Lovelace
Cancer Center

Dear Patient and Family,

Welcome to Lovelace Cancer Center.

Lovelace Cancer Center is comprised of three campuses: medical oncology, radiation oncology and the Gamma Knife Center of New Mexico. Although we have multiple campuses to meet your needs, our comprehensive care team has one mission – care for you and your family.

We understand this can be an overwhelming process, here are a few helpful reminders to get your first visit started.

- Complete the included paperwork prior to your first visit
- Arrive 30 minutes prior to your initial scheduled appointment
- Current insurance cards
- Form of co-payment
- Please provide 48 hours notice when appointments need to be rescheduled or canceled (failure to do so may result in a $25 late cancellation fee)

In order to provide you with the best care possible we offer patient care navigators, financial counseling and additional patient resources.

Additional information and resources may be found on our website, lovelacecancercenter.com.

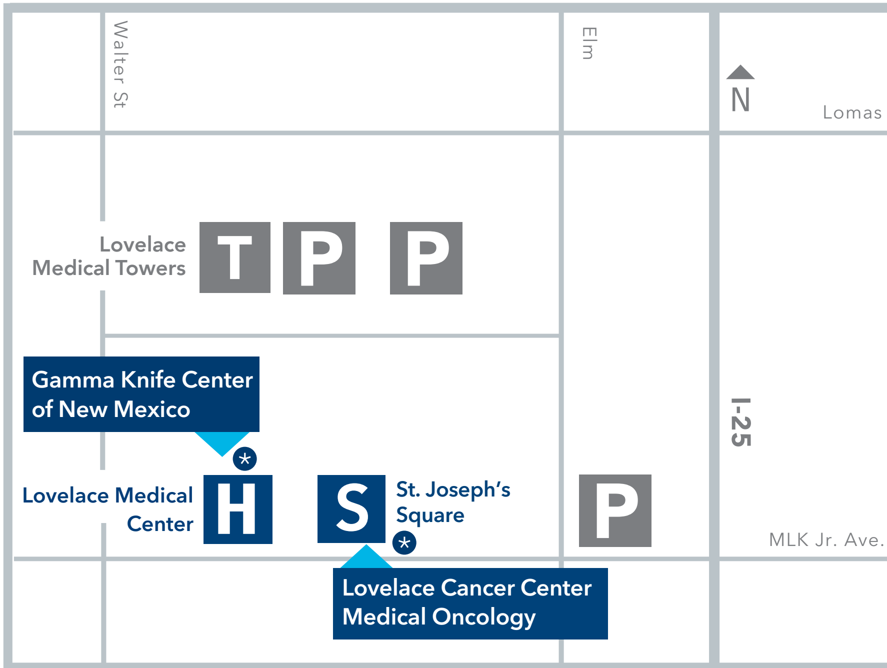
Sincerely,

Troy Greer
CEO, Lovelace Medical Center
505.727.7000

LovelaceCancerCenter.com

LOCATIONS

DOWNTOWN



valet available

Lovelace Cancer Center, Medical Oncology

St. Joseph's Square

715 Dr. Martin Luther King Jr. Ave., Ste 102

505.727.3040

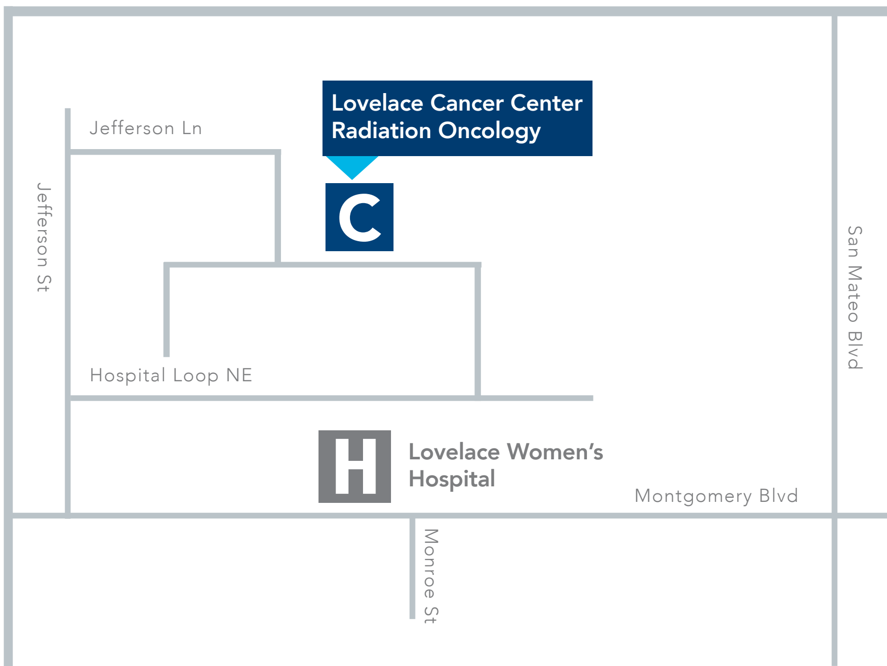
Lovelace Medical Center, Gamma Knife Center of New Mexico

601 Dr. Martin Luther King Jr. Ave. NE

Albuquerque, NM 87102

505.727.8288

NORTHEAST HEIGHTS



Lovelace Cancer Center, Radiation Oncology

4650 Jefferson Lane NE
Albuquerque, NM 87109

505.727.7900

New Patient
Medical History Questionnaire

Today's Date:

Demographics

Last Name:	*First Name:*	*MI:*	*Date of Birth:*	*(Age)*
Address:				
City: *State:* *ZIP:*			*Occupation:*	

Marital Status:	*Race:*	*Ethnicity:*
☐Single ☐Separated ☐Widowed ☐Married ☐Divorced ☐Common-law	☐African Amer ☐Asian ☐Native HI Pac Island ☐Caucasian ☐Native Amer / Alaska ☐Declined	☐Hispanic ☐Refused ☐Non-Hispanic

Medical and Surgical History

Medical History	Please list all significant prior medical illnesses and current medical problems for which you are under medical treatment	
Surgical History	Please list all surgical procedures you have had and the year they were performed	
	Year	**Procedure**

Trauma and Major Illness History

	Year	**Describe**
Hospitalizations/ Injuries		

Immunizations

Have you had any of the following immunizations?

1. Tetanus Booster	☐No	☐**Yes I have had this vaccination, Date:**
2. Hepatitis B Vaccine	☐No	☐**Yes I have had this vaccination, Date:**
3. Influenza vaccine	☐No	☐**Yes I have had this vaccination, Date:**
4. Pneumococcal vaccine	☐No	☐**Yes I have had this vaccination, Date:**

Obstetrical History

Obstetrical History	Please list all pregnancies including miscarriages and ectopic pregnancies		
	Number of Pregnancies:	Number of Deliveries:	Number of Miscarriages:
	Number of Pregnancy Terminations:		

Gynecologic History

Age at first period?	When was your last period?	How far apart are your cycles? Days
Age at last period?	How many days do they last?	

Have you used hormone replacement therapy?	☐No	☐Yes	If YES, how long _______________ , and what drug.______________________________	
Have you used birth control pills?	☐No	☐Yes	If YES, how long _______________ , and what drug. ______________________________	
Have you ever had an abnormal Mammogram?	☐No	☐Yes	If **YES,** what was abnormality: If **YES,** what was the treatment:	Date of Last Mammo:
Have you ever had an abnormal PAP smear?	☐No	☐Yes	If **YES,** what was abnormality: If **YES,** what was the treatment:	Date of Last PAP:

Family History (Mark all that apply)

Were you adopted? ☐**Yes** ▪ **No** **Are you a twin?** ☐**Yes** ☐**No** - **If YES:** ☐**Fraternal** / ☐**Identical**

Disease	Father	Mother	Maternal Grandparents Mother	Maternal Grandparents Father	Paternal Grandparents Mother	Paternal Grandparents Father	Brother / Sister (circle one) **B/S** **B/S**	**B/S** **B/S**	Children GENDER: Male / Female (circle one) **M/F**	**M/F**	**M/F**	**M/F**	Yourself
Current Age **(Age)** or if Deceased **(D)** + Age at death	( )	( )	( )	( )	( )	( )	( ) ( )	( ) ( )	( )	( )	( )	( )	
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bleeds Easily	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease/Stones	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Inherited Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
CANCER HISTORY													
Breast	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pancreas	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Prostate	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Uterine	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Genetic Screening Questionnaire

Question			
Have you, or anyone in your family, ever had any chromosomal abnormalities?	☐No	☐Yes: Relationship?	
Have you or anyone in your family ever had Hemophilia?	☐No	☐Yes: Relationship?	
Do you or your family have a disorder other than above?	☐No	☐Yes: Relationship? Describe disorder:	
In any current/previous marriages, have you had a stillborn child or three or more first-trimester pregnancy losses?		☐No	☐Yes

Question			Question		
Are you African American?	☐No	☐Yes	Are you of Italian, Greek, or Mediterranean ancestry?	☐No	☐Yes
Are you Hispanic?	☐No	☐Yes	Are you of Chinese, or South Asian ancestry?	☐No	☐Yes
Are you of Philippine ancestry?	☐No	☐Yes	Are you of Jewish or Cajun ancestry?	☐No	☐Yes

Social History

Question			Details		
Have you ever smoked cigarettes?	☐No	☐Yes	If **YES,** how many cigarettes per day? **How many years?** **If you quit, how long ago?**________________		
Do you drink alcohol?	☐No	☐Yes	If **YES,** how many drinks per week?		
Do you use recreational drugs?	☐No	☐Yes	If **YES,** which ones?		
Have you ever received a blood transfusion?	☐No	☐Yes	Have you ever had a transfusion reaction?	☐No	☐Yes
Have you recently been out of the Country?	☐No	☐Yes	If so, where?		

Review of Systems

Instructions: Mark all That Apply

System			
Constitutional	☐Weight loss? ☐Weight gain? How much?__________ Over what time frame? ______________		
	☐Fever? How high	☐Night sweats	☐Fatigue
Eyes	☐Double vision	☐Glasses	☐Contacts
	☐Visual Disturbances	☐Blind Spots	
Ears/Nose Mouth/Throat	☐Dentures	☐Dental problems	☐Nose bleeding
	☐Difficulty Swallowing	☐Hearing changes	☐Mouth Ulcers
	☐Ringing in the ears/tinnitus		
Cardiovascular	☐Chest pain	☐Phlebitis/Varicose Veins	☐Swelling of feet or legs
	☐Irregular heart beat/Palpitations	☐Murmur	☐High Blood Pressure
Respiratory	☐Shortness of Breath	☐Coughing up blood	☐Cough
	☐Sputum Production	☐Wheezing	☐History of Tuberculosis
	☐Pain with deep breathing		
Gastrointestinal	☐Nausea	☐ Vomiting	☐ Vomiting Blood
	☐Constipation	☐ Diarrhea	☐Heartburn
	☐ Blood in Stool/Black tarry stools	☐ Recent change in bowel habits	☐ Change in Stool Consistency/Size
Genitourinary	☐Urgency/Frequency	☐Urinary incontinence	☐Blood in urine
	☐Painful urination		
	Female: ☐Vaginal Dryness	☐Hot Flashes	*Male*: ☐Testicular Pain
	☐Are you sexually active?	☐Method of Birth Control	☐Are you sexually active?
	☐Change in Libido		☐Method of Birth Control
			☐Change in Libido
Musculoskeletal	☐Muscle aches	☐Muscle Weakness	☐ Neck Stiffness
	☐ Bone Aches	☐Pain, indicate pain level 0-10) __________	
	☐ Pain Location______________		☐Is Pain related to reason for referral? Yes/No
Skin	☐Rash (acne-like)	☐Itching	☐Redness of hands/feet
	☐Nail changes	☐ Change in moles or new moles?	
Breast	☐Nipple discharge	☐Breast lumps	☐Breast pain/tenderness
	☐Biopsy? Dates?		
Neurologic	☐Convulsions/Seizures	☐Headache	☐ Dizziness
	☐Numbness/Tingling	☐Difficulty with Memory	☐ Difficulty with speech
Psychiatric	☐Anxiety	☐Change in Sleep Pattern	☐Previous psychiatric care
	☐Depression	☐**Stress Score (0-10)**________________	
Endocrine	☐Lack of appetite	☐Hair Loss	☐Intolerance to heat or cold
Hematologic and Lymphatic	☐Bleeding tendency/Bruises or bleeds easily		☐Lymph node enlargement or tenderness
Allergic and Immunologic	☐Allergy to food	☐Animal allergies	☐Environmental/seasonal allergies
	☐Allergy to medication	☐Exposure to Hepatitis	☐Exposure to HIV

ADVANCE DIRECTIVE

Have you completed an Advance Directive? ☐ Yes **If YES**, please bring a copy to your Initial office visit.

☐ No **If NO**, would you like to have more information about Advance Directives? **Y / N**

PRIME-MD PHQ (2 Question Screen)

YES	NO	Please check the appropriate box in answer to the following questions:
		During the past month (30 days), have you often been bothered by feeling down, depressed, or hopeless?
		During the past month (30 days), have you often been bothered by little interest or pleasure in doing things?

If BOTH of your responses were "NO", you are finished with this form (sign at the bottom)

If you responded "YES" to either question, complete **PHQ-9** below.

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? (*Circle your numerical response*)	Not at all	Several Days	More than half the Days	Nearly Every Day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite: being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3

To be completed by Staff…………….**Add Columns:** ______ + ______ + ______

To be completed by Staff …………..………..**TOTAL:** ______

10. **If you circled any "1's", "2's" or "3's",** how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ___________ Somewhat difficult ___________ Very difficult ___________ Extremely difficult ___________

Patient Signature: ________________________________ **Date:** ________________

Patient Representative Signature: ________________________________ **Date:** ________________

(If form completed by someone other than the patient)

Medication Information

LOVELACE CANCER CENTER

**** PLEASE COMPLETE AS MUCH OF THE INFORMATION BELOW AS POSSIBLE****

Patient's Name:______________________ DOB:______________ Date:______________

PHONE NUMBER: ( )______________________

It is very important that your physician have a current phone number where you can be reached.

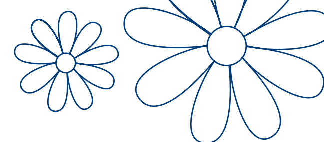
ALLERGIES: ☐ No Known Allergies

Medication	Reaction

CURRENT MEDICATIONS: (*Please bring all your medications or an accurate list of medications when you see the doctor.)* Please list all the medications, vitamins, herbs, or other supplements you are currently taking. We consider Aspirin/Tylenol or any other over-the-counter medicine to be a medication that needs to be on your list.

Medication	Dose or Strength	Frequency	Medication Instructions

Demographic Information Sheet



NEW PATIENT

PERSONAL/SELF

Date: ______________________

Patient name: ____ DOB:____/____/_____ SSN:__________________

Ethnicity: ☐Hispanic ☐Non-Hisp ☐Refused Language____________________________

Race: ☐African Amer ☐Asian ☐Cauc ☐NatAmer/Alaska ☐Native HI/Pac Isl ☐Declined

Sex: M / F / Transgender Religion______________________________ Marital Status: S M D W Other

Address____City_________________________State_______Zip______________

Home Phone_____________________ Cell Phone_____________________ E-Mail___________________________________

Contact Preference: ☐Cell Phone ☐Home Phone ☐Work Phone ☐E-mail ☐Mail (Home)

EMPLOYMENT

Employer_______________________Address___________________City____State____Zip_______Phone_______________

SPOUSE

Spouse Name_________________________Spouse's Employer_____________________Spouse's Cell____________________

RELATIVE/other than spouse

Relative Name____ Phone___________________________

EMERGENCY CONTACT

Name____ Phone___________________________

PHARMACY / LAB (per Insurance)

Preferred Pharmacy _________________________________Address(or corner of)____________________________________

Preferred Lab_______________________________________Address(or corner of)____________________________________

INSURANCE/PHYSICIANS

Primary___________________________Cardholder_________________Member#_____________Group#_________________

Address____City_______________State________Zip________________

Secondary_________________________Cardholder_________________Member#_____________Group#_________________

Address____City_________________State________Zip____________

Referring Physician (who referred you to our office)_____________________________________Phone____________________

Primary Care Physician____Phone______________________

AUTHORIZATION: I authorize Lovelace Cancer Center to release any medical or other information necessary to process my insurance claims or to any medical health care provider who will be following my care. In addition, I authorize and request payment directly to Lovelace Cancer Care of any medical benefit due to me under the terms of my insurance policy for services rendered. I understand that I will be ultimately responsible for any and all charges incurred for services rendered.

Signature____ Date___________________

CONSENT FOR TREATMENT: I authorize the physicians and staff of Lovelace Cancer Center to perform evaluation and management services and related laboratory blood-drawing necessary to treat my medical condition.

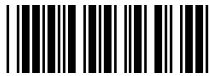
Signature____ Date___________________

HMO MEMBERS ARE RESPONSIBLE FOR OBTAINING CURRENT REFERRALS.

YOUR HMO POLICY PREVENTS US FROM SEEING ANY PATIENT WITHOUT A CURRENT REFERRAL.

Lovelace
Cancer Center

REV 0418


ROI

RELEASE OF INFORMATION AUTHORIZATION/REQUEST FORM

ROID0012 (Rev 09/11/16)

We are not able to process incomplete authorizations. To prevent delays in processing this request please complete all sections of the authorization. Incomplete authorizations will be returned.

Patient Information	Patient Name		
	Address		
	City/State/Zip		
	Phone #		
	Date of Birth		
RELEASING Facility	Facility Name	Lovelace Medical Center	***If you need information from another Lovelace facility, please specify which facility below:*** ______ ______
	Address	601 Dr. Martin Luther King Jr. Ave NE	
	City/State/Zip	Albuquerque, NM 87102	
	Phone #	(505) 727-8196	
	Fax #	(505) 727-7511	
Receiving Facility/ Individual(s)	Name		
	Address		
	City/State/Zip		
	Phone #		
	Fax #		

Information to be: ❑ Mailed to above address ❑ Picked up ❑ Call # above when ready for pickup ❑ Fax to above #

The requested information will be used for the following purpose(s):

❑ **Continuity of Care** ❑ **Disability Determination** ❑ **Insurance** ❑ **Legal** ❑ **Personal Use**

Date(s) of Service Requested: From______________________**To** ______________________

List specific description of Information to be released				
	❑ Billing Records	❑ Facesheet	❑ Medication Records	❑ Progress Notes
	❑ Consultation	❑ History & Physical	❑ Nursing Records	❑ Therapy Records
	❑ Discharge Summary	❑ X-Ray/Imaging Reports	❑ Operative Report	❑ All Records
	❑ EKG's	❑ X-Ray/Imaging Films/CD	❑ Pathology Report	❑ Other:
	❑ Emergency Records	❑ Laboratory	❑ Physician Orders	

Behavioral Health Records, HIV, STD

If these types of records are being requested, patient must sign below authorizing release.

❑ Behavioral Health Records
❑ HIV Records
❑ STD Records
❑ Alcohol/Drug Treatment Records

Patient or Legal Representative Signature Required:______________________

Request for Electronic Records
(Lovelace Medical Center, Westside & Women's only)

❑ I would like to request an electronic copy of my discharge instructions.
❑ I would like to request an electronic copy of my patient health information as defined here (including test results, problems, medications, allergies, discharge summary, and procedures). I understand the facility has three business days to provide this copy.

- The person/organization authorized to use/disclose the information will receive compensation for doing so.
  ❑ Yes ❑ No
- I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for our coverage of services, or ability to obtain treatment, except as provided under the NOTES listed at the bottom of this form.
- I understand that I may revoke this authorization at any time by notifying the facility releasing records in writing to the Lovelace Health System, except to the extent that; action has been taken in reliance on this authorization; or if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.
- This authorization shall be in force and effective for one year from the date of signing or until______________________, at which time this authorization to disclose this protected health information expires.

____	____________________________________
Signature of patient or patient's legal representative	Date
____	____________________________________
Printed name of patient or patient's legal representative	Relationship to patient or representative's authority to act for the patient, if applicable

NOTE: If the purpose of this authorization is for the use and/or disclosure of health information for a research study, and I refuse to sign this authorization, Lovelace Health System reserves the right to deny treatment associated with such research.

NOTE: If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Lovelace Health System reserves the right to deny that health care.

A copy of this signed form will be provided to the patient.

For Office Use Only:

ID Verified ❑ Yes ❑ No
Type of ID ✓'d ❑ Driver's License ❑ Military ❑ School ❑ Other____

Verified by______________________________ ______________________
Employee Name Date

Effective as of August 25, 2017

ACKNOWLEDGEMENT OF RECEIPT OF LOVELACE HEALTH SYSTEM
NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of the Lovelace Health System Notice of Privacy Practices.

______________________________	______________________________	__________
Patient Name (Print)	Signature	Date

-OR-

______________________________	______________________________	__________
Patient Personal Representative (Print)	Signature	Date

Patient Medical Record Number or Social Security Number ____

Patient Birth Date ____________________

LOVELACE HEALTH SYSTEM USE ONLY

Date acknowledgement received: ________________________

Signature of Lovelace Health System employee: ____

-OR-

Reason acknowledgement was not obtained (declined to sign): ______________________________

____

____

____

Effective as of August 25, 2017

LOVELACE HEALTH SYSTEM
NOTICE OF HEALTH INFORMATION 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.

Protected health information is stored electronically and is subject to electronic disclosure.

If you have any questions about this notice, please contact the Lovelace Health System (LHS) Privacy Officer at (505)727-7350.

This Notice Describes Our Practices And Those Of:

- Any medical staff member and any health care professional who participates in your care;
- Any volunteer we allow to help you while you are here; and
- All employees of any hospital, clinic, laboratory, or other facility affiliated with LHS.

All of these people follow the terms of this notice. They may also share health information that identifies you (also known as "protected health information") with each other for treatment, payment or health care operations as described in this notice.

Our Pledge Regarding Health Information:

We understand that health information about you and your health is personal. We are committed to protecting health information about you. This notice will tell you about the ways that we may use and disclose health information about you. This notice also describes your rights and certain obligations we have regarding the use and disclosure of protected health information. We are required to comply with any state laws that offer a patient/plan member additional privacy protections.

We Are Required By Law To:

- Maintain the privacy of health information that identifies you;
- Give you and other individuals this notice of our legal duties and privacy practices with respect to protected health information;
- Follow the terms of the notice that is currently in effect; and
- Notify affected individuals in the event of a breach involving unsecured protected health information.

How We May Use And Disclose Your Health Information:

- **For Treatment**. We may use and disclose your health information to provide you with medical treatment or services. For example, a health care provider, such as a physician,

nurse, or other person providing health services will access your health information to understand your medical condition and history. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions. This information is necessary for health care providers to determine what treatment you should receive and to coordinate your care.

- **For Payment**. We may use and disclose your health information for purposes of receiving payment for treatment and services that you receive. For example, we may disclose your information to health plans or other payors to determine whether you are enrolled with the payor or eligible for health benefits or to submit claims for payment. The information on our bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. We may provide health information to entities that help us submit bills and collect amounts owed, such as a collection agency.

- **For Health Care Operations**. We may use and disclose your health information for operational purposes. For example, your health information may be used by, and disclosed to, members of the medical staff, risk or quality improvement personnel, and others to evaluate the performance of our staff, to assess the quality of care and outcomes in your case and similar cases, to learn how to improve our facilities and services, for training, to arrange for legal or risk management services and to determine how to continually improve the quality and effectiveness of the health care we provide.

- **Health Information Exchange**. We may participate in one or more health information exchanges or other health information registries and may use and disclose your health information through these exchanges for certain purposes described in this notice. For example, we may disclose your health information to or obtain your health information from other participants in a health information exchange that have treated you in order to coordinate your care. We may use a health information exchange to obtain information for payment for the care you receive. We may also disclose or obtain your health information through a health information exchange for quality assessment or improving health and reducing health care costs. We may disclose your health information to an electronic health information registry to report certain diseases or for other public health purposes.

- **Facility Directory**. Unless you object, we may include you in the facility directory. This information may include your name, location in the facility, general condition (*e.g.*, fair, stable, *etc.*) and religious affiliation. We may give your directory information, except for religious affiliation, to people who ask for you by name. Unless you object, your religious affiliation and other directory information may be released to members of the clergy even if they do not ask for you by name.

- **Others Involved In Your Care**. We may disclose relevant health information to a family member, friend, or anyone else you designate in order for that person to be involved in your care or payment related to your care. We may also disclose health information to those assisting in disaster relief efforts so that others can be notified about your condition, status and location.

- **Fundraising**. We do not use or disclose your information for fundraising.

- **Required By Law**. We may use and disclose information about you as required by law. For example, we are required to disclose information about you to the U.S. Department of Health and Human Services if it requests such information to determine that we are complying with federal privacy law.

- **Reporting Abuse, Neglect or Domestic Violence**. We may disclose health information to an appropriate government authority, including a protective services agency, if we believe an individual is the victim of abuse, neglect or domestic violence. We will inform the individual that we have made such a report, unless we believe that doing so would place the individual at serious risk of harm. We will make such reports only as required or authorized by law, or if the individual agrees.

- **Public Health**. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities (*e.g.*, state health department, Center for Disease Control, *etc*.) to prevent or control disease, injury, or disability, or for other public health activities.

- **Law Enforcement Purposes.** Subject to certain restrictions, we may disclose information needed or requested by law enforcement officials.

- **Judicial And Administrative Proceedings.** We may disclose information in response to an appropriate subpoena, discovery request or court order.

- **Health Oversight Activities**. We may disclose your health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections to monitor the health care system.

- **Decedents**. Health information may be disclosed to funeral directors, medical examiners or coroners to enable them to carry out their lawful duties.

- **Organ/Tissue Donation**. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

- **Research**. We may use or disclose your health information for research purposes after a receipt of authorization from you or when an institutional review board (IRB) or privacy board has waived the authorization requirement by its review of the research proposal and has established protocols to ensure the privacy of your health information. We may also review your health information to assist in the preparation of a research study.

- **Health And Safety**. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

- **Government Functions**. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

- **Workers' Compensation**. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

- **Business Associates.** We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.

- **Other Uses And Disclosures**. We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods. Except for uses and disclosures described above, we will only use and disclose your health information with your written authorization. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization. You may revoke an authorization by notifying us in writing, except to the extent we have taken action in reliance on the authorization.

Your Health Information Rights:

You have the right to:

- Obtain a paper copy of this notice of information practices upon request, even if you have previously agreed to receive this notice electronically.

- Inspect and obtain a copy of your health information that we maintain, or direct us to send a copy of your health information to another person designated by you in writing. In most cases we will provide this access to you, or the person you designate, within 30 days of your request.

- Request an amendment to your health information if you think it is incorrect or incomplete. We may say "no" to your request, but we will tell you why within 60 days of receiving your request.

- Request a confidential communication of your health information by alternative means or at alternative locations. Please be advised that this request for alternative means or locations of communications applies only to this provider or location.

- Receive an accounting (a list) of the disclosures we have made of your health information for the six years prior to your request, except for certain disclosures that we are not required to include (such as disclosures that you have authorized us to make). We will also include in the list the reason for the disclosure and the recipient. We will provide one accounting per year at no charge, but if you ask for additional accountings within the same 12-month period, we may charge a reasonable, cost-based fee.

- Request a restriction on certain uses and disclosures of your information. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid for the item or service

covered by the request out-of-pocket and in full and when the uses or disclosures are not required by law.

If you have given another individual a medical power of attorney, or if another individual is appointed as your legal guardian or is authorized by law to act on your behalf, that individual may exercise any of the rights listed above for you. We will confirm this individual has the authority to act on your behalf before we take any action.

To exercise any of these rights, please contact our Privacy Officer at the address at the end of this notice.

Changes To This Notice:

We reserve the right to change the terms of this notice and make the new terms effective for all protected health information kept by LHS. We will post a copy of the current notice in our facility and on our website, http://www.lovelace.com. You may also get a current copy by contacting our Privacy Officer at the address at end of this notice. The effective date of the notice is in the top right-hand corner of each page.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with LHS or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with LHS, submit your written complaint to our Privacy Officer at the address at end of this notice. You will not be penalized for filing a complaint.

Contact Information For Questions Or To File A Complaint:

If you have any questions about this notice, want to exercise one of your rights that are described in this notice, or want to file a complaint, please contact the LHS Privacy Officer at:

Lovelace Medical Center
601 Dr. Martin Luther King Jr. Ave. NE
Albuquerque, New Mexico 87102
Phone: (505) 727-7350
E-mail: LovelacePrivacy@Lovelace.com

Lovelace Regional Hospital - Roswell
117 East 19th Street
Roswell, New Mexico 88201
Phone: (505) 727-7350
E-mail: LovelacePrivacy@Lovelace.com

Heart Hospital of New Mexico
504 Elm St. NE
Albuquerque, New Mexico 87102
Phone: (505) 727-7350
E-mail: LovelacePrivacy@Lovelace.com

Lovelace UNM Rehabilitation Hospital
505 Elm St. NE
Albuquerque, New Mexico 87102
Phone: (505) 727-7350
E-mail: LovelacePrivacy@Lovelace.com

Lovelace Westside Hospital
10501 Golf Course Rd. NW
Albuquerque, New Mexico 87114
Phone: (505) 727-7350
E-mail: LovelacePrivacy@Lovelace.com

Lovelace Women's Hospital
4701 Montgomery Blvd. NE
Albuquerque, New Mexico 87109
Phone: (505) 727-7350
E-mail: LovelacePrivacy@Lovelace.com

Lovelace Central Billing Office
4411 The 25 Way NE, Suite 100
Albuquerque, New Mexico 87109
Phone: (505) 727-7350
E-mail: LovelacePrivacy@Lovelace.com

Lovelace Medical Group
4101 Indian School Rd. NE
Albuquerque, New Mexico 87110
Phone: (505) 727-7350
E-mail: LovelacePrivacy@Lovelace.com

Lovelace
Health System

HIPAA – F29

Appointment of Personal Representative

This form will allow me, as a Lovelace Health System patient, to designate another person as my representative.

I understand that by completing and signing this form, I authorize Lovelace Health System to treat my Representative as myself. As my personal representative the person I designate will have the ability to obtain my medical information, obtain laboratory results, obtain information about and make medical appointments. I understand correspondence will continue to be addressed and sent to me. If I wish my correspondence from Lovelace Health System to be sent to someone other than myself I will need to request an alternative method of communication through the Privacy Officer. I also understand that I may revoke this Appointment of Personal Representative at any time by contacting Medical Records at the number or address listed below.

Verification

Identification of Patient: (The following information is needed for verification. Please complete all applicable items.)

Name of Patient: ______________________________ Date of Birth: ______________

(Please print) Phone: ______________

Social Security #: ______________________________ Medical Record Number: ____________

Representative Information

(Please complete the information below or ask your designated representative to complete the section below.)

Identification of Representative: [The following information is needed to make sure we are releasing the information to the authorized Representative.]

1. Name of Representative: ______________________ Date of Birth: ______________

(Please print) Phone: ______________

Expiration Date: ____/____/____ **or valid for one year from the date of this request if not date not indicated, or until revoked.**

- ❑ Appointment Information
- ❑ Lab Results
- ❑ Claims and Billing Information/Issues
- ❑ Referral Information
- ❑ Other ______________________

- I understand that if the information on this form is not complete, Lovelace Health System will return the form to me and will not be able to recognize any individual(s) as my Representative until Lovelace Health System has received the completed information.
- I understand that this information is for the Lovelace Health System facilities only.

I understand that I may end or change this request by notifying Compliance in writing at 4101 Indian School Rd. NE or by calling (505) 727-5598.

Signature

I have read and understand the above information:

Signature of Patient, Parent/Guardian, ______________________________ Date: ______________

Relationship if person signing is other than Patient: ______________________________

Note that, if not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.

If request is made by a Parent/Guardian, complete the following:

If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete. Patient is a minor < 18 years of age.

Signature of Patient, Parent/Guardian: ____

To return your completed form, please:

Fax to: Lovelace Health System Compliance at (505) 727- 9181 OR Mail to Compliance, Lovelace Health System, 4101 Indian School Rd. NE Suite 325, Albuquerque, NM, 87110.