Duval Family
HEALTH CENTER

Duval Family Health Center
Medical Services Application

Your application will only be reviewed when all necessary documents are returned to the clinic.
To qualify for the sliding fee discount, you must complete **all** paperwork.

To apply for Sulzbacher Medical Center services:

1. Complete the attached Patient Registration Form
2. Provide a photo ID
3. Bring in one of the following to verify where you live:

☐ **Homeless/Unstable Housing**

- ☐ Letter from shelter
- ☐ Letter from Program Staff
- ☐ Notarized Letter of Support
- ☐ Notarized Unstable Housing Form

☐ **Not Homeless**

- ☐ Driver's License
- ☐ Car Registration
- ☐ Bill/Mail addressed to you
- ☐ Copy of Lease/Mortgage

4. Bring in one of the following to verify your total household income:

☐ **Unemployed**

- ☐ Letter from shelter
- ☐ Letter from Program Staff
- ☐ Notarized Letter of Support
- ☐ Notarized Unstable Housing Form
- ☐ Current Social Security Award Letter
- ☐ Letter of unemployment benefits

☐ **Employed**

- ☐ 1 Month of Paystubs
- ☐ 3 Months of Bank Statements
- ☐ Current tax return or W2
- ☐ Letter from Employer

5. Do you have insurance? ☐ Yes ☐ No
   a. If yes, what insurance? _____
   b. What is your policy number? _____

Once you have obtained all this information, please bring it to the clinic to meet with our eligibility coordinator. Please expect your meeting to take up to 20 minutes. If you have any questions about the documents required for this application, please call 904.227.3197.

For downtown **medication refills** *(you must call 48 hours in advance)*: 904.394.1647

For **behavioral health** appointments: 904.394.1656

Duval Family Health Center
Downtown: (904) 394-1660
Beaches: (904) 224-3550
Family Practice: (904) 394-4958

Patient Registration and Consent Form

Legal Name (first, middle, last): _____ Chosen Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security Number: _____

Phone #: _____ Email Address: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ Widowed ☐ Partner ☐ Other

Gender: ☐ Male ☐ Female ☐ Choose Not to Disclose

Sexual Orientation: ☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Don't Know ☐ Choose Not to Disclose

Residence Status: ☐ US Citizen ☐ Legal Resident

Veteran Status: ☐ Veteran ☐ Not a Veteran

☐ Black/African American	☐ Native Hawaiian	☐ Asian Indian	☐ Other Asian	**Ethnicity:**
☐ American Indian/Alaska Native	☐ Other Pacific Islander	☐ Chinese	☐ Mexican	☐ Hispanic
☐ White	☐ Guamanian/Chamorro	☐ Filipino	☐ Puerto Rican	☐ Non-Hispanic
☐ More than one race	☐ Samoan	☐ Japanese	☐ Cuban	
☐ Choose Not to Disclose	☐ Korean	☐ Vietnamese	☐ Other Hispanic/Latino/Spanish	

Please check any health insurance you currently receive:

☐ Medicaid	☐ UF City Contract Card	☐ Other Insurance
☐ Medicare	☐ Ryan White Health Insurance	☐ No Insurance
☐ Share of Cost Medicaid	☐ Private Health Insurance	**Your Policy ID#:** _____

Does the patient currently smoke cigarettes? ☐ Yes ☐ No

Has the patient ever smoked cigarettes? ☐ Yes ☐ No

Is the patient currently homeless? ☐ Yes ☐ No

Has the patient been homeless in the last 12 months? ☐ Yes ☐ No

If yes, check **all** that apply:

☐ Lived in transitional housing or treatment center ☐ Temporarily living with another family member or friend

☐ Lived in a homeless shelter ☐ Lived on the street or in car, park, sidewalk or abandoned building

By signing this document, I confirm that this information correctly describes my insurance/living situation. I understand that giving false information may affect my ability to receive services. I understand that the Sulzbacher Clinic may check this information and I give them permission to do so. I understand that this consent form will be good until I provide Sulzbacher with written directions otherwise.

I allow the Sulzbacher Clinic to give treatment, perform exams/tests to find out what is wrong, take blood or other samples for lab tests (including HIV), teach me about health-related topics, allow medical/nursing/dental students and residents/interns to help with care, allow providers to prescribe medicines and ot obtain medication history information.

Printed Patient Name: (or Legal Representative)		Date:
Patient Signature: (or Legal Representative)		Date:

Duval Family Health Center

Patient Consent for Treatment Form

I, _____, understand that by signing this consent, I am allowing Duval Family Health Center to:

- Give treatment
- Perform tests to treat me or to find out what is wrong
- Take blood or other samples for lab tests ordered by the provider including HIV testing
- Allow medical/nursing/dental students/residents/interns to help the provider with my care
- Allow providers to obtain medication history information

I understand that the provider may do these things before he/she can tell me what is wrong and that my permission will continue even after the doctor finds what is wrong and suggests treatment.

I understand that I can change my mind and revoke consent but must do so in writing.

_____ _____

Signature of Patient Date

_____ _____

Printed Name of Patient Date

_____

Patient Date of Birth

Duval Family
HEALTH CENTER

Health Services Policy

Duval Family Health Center Eligibility Policy

Office Policy

The Sulzbacher Health Center has a low-cost fee schedule based on the current Federal Poverty Guidelines. Patients with income are expected to pay their fee at the time of the visit when services are rendered. After three non-[paid visits, no new scheduled appointments will be made until at least one visit is paid. During this period, you can continue to receive care via the walk-in or emergency clinics. If the payments are not made, a meeting may be set up with the clinic manager to discuss a payment plan.

Income Verification

Income verification must be provided to the clinic at the initial visit. If you do not bring the required documents to the first visit, you must bring them to your second appointment. Future appointments will not be scheduled until the clinic receives your income verification. Income verification is required annually or anytime there is a change in your income. Income verification is required for free medication and specialty referrals if ordered by your doctor. If you do not currently have income, please request the letter of support from the front desk (this letter of support must be notarized).

I understand that it is my responsibility to notify the health center within ten days of any changes in my financial or insurance situation. I give permission to Sulzbacher to verify my income through the Department of Social Services, Social Security Administration, my employer Veterans Administration and any other company, business, or organization from which I receive income. I authorize representatives of Sulzbacher Health Center to ask for necessary information of my health care providers, to complete applications for medical assistance and to share this information with pharmaceutical companies as required.

Cancellation

In order to provide the best care to you, we expect for you to show up to your appointments. If you do not contact Sulzbacher to cancel your appointment within 24 hours of the scheduled appointment time, arrive more than 15 minutes late for a scheduled appointment, or do not show for a scheduled appointment, the appointment will be flagged as a 'no-show. If you have three consecutive no-shows, you will be charged a 10.00 fee and you will be unable to schedule any future appointments for a sx-month period. During this time, you can still receive health care services through emergency clinics and walk-in clinic days. Instructions on how to cancel an appointment is clearly detailed on your appointment card and posters displayed in the clinic.

By signing below, I agree that I have read and understand the Sulzbacher office policy.

_____ _____

Patient Signature **Date**

_____ _____

Patient Printed Name **Date**

VOLUNTEER HEALTH CARE PROVIDER PROGRAM ELIGIBILITY FORM

CLINIC/PROGRAM/PROVIDER:

Section 1

Does the client/patient have insurance that covers the health or dental condition? YES _____ NO _____

Does anyone in the client/patient's family have an active FL Medicaid card? YES ____ NO ____

Name of the card holder and Medicaid No. _____

Client/Patient/Head of Household's Name: _____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

Address: _____
(STREET) (CITY/STATE) (ZIP CODE)

Telephone or Contact Number: _____ Name of Contact: _____

Section 2

Family Size: Adults____ Under 18 ____ **18-21--Student ____** **Unborn _____** **Family Size TOTAL _____**

FAMILY MEMBERS NAME (First and Last)	**DOB**	**EMPLOYER**	**GROSS EARNED INCOME LAST 4 WKS**	**GROSS UNEARNED INCOME LAST 4 WKS** (Do not include TCA or SSI)
SELF			$	$
SPOUSE/PARTNER			$	$
CHILD			$	$
CHILD			$	$
CHILD			$	$
CHILD			$	$
		TOTALS	$	$
		Add earned and unearned income to determine total		**TOTAL INCOME** $_____

Section 3 BUDGET COMPUTATION (To be completed if family income is above federal poverty level.)

Step 1. **"TOTAL FAMILY INCOME"** for family unit (Earned and unearned income). (1) $_____ (Above)

Step 2. Subtract $90 for EACH employed member of the family unit. (2) $_____ (Minus)

(2a) $_____ (Total)

Step 3. Subtract childcare PAID each month (up to $175 per child age 2 and older; up to $200 per child under age 2). (3) $_____ (Minus)

(3a) $_____ (Total)

Step 4. Subtract up to $50 per month of total child support received. (4) $_____ (Minus)

Step 5. **TOTAL NET INCOME** (5) $_____ (Total)

Section 4 **USE CURRENT YEAR FEDERAL POVERTY GUIDELINES FOR INCOME DETERMINATION**

I certify by my signature that, to the best of my knowledge, the above information is a true and complete statement of my financial situation. I understand that the information I have given is subject to verification by the Department of Health. I acknowledge I am responsible to inform the Department of Health of any change in my financial or health insurance status prior to my next visit. I acknowledge receipt of the Department of Health's Notice of Privacy Practices.

_____ _____

SIGNATURE OF CLIENT/PATIENT/PARENT OR GUARDIAN AND DATE **PRINT NAME OF DEPARTMENT OF HEALTH VOLUNTEER OR EMPLOYEE**

(VALID FOR ONE YEAR) Expiration date: _____

Duval Family Health Center

PATIENT COMMUNICATION PREFERENCES

1. CONSENT TO CALL

Do you agree to be contacted by the clinic via phone? These calls will primarily consist of automated appointment reminders, as well as communication from clinic staff about your care.

- ☐ YES, I agree to receive phone calls from the clinic.
- ☐ NO, I do NOT agree to receive calls from the clinic.
- ☐ I do not have a good phone number for contact.

*If YES, are we able to leave a voicemail if we are unable to reach you?

- ☐ YES, you may leave a voicemail on the phone number I have provided.
- ☐ NO, you may not leave a voicemail on the phone number I have provided.

2. CONSENT TO TEXT

Would you like to receive automated texts from the clinic? These texts will mainly consist of appointment reminders.

- ☐ YES, I would like to receive automated texts from the clinic.
- ☐ NO, I would not like to receive automated texts from the clinic.

*If YES, please provide the best **mobile phone number** to contact you:

☏: _____

3. CONSENT FOR PATIENT PORTAL

Our online patient portal allows you to see your upcoming appointments, request to change or schedule appointments, request medication refills, view your lab results, and communicate with your provider. Would you like to sign up for the patient portal? An email is required for this service.

- ☐ YES
- ☐ NO

*If YES, please provide an **email address** so that we may give you access:

✉: _____

By signing this document, I confirm that I agree to the above methods of communication from the clinic.

_____ _____

Signature of Patient Date

Duval Family
HEALTH CENTER

TELEHEALTH CONSENT FORM

Print Patient Name: _____

- I hereby authorize Duval Family Health Center to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition.
- I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.
- I accept that professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication the technical requirements such as internet speed cannot be met.
- I understand that if I have insurance, the telehealth visit(s) may be billed; however, I will not be billed if insurance does not cover the cost.
- I agree that my medical records on telehealth can be kept for further evaluation, analysis, and documentation, and in all of these, my information will be kept private.

Parent/Guardian Signature : _____ **Date :** _____

Print Parent/Guardian : _____

Verbal Consent :

In the event the patient is accessing Telehealth services from their home or other location, and is otherwise unable to sign this consent form, provider has explained and discussed the benefits and shortcomings of receiving Telehealth services and the patent has verbally consented to receiving Telehealth services.

Provider Signature: _____ **Date:** _____

Duval Family Health Center

Disclosure of Protected Health Information and Privacy Authorization Form (HIPAA)

Last Name	First Name	Middle Name	Suffix
Street Address	City	State	Zip Code

Social Security Number	Date of Birth	Phone Number

1. Disclosure of Health Information for Treatment, Payment & Healthcare Operations

   I consent to the use and disclosure of my protected health information for treatment, billing and healthcare operations. I have been given a copy of the Notice of Privacy Practices and understand that I have the following rights and privileges:

   - The right to review the Notice prior to signing the consent
   - The right to inspect and receive a copy of my clinical information
   - The right to request to amend clinical information I feel is incorrect or incomplete
   - The right to request that Sulzbacher restricts its use and disclosure of my personal health information
   - The right to revoke my permission at any time by giving written notice to Sulzbacher

This authorization will remain in effect until my death or the day I withdraw my permission (in writing).

I, _____, have read this consent form and the Notice of Privacy Practices. I understand that I am giving you consent to use and disclose my health information for treatment, billing, and healthcare operations.

Patient Signature	Date

2. HIPAA Privacy Authorization Form

   Who can see my health information? Please list any family member/friend or others who may be involved in coordinating your care.

Name of Person	Relationship to Patient

How long can they see my information?

☐ All past, present and future health information

☐ From _____ to _____

What can they see?

Everything

Everything EXCEPT the following (check all that apply)

- ☐ Mental Health Records
- ☐ HIV/AIDS/Other communicable diseases
- ☐ Alcohol/drug abuse treatment
- ☐ Other, specify: _____

This medical information may be used by the person I authorize for medical treatment, billing or claims, discussions about my health, or other purposes that I allow.

I understand that I have the right to revoke this authorization (in writing) at any time. I understand that any revocation is not effective on any information that has already been shared. I understand that I can refuse to sign this release and that my treatment, payment, enrollment, or eligibility for services will not be withheld.

_____ _____

Patient Signature Date

Duval Family
HEALTH CENTER

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ State: _____ Zip: _____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: ALL MY HEALTH INFORMATION including any information about sensitive conditions (if any) [See page 2 for details]
FROM WHOM: ALL information sources [See page 2 for details]
TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: **DUVAL FAMILY HEALTH CENTER** Phone: **(904) 394-4958**

Address: **5455 SPRINGFIELD BOULEVARD, JACKSONVILLE, FL 32208** Fax: **(904) 453-7200**

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- **I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.**
- **I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].**
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read all pages of this form and agree to the disclosures above from the types of sources listed.**

_____ _____

Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Guardian
- ☐ Other personal representative (explain: _____)

Explanation of Form Florida AHCA FC4200-004
"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
    a. Drug, alcohol, or substance abuse
    b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
    c. Sickle cell anemia
    d. Birth control and family planning
    e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
    f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form.**

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Revocation": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

Duval Family
HEALTH CENTER

Duval Family Health Center

Notice of Privacy Practices

(You Keep This)

This Notice of Privacy Practices describes how we use and disclose your health information, how you can get access to this information, your rights concerning your health information and our responsibilities to protect your health information. We are required by State and Federal laws to provide you with this Notice, and we will comply with its terms during the period when it is in effect. The Notice will take effect on February 23, 2016, and will remain in effect until it is amended or replaced by the Health Services Administrator and Board of Directors. You have a right to a copy of any new revisions if they should become necessary.

Treatment: We may use clinical information about you to provide you with clinical treatment or services. We may also disclose clinical information about you to other doctors and/or specialty care providers, counselors, medical caseworkers, or other authorized personnel involved in your care.
For example: A doctor may need to tell the specialty doctor who you were referred to about medication that was prescribed and if any medications need to be prescribed after your visit with the specialty doctor. We may share information with outside people if they are also responsible for services related to those you receive here.

For Payment: We may use and disclose clinical information about you so that treatment and services you receive at the center may be billed to and payment may be collected. This disclosure involves our billing staff, insurance organizations, collections and/or a third-party payor.
For example: We may need to inform your health plan about treatment you are going to receive to obtain prior approval so your plan will cover treatment. We may need to share information with your insurance company about your treatment plan so your health plan will pay us or to reimburse you.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, and/or other persons you choose to involve in your care, only if you agree If an individual is deceased, you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Other Uses of Your Clinical Information: Other uses and disclosures of clinical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us with written permission to use or disclose clinical information about you, you may revoke that permission, in writing, at any time.

If you revoke your permission, we will no longer use or disclose clinical information about you for the reasons covered in your written authorization.

We are unable to take back any disclosures we have already made with your permission.

We are required to retain our records of the care we provided to you.

Your Rights Concerning Privacy of Your Clinical Information: You have the right to inspect and receive a copy of your clinical information including clinical and billing records. To inspect and request a copy of your clinical information that may be used to make decisions about you, you must submit a request in writing.

If you request a copy, we may charge a fee to cover the cost of copying, mailing, or other costs of other supplies associated with your request.

You have the right to request to amend clinical information you feel is incorrect or incomplete. You may request an amendment for as long as we keep the information.

To request an amendment, your request including a reason to support the request, must be in writing.

We may deny the request for the amendment of clinical information. We may deny your request for amendment if it is not in writing.

We may deny your request for amendment if it does not include a reason to support the request.

We may deny your request for amendment if the information you are requesting to amend was not created by us; unless the person that created the information is no longer available to make the amendment.

We may deny your request for amendment if it is not part of the information kept by the center.

We may deny your request for amendment if it is not part of the information, you would be permitted to inspect.

We may deny your request for amendment if the information is accurate and complete.

For Health Care Operations:

We may use and disclose your Protected Health Information (PHI) for internal purposes regarding your care. For Example: We may use information within our organization to acquire additional recommended treatment possibilities from other clinicians with other experience. Our organization may use information for learning purposes. Our organization may use information to evaluate the performance of our staff in providing services to you. We will use this information for appointment reminders. Our organization may use this information to tell you about treatment alternatives.

Duval Family Health Center

We may disclose your PHI externally with appropriate releases as required. For Example: Our organization may release information to your insurance company, caregiver, or someone who helps pay for your care. Our organization may release information to disaster relief personnel to locate family or you if necessary. Our organization may combine information from our center with that of other centers for quality review and for evaluating services offered or for research. Our organization may remove information that identifies you from this information.

We will seek specific permission if researchers have access to information that would identify you. We will disclose information about you when required by federal, state, or local law.

Other uses and disclosures we are allowed to make without your explicit authorization. We may release information about you:

For public health activities:

These would include report of child or adult abuse or neglect, to notify people of recalls of products, to notify authorities of a victim of abuse, neglect, or domestic violence when authorized by the patient or required by law, and prevention or control of disease.

To a health oversight agency as authorized by law: If you are involved in a lawsuit- in response to a court or administrative order, or in response to a subpoena, delivery request, or other lawful process by another party in the dispute. Efforts will be made to tell you about the request.

To a coroner or medical examiner: To authorize federal officials in service to protect the President, other heads of state, or conduct special investigations.

To the institution or official if you are an inmate of a correctional institution or under custody of law enforcement officials.

To a law enforcement official in response to a court subpoena, warrant summons, or other lawful process, to identify a suspect, fugitive, witness, or missing person, about a victim, criminal conduct, or criminal death. For emergency circumstances concerning crime information.

If you are a member of the armed forces as required by military command authorities.

Your Rights Concerning Privacy of your Protected Health Information: Individuals seeking treatment have the right to request that we restrict our uses and disclosures of their PHI. We are not obliged to agree to those restrictions, but if we do, we must abide by them. Therefore, restrictions to consent will not be granted without the express permission of the Medical Director and/or Health Services Administrator who will evaluate an individual's request and determine:

1. if the restrictions are reasonable and
2. if it is possible to implement the restriction in our practice

Should the request be granted, the consent form will reflect the restrictions allowed.

Your request must tell us what information you want to limit, whether you want to limit use or disclosure or both and who you want the limits to apply to. Your request must be made in writing.

Breach Notification Requirements. It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

Questions and Complaints:
You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to the Office Manager. If you feel we may have violated your privacy rights, or if you disagree with a decision, we made regarding your access to your health information, you can complain to us in writing. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US:

Duval Family Health Center

Downtown Clinic
611 East Adams Street
Jacksonville, Florida 32202
(904) 394-1660

Beaches Clinic
850 6th Avenue South
Jacksonville Beach, Florida 32250
(904) 536-2438

Family Practice
5455 Springfield Boulevard
Jacksonville, FL 32208
(904) 394-4958