WWH is committed to involving me in my care and that no one can be given care at WWH without agreeing to the care unless there is an emergency. If there is an emergency, I know that someone at WWH may help me without waiting for me to say okay. I understand that some services require me to sign another Informed Consent to Treatment so I may be asked to complete that later.

I understand that WWH is committed to involving me in my care and that no one can be given care at WWH without agreeing to the care unless there is an emergency. If there is an emergency, I know that someone at WWH may help me without waiting for me to say okay. I understand that some services require me to sign another Informed Consent to Treatment so I may be asked to complete that later.

NOTICE OF PRIVACY PRACTICE

I have been given a copy of WWH's Notice of Privacy Practices and I understand that WWH is required by law to protect my personal health information. I have had the chance to ask questions about WWH's Notice of Privacy Practices and feel comfortable with the protections that it offers me. I understand that there are times when the law allows my personal health information to be shared with individuals or entities outside of WWH, including but not limited to for treatment, payment and operations purposes, when required by law, and in connection with the mandatory reporting of certain diseases.

INTEGRATED MODEL OF CARE

WWH offers a wide variety of services to its clients. I understand that in order for me to get the best service for my needs, programs within WWH may share information concerning my health to ensure the quality and continuity of my care across service areas. For example, WWH may share my demographic information, medical and other service referrals, and other non-clinical information with WWH Legal Services to allow for legal referrals and for scheduling purposes. The details of my health records will only be shared with WWH lawyers if I agree for them to take my legal case.

HEALTH INFORMATION EXCHANGE

I understand that WWH participates in certain health information exchanges with other hospitals and health centers located in the metropolitan area, including the Chesapeake Regional Information System for our Patients (CRISP) and the Capital Partners in Care Health Information Exchange. I have been informed that my health information, including limited information relating to mental health and substance abuse services that I may receive at WWH, will be shared with these exchanges. Notes from my psychiatrist, mental health therapist or addiction counselor will not be shared, but diagnosis codes and a history of my visits will be shared. My understanding is that information about me is being shared with providers and public health officials outside of the health center for treatment purposes, in order to better coordinate my care and to assist providers and public health officials in making more informed decisions. I have been advised by WWH that I have the right to "opt-out" of health information exchanges at any time. I understand that I can request a copy of the "opt-out" form from WWH and direct WWH to disable access to my health information, except to the extent that disclosure of such information is permitted or mandated by law.

PATIENT RIGHTS AND RESPONSIBILITIES AND CLIENT HANDBOOK

I have been given a copy of the WWH Patient Rights and Responsibilities document and understand that both the Rights and the Responsibilities laid out in that document must govern my interactions at WWH. I also understand that WWH and I are responsible for adhering to the Rights and Responsibilities. I understand that I have a right to file a complaint or grievance with WWH, as described in WWH's Patient Handbook. The Patient Handbook contains information about being a patient at WWH, including services that WWH offers, hours of operation, and contact information for services. I have been provided with a copy of the Patient Handbook.

WHITMAN-WALKER HEALTH

Consents and Acknowledgements (CONTINUED)

RELEASE OF INFORMATION FOR BILLING AND CONSENT TO REIMBURSE

I know that WWH needs to send parts of my personal health information to organizations that help pay for my care, such as my insurance company or an organization that grants money to WWH. I allow WWH to release the relevant parts of my records so that my care can be paid for. If I do not feel comfortable with this, then I understand that I can request a higher level of privacy protection than is afforded to me under the Health Insurance Portability and Accountability Act (HIPAA).

CONSENT TO COMMUNICATIONS VIA E-COMMUNICATIONS

The U. S. Department of Health and Human Services permits patients to request electronic communications with their providers. I acknowledge that the most secure means of communicating with WWH is by use of the patient portal. Any other method of communicating electronically presents a greater risk of breach of privacy because the communications may be intercepted by third parties or transmitted to unintended parties. WWH will make an effort to limit the information it includes in e-communications with me. I understand, however, that information about my medical care (including appointments, billing information, prescriptions and test results) may be sent to me electronically. By signing below, I am choosing and consenting freely to electronic communications. If I wish to discontinue e-communications with WWH, I can submit an E-communications Opt-Out Form available from Client Services or on the WWH website.

ACKNOWLEDGMENT OF DUTY TO REIMBURSE WWH FOR HEALTH CARE SERVICES

I understand that WWH offers a Sliding Fee Scale of discounted or free health care items and services to individuals who are deemed unable to pay based on their level of income. In order to be eligible for WWH's Sliding Fee Scale of discounted or free services, I will need to provide WWH's Public Benefits and Insurance Navigation team with documents establishing that I meet income eligibility requirements. If I do not provide the required documents to WWH, I am responsible for paying my fees for medical, behavioral health, or dental services received at WWH in full at the time of service. I also understand that if I am an insured patient with insurance WWH does not accept, or an insured patient with a copay obligation who fails to pay fees or copays due at the time of service, I will not be scheduled for future appointments until such time as my outstanding fees or copays are paid.

By signing my name below, I am acknowledging that I have read, and fully understand, each of the separate paragraphs set forth above.

Signature:	**Date:**
Printed Name: (If other than patient, print relationship)	**Date of Birth:**

WHITMAN-WALKER HEALTH

E-Communications Opt Out Form

I, _____, do not wish to receive
Patient Name (Printed)
electronic communications from Whitman-Walker Health (WWH) effective this date.

As a result of opting out of e-communications, I understand that a WWH Workforce member will be required to communicate with me via phone and or United States Postal Service. I further accept the responsibility of ensuring my mailing address and phone information are current and accurate.

If I decide to reengage in electronic communications in the future, I understand that I will be required to resubmit a signed "Consents and Acknowledgements" form to a member of the WWH Client Services Department.

_____

Patient Signature Date

WHITMAN-WALKER HEALTH

Patient Acknowledgement of Financial Obligation

PREAMBLE

Whitman-Walker Health ("WWH") is a Federally Qualified Health Center Look-Alike ("FQHC- LA" or "Health Center") that is subject to Section 330 of the Public Health Service Act. Section 330 specifies that Health Centers must assure that no patient will be denied services due to their inability to pay for such services. It also requires Health Centers to adopt written policies and procedures to maximize collections and reimbursement for their costs in providing health services.

I UNDERSTAND THAT I AM RESPONSIBLE FOR:

- Contributing to the cost of my care and treatment as my health insurance coverage requires and based on my ability to pay;
- Providing WWH with the information it needs to receive reimbursement for the treatment or services it provides to me;
- Requesting consideration for discounted fees under WWH's Sliding Fee Scale based on my level of income, and providing documentation to support eligibility for discounted fees that may be requested by WWH's Public Benefits and Insurance Navigation team;
- Assisting the Public Benefits and Insurance Navigators with any application for insurance or public benefits that I may be entitled to;
- Paying my co-payment (if applicable) when I check-in for my appointment and paying my deductible or any other fees that may be owed at the conclusion of the medical visit;
- Paying my fees for medical, behavioral health, or dental services received at WWH in full at the time of service, either upon check-in or at check-out as requested by WWH if I have been deemed a self-pay patient based on the fact that I have insurance coverage that WWH does not accept but have elected to remain in care at WWH.

I understand that if I am an insured self-pay patient or an insured patient with a copay obligation who fails to pay fees or copays due at the time of service, I will not be scheduled for future appointments until such time as my outstanding fees or copays are paid. If I fail to pay my outstanding fees or copays in 30 days, WWH presumes that you are transitioning your care to another provider. If you have a health care issue requiring immediate care during the next 30 days, you may contact WWH and your provider will determine whether you should be seen. To prevent you from running out of medications, a thirty (30) day renewal will be made available if needed.

Signature:	**Date:**
Printed Name: (If other than patient, print relationship)	**Date of Birth:**

WHITMAN-WALKER HEALTH

Patient Rights and Responsibilities Statement

AS A WWH PATIENT, YOU HAVE THE RIGHT TO:

ACCESS SERVICES in a safe and respectful manner
- Receive services at WWH regardless of your race, color, religion, sex, marital status, sexual orientation, gender identity or expression, English language proficiency, national origin, age, disability, veteran status, or any other status protected by law.
- Receive respect and consideration from every employee, volunteer or trainee you interact with at WWH.
- Feel safe from harm and free from verbal, physical, or psychological abuse, intimidation or harassment when you are at WWH's facilities.

PRIVACY regarding your personal health information
- Expect WWH to comply with the Federal and State privacy laws when using or disclosing information about you or the health care and related services you receive at WWH.
- Receive a copy of WWH's Notice of Privacy Practices when you register as a new patient so that you will be more fully informed about your privacy rights.
- Active involvement in your ongoing care
- Help WWH providers and staff to develop a plan for the treatment and services you receive at WWH.
- Provide (or withhold) your consent to voluntary treatment, including your participation in clinical research, and be informed about the consequences of refusing any treatment or service.
- Provide WWH staff members with positive or negative feedback about your care, or voice your concerns or complaints about the Health Center.

TIMELY INFORMATION about your care
- Receive complete information about your diagnosis, and treatment or service plan in plain language that you can understand.
- Obtain a copy of your medical records upon request unless the law permits WWH to withhold the records.
- Receive an explanation of the costs associated with your care at WWH.
- Obtain assistance with referrals to other providers.

QUALITY SERVICES from our health center
- Receive coordinated health care treatment and services consistent with professional standards.
- Receive services from licensed and credentialed WWH providers.
- Request WWH to provide hearing, language, literacy or other communication assistance required by law.
- Receive services and care in the least restrictive environment feasible, free from chemical or physical restraints.

AS A WWH PATIENT, YOU ARE RESPONSIBLE FOR:

YOUR PERSONAL INTERACTIONS with our health center team
- Treat WWH employees, volunteers, trainees, contractors, other patients, and guests with respect at all times.
- Do not make any threatening or offensive statements at WWH's facilities.
- Do not engage in any act of physical violence or other threatening or inappropriate behavior at WWH's facilities, which includes bringing a weapon of any kind on site.
- Do not distribute or use alcohol or drugs on WWH's property or enter a WWH facility or program under the influence of illegal drugs or alcohol.

ACTIVE ENGAGEMENT in your care
- Take an active part in your treatment or service plan at WWH and stay in contact with your providers about your care.
- Request any hearing, language, literacy or other communications assistance you may need at least 48 hours prior to your visit.
- Show up for your appointments at least 15 minutes ahead of schedule and provide advance notice whenever it becomes necessary to cancel an appointment at WWH.
- Contribute to the cost of your care that the law or the health plan that you participate in require you to pay.

TIMELY INFORMATION sharing
- Provide WWH with complete, accurate, and truthful information at all times.

WWH's Patient Rights and Responsibilities Policy grants WWH discretion to take action placing limits on a patient's ability to receive treatment or services at WWH based on a patient's failure to meet their Responsibilities or for any other reason permitted by law. Likewise, any WWH patient has discretion to decide not to seek further treatment or services at WWH based on WWH's failure to abide by the patient Rights set forth in this Statement or for any other reason.

If you believe your rights as a Whitman-Walker Health patient have been violated...
please contact our Senior Director of Compliance at 202.939.7694.

WHITMAN-WALKER HEALTH

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed by Whitman-Walker Health (WWH) and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communications
- Ask us to limit the information about you that we share
- Get a list of those with whom we've shared your information
- Get a copy of this Notice of Privacy Practices
- Choose someone to act as your personal representative for purposes of your health information
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:
- Tell family and friends about your health
- Provide disaster relief
- Provide mental health care
- Market our services and sell your information
- Raise funds

OUR USES AND DISCLOSURES

We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

A more detailed description of your rights, your choices and our uses and disclosures of your health information is set forth below:

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section of our Notice of Privacy Practices explains your rights and some of our responsibilities under the law.

Get an electronic or paper copy of your medical record.
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- You can ask us to correct health information about you that you think is incorrect or incomplete.

Ask us to amend your medical record

We may say "no," but we'll tell you why in writing within 60 days
.

Request confidential communications
- Make a reasonable request to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Notice of Privacy Practices
- You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically and we will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone health care power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- Our Legal Services Department can assist you with the preparation of a health care power of attorney document that provides authority for another person to act on your behalf.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting Whitman-Walker's Privacy Officer at 202.939.7694.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW, Washington, DC 20201, calling 1.877. 696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

WHITMAN-WALKER HEALTH

Notice of Privacy Practices (continued)

In these cases we generally do not share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES OF INFORMATION ABOUT YOU

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

To treat you
We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

To run our organization
We can use and share your health information to run our health center, improve your care, and contact you when necessary.
Example: We use health information about you to improve the quality of care we provide to you and others.

In order to bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.
Example: We can give information about you to your health insurance plan in order to be paid for the services you receive at the health center.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?
We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. If you want to learn more you can go to: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information about a deceased patient with a coroner, medical examiner, or funeral director.

Address workers' compensation, law enforcement, and other government requests.
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know in writing if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We do not share records relating to your participation in a WWH substance abuse program or your mental health records with providers outside of WWH without your written authorization.

The original effective date of this Notice is April 14, 2003 and the Notice was most recently updated on September 23, 2013. We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice of Privacy Practices will be available upon request, in our office, and on our web site.

WWH is participating in the District of Columbia and Maryland's regional Health Information Exchange (HIE). The HIE is a way of sharing your health information among participating doctors' offices, hospitals, labs, radiology centers, hospitals and other providers through secure, electronic means. Participating in the HIE permits our medical providers to better coordinate the health care you receive, but you have the right to opt-out of the HIE at any time by completing an Opt-Out Form. You can request a copy of the Form from our front desk staff.

Acknowledgement of receipt of this Notice of Privacy Practices is indicated by your signature on our Informed Consent Form that is scanned into your electronic medical record.