GRAND LAKE PRIMARY CARE
AT ST MARYS™
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM

We would like to take this opportunity to welcome you to Grand Lake Primary Care at St. Mary's and ask for your assistance in filling out the attached forms. Please drop off or mail the forms back to our office when completed to the address at the bottom of the page. It is necessary for us to have your completed information before we can schedule you for your establishment appointment. All new patients must be seen for a new patient establish appointment before we can see you in our office for any other issues. Once you have returned this information to us we will contact you to schedule an appointment.

Thank you for taking the time to complete the enclosed paperwork. If you have any questions, please do not hesitate to call our office at 419-394-9959. We look forward to meeting you and helping with your health care needs.

Thank you,

Physicians and Staff

1140 S. Knoxville Ave., Ste. A | St. Marys, Ohio 45885 | 419-394-9959 | fax 419-394-0255
WWW.GRANDLAKEHEALTH.ORG

GRAND LAKE HEALTH SYSTEM

PATIENT INFORMATION

HOW DID YOU HEAR ABOUT US? _____

SOCIAL SECURITY # _____

FIRST NAME _____ MIDDLE _____

LAST NAME _____

SEX _____ DATE OF BIRTH ___/___/_____ RACE _____

PREFERRED LANG. ☐ ENG. OTHER _____ ETHNICITY _____

MARITAL STATUS ☐ MARRIED ☐ SINGLE

☐ DIVORCED ☐ WIDOWED ☐ LEGALLY SEPARATED

E-MAIL _____

HOME ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____

CELL PHONE _____

WORK PHONE _____

EMPLOYER/OCCUPATION _____

REFERRING PHYSICIAN _____

FAMILY DOCTOR _____

EMERGENCY CONTACT

NAME _____ HOME PHONE _____

RELATIONSHIP WORK PHONE _____

IF MARRIED, SPOUSE INFORMATION

NAME _____ DATE OF BIRTH ___/___/_____ SSN _____

EMPLOYER _____ WORK PHONE _____

IF MINOR (UNDER THE AGE OF 18) WHO IS FINANCIALLY RESPONSIBLE? ☐ MOTHER ☐ FATHER

MOTHER'S NAME _____ FATHER'S NAME _____

ADDRESS _____ ADDRESS _____

_____ _____

SSN _____ DOB _____/_____/_____ SSN _____ DOB _____/_____/_____

EMPLOYER _____ EMPLOYER _____

WORK PHONE _____ CELL PHONE _____ WORK PHONE _____ CELL PHONE _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

☐ Medicaid ☐ Medicare ☐ None ☐ Other INSURANCE COMPANY _____

INSURED'S NAME _____ RELATIONSHIP _____

DATE OF BIRTH ___/___/____ SSN _____ CO-PAY _____ POLICY NUMBER _____

SECONDARY INSURANCE INFORMATION

☐ Medicaid ☐ Medicare ☐ None ☐ Other INSURANCE COMPANY _____

INSURED'S NAME _____ RELATIONSHIP _____

DATE OF BIRTH ___/___/____ SSN _____ CO-PAY _____ POLICY NUMBER _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESSS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICES AS DESCRIBED, REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES. I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT NECESSARY TO PROCESS INSURANCE CLAIMS.

The patient or representative, recognizing the need of medical care and/or evaluation, consents to services as ordered by the attending physician including local anesthesia, laboratory procedures, medical treatment, minor or emergency surgical treatment, radiology procedures, physical examination, or other services rendered under the general and specific instructions of the physician.

_____

SIGNATURE (Patient or Parent if Minor) DATE

GRAND LAKE™ HEALTH SYSTEM

NEW PATIENT HISTORY

Patient Name: _____ Date of Birth: _____

YOUR ALLERGIES – please indicate reaction if there is a positive allergy:

☐ Dairy	☐ Tylenol	☐ Adhesive Tape	☐ Animal Dander
☐ Eggs	☐ Aspirin	☐ Cosmetics	☐ Dust
☐ Grains/Wheat	☐ Codeine	☐ Detergent	☐ Grass
☐ Nuts/Peanuts	☐ Sulfa Drugs	☐ Latex	☐ Insect bites/Stings
☐ Shellfish	☐ NSAIDS	☐ Metals	☐ Mites
☐ Strawberries	☐ Penicillin	☐ Molds/Mildew	☐ Pollen
			☐ Other

Please list any other allergies/reactions: _____

_____

_____

IMMUNIZATIONS:
Please attach or bring in a list of your immunization record.

YOUR MEDICAL HISTORY – Please check if you have any of these diagnoses:

☐ Alcohol Abuse	☐ Cancer type _____	☐ High Blood Pressure
☐ Anemia	☐ Depression	☐ High Cholesterol
☐ Arthritis	☐ Diabetes	☐ Liver Disease
☐ Asthma	☐ Drug Abuse	☐ Lung Disease
☐ Bleeding Disorders	☐ Epilepsy	☐ Mental Disorder
☐ Migraines	☐ Stroke	☐ Thyroid Disorder

Other medical problems: _____

_____

FAMILY MEDICAL HISTORY – please indicate who has this in your family (Mother, Father, Brother, Sister, Children Paternal Grandmother, Paternal Grandfather or Maternal Grandmother, Maternal Grandfather)

Arthritis _____
Asthma _____
Bleeding Disorder _____
Cancers _____
Diabetes _____
Heart Disease _____
High Cholesterol _____
High Blood Pressure _____
Kidney Disease _____
Liver Disease _____
Mental Illness _____
Seizures _____
Alcohol Abuse _____
Drug Abuse _____
Thyroid Disorder _____
Tuberculosis _____
Birth Defects _____
Bed Wetting (over age of 10) _____
Genetic Disorders _____
Other _____

SURGICAL HISTORY
Please list all of your surgeries and the date they were done.

_____

_____

_____

_____

_____

YOUR SOCIAL HISTORY
Marital Status _____ Spouse Name: _____
Culture/Language _____
Living situation ☐ alone ☐ with spouse/partner ☐ with family ☐ Group Home ☐ Nursing Home
Occupation _____
Do you drink alcohol? ☐ YES ☐ NO
How much alcohol do you consume a week? _____
Do you smoke? ☐ YES ☐ NO
How much do you smoke? _____
Are you a former smoker? ☐ YES ☐ NO
How long did you smoke? _____
Do you have any tobacco smoke exposure? ☐ YES ☐ NO
How much caffeine do you drink daily? _____
If you have firearms in your home, do you keep them secured? ☐ YES ☐ NO ☐ Decline to answer
Do you have pets in the home? ☐ YES ☐ NO
Please list type of pets? _____

TRAVEL
What countries have you traveled to in the last 6 months? _____

YOUR PREGNANCY HISTORY?
How many times have you been pregnant? _____
Number of live births? _____
Number of living children? _____
Biggest babies weight? _____
Abortions? _____
Miscarriages? _____
Vaginal Deliveries? _____
C-Section Deliveries? _____
Premature Births? _____
Breech? _____

Do you perform your own self breast exams monthly: ☐ YES ☐ NO

Contraception History:
Are you currently sexually active? ☐ YES ☐ NO
How are you preventing pregnancy? _____
Are you interested in information on types of birth control? ☐ YES ☐ NO
Have you been exposed to any sexually transmitted infections? ☐ YES ☐ NO
If yes, please check:

☐ Chlamydia ☐ Gonorrhea ☐ HPV ☐ Syphilis ☐ Genital Herpes ☐ HIV

Menstrual History:
Last Menstrual Period (date): _____
Age cycles Began: _____
Length of Cycles (start to start, number of days): _____
How many days does the bleeding last: _____
Color: ☐ Bright Red ☐ Dark Brown
Menstrual Cycles: ☐ Regular ☐ Irregular
Type of flow: ☐ Light ☐ Moderate ☐ Heavy
Clotting: ☐ Rarely ☐ Frequently ☐ Occasionally
Mid Cycle Bleeding: ☐ YES ☐ NO
Age at Menopause: _____
Postmenopausal Bleeding: ☐ YES ☐ NO

YOUR MEDICATIONS
Please List or attach a copy of all of your current medications with dosages.

MEDICATION	DOSAGE

ADVANCE DIRECTIVES
Do you have a living will? ☐ YES ☐ NO
Do you have a healthcare Power of Attorney? ☐ YES ☐ NO
Are you an Organ Donor? ☐ YES ☐ NO
Do you have a DNR or DNRCC? ☐ YES ☐ NO
If yes to any of the above, are the documents on file at JTDMH? _____
_____
_____

PROVIDERS
Please list information for any other physicians you currently see: (*ex: Dr. Smith - Urologist, Celina, OH*)

_____
_____
_____
_____
_____
_____

GRAND LAKE PRIMARY CARE AT ST. MARYS™
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM

Printed Patient Name: _____

DOB: _____

Prescription Refill Policy and Renewal Guidelines for Grand Lake Physician Practice Offices

Prescription medication requires skilled oversight by a licensed healthcare provider. It also requires the patient to have an awareness of what they are taking, how they take it and any noticeable effect it may have on their person.

In order to ensure that you have current and adequate medication, we are asking that you participate in your care by doing the following:

1. Before your appointment, gather all your medications (diabetic supplies, inhalers, etc.) and look at the number of pills and date of refill. Make a note of any that need to be addressed at your visit and point that out to our nurse when she is talking to you about your medication history.
2. Bring all of your prescription bottles with you to your appointment. This is important as it helps us make sure our records match what you are currently taking. We will match the medication and doses to our records and address any differences that we find. It is very important that if you are cutting any of your pills in half or otherwise changing the amount taken compared to what is prescribed that you let us know for your safety.
3. For your safety, we require regular office visits for all our patients taking prescription medication. It is VERY important that you come to these appointments and that you follow up with all requested lab or other testing. It is also important for your safety that you limit the number of pharmacies where you fill your prescriptions. This allows the pharmacist to be alert for potential drug interactions and helps them ensure you have the right medication for you. For these reasons, we will handle refill requests as follows:
   - ✓ We ask that you limit yourself to no more than one local and one mail-in pharmacy service.
   - ✓ We can send most prescriptions electronically to the local pharmacy of your choice (you will need to let the nurse know what pharmacy you prefer to work with). Generally it is best to call your pharmacy to see when your prescription will be ready, that way you will not have to wait too long when you get there.
   - ✓ We can send prescriptions electronically to a mail-order pharmacy. You need to have an account set up with the mail-order pharmacy for us to do this.
   - ✓ We can provide electronically written prescriptions. This will be on a very limited basis.
   - ✓ Prescriptions for certain narcotics or attention deficit disorders medication **must be picked up at our office**. These medications will be monitored to make sure you are taking them correctly; this is required by the new state laws.

Our new policy will be to send in appropriate requests for prescription refills **within 2 business days**. Written prescriptions will be available for pickup within 2 business days. Please let our staff know if your request is urgent or if you are out of medication, in which case we will try to try to provide refills sooner.

_____
Initials

Printed Patient Name:

_____

DOB: _____

If you call to request a refill but are overdue for a follow-up visit and/or blood work (necessary for monitoring the safety or effectiveness of a medication), the staff will schedule for the next visit available and the provider may agree to call in enough medication to a local pharmacy to last until that date. It is your responsibility to schedule an appointment before you run out of medication. It is best for you to schedule your next visit before you leave our office.

It is very important to request your prescription during your office visit. There may be a charge of $5.00 for those patients consistently running out of their medications or not asking at the time of their office visit.

We understand that there might be a situation when you do have to call for a prescription. Please look at the list below and see what you can do to avoid getting a prescription refill fee.

- **Are you changing to a new pharmacy?** You should call your new pharmacy and request that your prescriptions be transferred from your old pharmacy. We sometimes do not have to write new prescriptions.
- **Are you going on an extended vacation and need to use an out-of-town pharmacy?** You need to call the NEW pharmacy that you will be using and have them contact your hometown pharmacy to have your prescriptions transferred. When you return home, you will have to reverse the process.
- **Are you changing to a new mail order pharmacy?** Some pharmacies will transfer your prescriptions to the new pharmacy. If you still have refills on your current prescriptions, please check with your current mail order pharmacy to see if your prescriptions can be transferred.

Thank you for choosing Grand Lake Physician Practices for your Medical Home. We look forward to working with you to assure safe and high quality medical care.

_____

Patient's Signature Date

_____

Staff Signature Date

GRAND LAKE™ HEALTH SYSTEM
200 St. Clair Street
St. Marys, Ohio 45885
(419) 394-3335

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.

The terms of this Notice of Privacy Practices apply to Grand Lake Health System (GLHS) operating as a clinically integrated health care arrangement composed of the Joint Township District Memorial Hospital, Grand Lake Physician Practices, Home Health/Hospice, and Transitional Care Unit, the physicians, licensed professionals and other professionals seeing and treating patients at GLHS. The members of this clinically integrated health care arrangement work and practice at GLHS. All of the entities and persons listed will share personal health information of our patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to your personal health information and to notify you in the unlikely event of a breach or unauthorized disclosure of your personal health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all personal health information maintained by us. You may receive a copy of any revised notices at the Registration desk or a copy may be obtained by mailing a request to the Privacy Officer at GLHS, 200 St. Clair Street, St. Marys, OH 45885.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Your Authorization. Except as outlined below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization. There are certain uses and disclosure of your personal heath information for which we will always obtain a prior authorization and these include:

- **Marketing communications** unless the communication is made directly to you in person, is simply a promotional gift of nominal value, is a prescription refill reminder, general health or wellness information, or a communication about health related products or services that we offer or that are directly related to your treatment.
- **Most sales** of your health information unless for treatment or payment purposes or as required by law.
- **Psychotherapy notes** unless otherwise permitted or required by law.

Uses and Disclosures for Treatment. We will make uses and disclosures of your personal health information as necessary for your treatment. For instance, doctors, nurses, and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, tests, etc. We may also release your personal health information to another health care facility or professional who is not affiliated with our organization but who is or will be providing treatment to you. For instance, if, after you leave the hospital, you are going to receive home health care, we may release your personal health information to that home health care agency so that a plan of care can be prepared for you.

Uses and Disclosures for Payment. We will make uses and disclosures of your personal health information as necessary for the payment purposes of those health professionals and facilities that have treated you or provided services to you. For instance, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations. We will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations which include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and care of our patients. We may also disclose your personal health information to another health care facility, health care professional, or health plan for such things as quality assurance and case management, but only if that facility, professional, or plan also has or had a patient relationship with you.

Our Facility Directory. We maintain a facility directory listing the name, room number, general condition and, if you wish, your religious affiliation. Unless you choose to have your information excluded from this directory, the information, excluding your religious affiliation, will be disclosed to anyone who requests it by asking for you by name. This information, including your religious affiliation, may also be provided to members of the clergy. You have the right during registration to have your information excluded from this directory and also to restrict what information is provided and/or to whom.

Family and Friends Involved In Your Care. With your approval, we may from time to time disclose your personal health information to family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with such individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide certain portions of your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Fundraising. We may contact you to donate to a fundraising effort for or on our behalf. You have the right to opt-out of receiving fundraising materials/communications and may do so by sending your name and address to JTD Hospital Foundation, 200 Saint Clair Street, Saint Marys, Ohio 45885 together with a statement that you do not wish to receive fundraising materials or communication from us.

Appointments and Services. We may contact you to provide appointment reminders or test results. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You may request such confidential communication in writing and may send your request to the Privacy/Security Officer at GLHS, 200 St. Clair Street, St. Marys, OH 45885.

Health Products and Services. We may from time to time use your personal health information to communicate with you about health products and services necessary for your treatment, to advise you of new products and services we offer, and to provide general health and wellness information.

Research. In limited circumstances, we may use and disclose your personal health information for research purposes. For example, a research organization may wish to compare outcomes of all patients that received a particular drug and will need to review a series of medical records. In all cases where your specific authorization has not been obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board or privacy board which oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

Disaster Relief. We may disclose limited personal health information to federal, state, or local government agencies engaged in disaster relief activities, as well as to private disaster relief or disaster assistance organizations (such as Red Cross) authorized by law or by their charters to assist in disaster relief efforts.

Health Information Exchange. We may disclose personal health information to a secure health information exchange (HIE). HIEs facilitate access to and retrieval of clinical data to provide timely and efficient patient centered care. You can opt out of the HIE by contacted the GLHS Privacy Officer.

Applications to Access Patient Data

GLHS provides the ability for patients to access their health information either through the patient portal or through a 3rd party application. The available information will be the same in both the portal and the app. If you have an application that you want to use to access your information, please contact the GLHS Privacy Officer to get further details. Any person seeking access through an app must be a current GLHS patient. GLHS reserves the right to deny access or disable any application that is deems does not meet GLHS' security guidelines.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization.

- We may release your personal health information for any purpose required by law;
- We may release your personal health information for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
- We may release your personal health information as required by law if we suspect child abuse or neglect; we may also release your personal health information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence;
- We may release immunization records to a student's school by only if parents or guardians (or the student if not a minor) agree either orally or in writing;
- We may release your personal health information to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
- We may release your personal health information to your employer when we have provided health care to you at the request of your employer to determine workplace-related illness or injury; in most cases you will receive notice that information is disclosed to your employer;
- We may release your personal health information if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
- We may release your personal health information if required to do so by subpoena or discovery request; in some cases you will have notice of such release;
- We may release your personal health information to law enforcement officials as required by law to report wounds and injuries and crimes;
- We may release your personal health information to coroners and/or funeral directors consistent with law;
- We may release your personal health information if necessary to arrange an organ or tissue donation from you or a transplant for you;
- We may release your personal health information for certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy;
- We may release your personal health information if in limited instances we suspect a serious threat to health or safety;
- We may release your personal health information if you are a member of the military as required by armed forces services; we may also release your personal health information if necessary for national security or intelligence activities; and
- We may release your personal health information to workers' compensation agencies if necessary for your workers' compensation benefit determination.

Reproductive Health Care. Includes all healthcare matters related to the reproductive system or to its functions and processes. GLHS is prohibited from using or disclosing PHI to conduct investigations or impose liability (whether criminal, civil, or administrative) on any person for the mere act of seeking, obtaining, or facilitating reproductive healthcare that is lawful under the circumstances; or identify any person for the purpose of conducting such investigation or imposing such liability. This prohibition applies only if the reproductive healthcare is: lawful in the state where the care is provided and under the circumstances in which it is provided; protected, required, or authorized by federal law

under the specific circumstances, regardless of the state in which the care is provided (for example, the right to use contraception is generally protected by the U.S. Constitution); or provided by a third party and the rule's presumption applies.

State Requirements. Ohio law requires that we obtain a consent from you in many instances before disclosing the performance or results of an HIV test or diagnoses of AIDS or an AIDS-related condition; before disclosing information about drug or alcohol treatment you have received in a drug or alcohol treatment program; before disclosing information about mental health services you may have received; and before disclosing certain information to the State Long-Term Care Ombudsman. For full information on when such consents may be necessary, you can contact the GLHS Privacy/Security Officer.

RIGHTS THAT YOU HAVE

Access to Your Personal Health Information. You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We may charge you per page if you request a copy of the information. We may also charge for postage if you request a mailed copy and will charge for preparing a summary of the requested information if you request such summary. You may obtain an Authorization for Access And Release of Patient Information form from the Health Information Management Department at Joint Township District Memorial Hospital (JTDMH), GLHS Home Health/Hospice, or a GLHS Physician Office.

You have the right to obtain an electronic copy of your health information that exists in an electronic format and you may direct that the copy be transmitted directly to an entity or person designated by you, provided that any such designation is clear, conspicuous, and specific with complete name and mailing address or other identifying information. We may charge you a fee for our labor and supplies in preparing your copy of the electronic health information.

Amendments to Your Personal Health Information. You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an Amendment Request form from the Health Information Management Department at JTDMH, GLHS Home Health/Hospice or a GLHS Physician Office

Accounting for Disclosures of Your Personal Health Information. You have the right to receive an accounting of certain disclosures made by us of your personal health information for six years prior to the date of your request. Requests must be made in writing and signed by you or your representative. Accounting Request forms are available from the Health Information Management Department at JTDMH, GLHS Home Health/Hospice, or a GLHS Physician Office. The first accounting in any 12-month period is free; a fee may be applied for any subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your Personal Health Information. You have the right to request restrictions on our uses and disclosures of your personal health information for treatment, payment, or health care operations. A Restriction Request form can be obtained from the Health Information Management Department at JTDMH, GLHS Home Health/Hospice, or a GLHS Physician Office. In most cases, we are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the Health Information Management Department at JTDMH, 200 St. Clair Street, St. Marys, OH 45885.

Breach Notification. In the unlikely event that there is a breach, or unauthorized release of your personal health information, you will receive notice and information on steps you may take to protect yourself from harm.

Complaints. If you believe your privacy rights have been violated, you can file a complaint with the Patient Representative or Privacy/Security Officer by calling or writing to their attention. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

Acknowledgment of Receipt of Notice. You may be asked to sign an acknowledgment statement that you received this Notice of Privacy Practices.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact the GLHS Privacy Officer by mail at 200 St. Clair Street, St. Marys, OH 45885 or by phone at (419) 394-3335.

As a patient you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means.

EFFECTIVE DATE

This Notice of Privacy Practices is effective December 23, 2024.

GRAND LAKE™ HEALTH SYSTEM
200 St. Clair Street
St. Marys, Ohio 45885
(419) 394-3335

PATIENT REQUEST FOR ACCESS TO HEALTH INFORMATION

GLHS recognizes a patient's right of access under HIPAA.

Patient Name: _____ Patient Date of Birth: _____

1. Request access for Dates of Service:_____
   OR ☐ Any and All Past, Present and Future information (until revoked in writing)

2. Information to be accessed or released: (check ONLY ONE box below)
   ☐ ALL Grand Lake Health System Records: Joint Township District Memorial Hospital (JTDMH) and all Physician Practice records
   ☐ Joint Township District Memorial Hospital records ONLY (this includes ER, Inpatient, Urgent Care, Outpatient testing, Outpatient Services, Rehab/Therapy, Outpatient Clinics (Pain/Sleep/IV, etc)
   ☐ ONLY specific portions of the JTMDH record:
   - ☐ Discharge Summary
   - ☐ History & Physical
   - ☐ Consultation
   - ☐ Operative Report
   - ☐ Discharge Instruction Sheet
   - ☐ ER Chart
   - ☐ Urgent Care Chart
   - ☐ Laboratory Reports
   - ☐ Medical Imaging Reports/CD Images
   - ☐ EKG
   - ☐ Physician Orders
   - ☐ Progress Notes
   - ☐ All Dictated Reports
   - ☐ Other (specify): _____

   ☐ ALL Grand Lake Physician Practice Records (ALL Offices, including family practice and specialty)
   ☐ ONLY records from specificPhysician Practice Office; Office Name:_____

3. Requestor: (check one)☐ Self (Patient) ☐ Patient Representative; Name _____
   IF Patient Representative, check one below AND validate parent OR documents
   ☐Parent/Guardian ☐HPOA ☐Executor of Estate ☐Other: _____

4. How would you like record copies delivered? (check all that apply)
   ☐ Paper Copy ☐ Electronic Copy via USB/Flash Drive (ONLY on device supplied by GLHS)
   - ☐ In-Person Pickup (self)
   - ☐ Allow someone else to pick up my records; Name: _____
   - ☐ Mail Delivery; Street Address: _____
     City/State/Zip: _____

   ☐ Email Copy; email address: _____ * NOTE: EMAIL is NOT a secure method of sending medical information. I understand I am requesting my information to be sent in a non-secure method. _____ (patient initials)

   ☐ Fax copies to Patient (Note: Confirm with patient that their fax machine is in a secure location) (GLHS is not responsible for unauthorized disclosure as a result of an unsecured patient fax machine). Patient Initials _____

   ☐ Release Lab Results over the phone. Please provide a password _____ (GLHS is not responsible for unauthorized disclosure as a result of someone other than the patient calling to receive Lab Results over the phone with above identified password). Patient Initials _____

_____ _____
Signature of Patient or Representative Date

For Internal use only:

Patient MRN #:	*Patient Visit #:*	
Date Requested:	*Date Completed:*	*Completed By:*