Children's Hospital
Greenville Health System

Children's Hospital Spartanburg Night Clinic

Patient Registration Packet

Please fill out the attached forms as completely as possible and bring them with you to your visit. PLEASE – DO NOT FAX THIS PACKET.

We care about your child's total health and knowing the medical history can help us provide the best care for child's needs.

Thank you for your time and patience. Let us know, if you have any questions.

Children's Hospital Spartanburg Night Clinic
1650 Skylyn Drive, Suite 240
Spartanburg, South Carolina 29307
Tel# 864.598.0460

Visit our website at:
www.ghschildrens.org/childrens-hospital-spartanburg-night-clinic

GREENVILLE HEALTH SYSTEM

Patient Information

(Please print)

Full Legal Name: _____ Preferred Name: _____
Last *First* *Middle*

Sex: ☐ Male ☐ Female

Date of Birth: _____ SS#: _____ Ethnicity: Hispanic/Latino ☐
Month/Day/Complete Year Non-Hispanic/Non-Latino ☐
Refuse/Decline ☐

Primary Care Physician: _____

Preferred Pharmacy Name: _____ Phone Number: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Legally Separated

Race: ☐ Caucasian (white) ☐ American Indian ☐ African American (black) ☐ Hispanic
☐ Biracial ☐ Asian Oriental ☐ Other ☐ Unknown

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

Mail to Address: _____ City: _____ State: _____ Zip: _____

County: _____ Home Phone: ( ) _____ Cell Phone: ( ) _____

Preferred language: _____ E-mail: _____

Veteran: ___Yes ___No ___Unknown Religion: _____

Guarantor Information *(If guarantor is Self, skip to Emergency Contact)*
Parent/guardian presenting minor child for treatment will be listed as the guarantor. If 18 or older, patient will be listed as guarantor and does not have to complete this section. The guarantor will be responsible for any balance due.

Name: _____ Patient relation to Guarantor: _____
Last *First* *Middle*

Home Phone: ( ) _____

Date of Birth: _____ SS#: _____ Cell Phone: ( ) _____

Home Address: _____ City: _____ State: _____ Zip: _____ Country: _____

Mail to Address
(if different): _____ City: _____ State: _____ Zip: _____ Country: _____

Emergency Contact *(Pediatric Patients please list someone other than parent(s)/guardian)*

Primary Contact Name: _____ Home Phone: ( ) _____

Patient Relation to Emergency Contact _____ Cell Phone: ( ) _____

Secondary Contact Name: _____ Home Phone: ( ) _____

Patient Relation to Emergency Contact _____ Cell Phone: ( ) _____

Employment

Patient Employer: _____ **Work Phone:** _____ **Ext:** _____

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

Employment Status: ☐ **Full-Time** ☐ **Part-Time** ☐ **Self Employed** ☐ **Active Military** ☐ **Student Full Time**
☐ **Student Part-Time** ☐ **Retired Date** _____ ☐ **Disabled** ☐ **Not Employed** ☐ **Unknown**

(Pediatric Patients Only) Parent/Guardian & Immediate Family Information

Mother *(If the address, phone numbers and employer information is the same as guarantor, please indicate same.)*

Full Name: _____ Nickname: _____
Last *First* *Middle*

Date of Birth: _____
Month / Day / Complete Year

SS#: _____

Home Address: _____ City: _____ State: _____ Zip: _____
(if different from patient)

Home Phone: _____ Cell Phone: ( ) _____

Employer: _____ Work Phone: ( ) _____ Ext: _____

Father *(If the address, phone numbers and employer information is the same as guarantor, please indicate same.)*

Full Name: _____ Nickname: _____
Last *First* *Middle*

Date of Birth: _____
Month / Day / Complete Year

SS#: _____

Home Address: _____ City: _____ State: _____ Zip: _____
(if different from patient)

Home Phone: _____ Cell Phone: ( ) _____

Employer: _____ Work Phone: ( ) _____ Ext: _____

Patient Name _____ DOB _____

(Pediatric Patients Only) Brothers, Sisters & Other Family Members

Full Name	*M or F*	*Date of Birth*	*Relationship*	*Lives with child*	
				Yes	No
				Yes	No
				Yes	No
				Yes	No

☐ **Check here if no insurance. And, skip to Authorization (below).**

Accident Information

Is visit the result of an accident? (Examples: auto accident, workers compensation, etc.) ☐ Yes ☐ No

Type of Accident: _____ Date of Accident:_____ County of Accident: _____

Primary Insurance Information

Subscriber: This is the person who carries the insurance. If Subscriber is the Patient, skip to Insurance Co Name field.

Subscriber's Name on card: _____ Date of Birth: _____
Month / Day / Complete Year

Patient Relationship to Subscriber: _____ Sex: ☐ Male ☐ Female

If address and phone number is same as patient, please indicate same.

Address: _____ SS#: _____

City, State, Zip: _____ Home Phone:_____

Employer: _____ Work Phone: _____ Ext._____

Insurance Co. Name: _____ **Phone:** _____

Policy/Cert #:_____**Group No:** _____ **Effective Date:**_____

Subscriber Status: ☐ **Full-Time** ☐ **Part-Time** ☐ **Self Employed** ☐ **Active Military** ☐ **Student Full Time**
☐ **Student Part-Time** ☐ **Retired Date** _____ ☐ **Disabled** ☐ **Not Employed**

Secondary Insurance Information

SUBSCRIBER: This is the person who carries the insurance. If Subscriber is the Patient, skip to Insurance Co Name field.

Subscriber's Name on card: _____ Date of Birth: _____
Month / Day / Complete Year

Patient Relationship to Subscriber: _____ Sex: ☐ Male ☐ Female

If address and phone number is same as patient, please indicate same.

Address: _____ SS#: _____

City, State, Zip: _____ Home Phone:_____

Employer: _____ Work Phone: _____ Ext._____

Insurance Co. Name: _____ **Phone:** _____

Policy/Cert #:_____**Group No:** _____ **Effective Date:**_____

Subscriber Status: ☐ **Full-Time** ☐ **Part-Time** ☐ **Self Employed** ☐ **Active Military** ☐ **Student Full Time**
☐ **Student Part-Time** ☐ **Retired Date** _____ ☐ **Disabled** ☐ **Not Employed**

Authorization

I authorize medical evaluation & treatment, and release of information for insurance/medical purposes concerning my illness and treatment. I hereby authorize payment from my insurance company to the Greenville Health System for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of Patient/Guardian/Guarantor: _____ **Date:**_____

GREENVILLE HEALTH SYSTEM

Medications, Allergies and Immunizations

Today's Date _____ Patient Name_____ DOB _____

Please Bring All Medications to Your Visit

Prescription Medications –List all medications you are presently taking

	Name and Dose	Prescribed by:	How Often	Date Started
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Non-Prescription Medications –List all medications you are presently taking

	Name and Dose	How Often	Date Started
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Current Pharmacy

Name and Location _____ Phone Number _____

Preferred _____

Other _____

GREENVILLE HEALTH SYSTEM

Today's Date _____ Patient Name_____ DOB _____

Allergies – list all allergies or unusual reactions you have to medications, foods, dyes latex and other agents.

Allergy	Reaction
1	
2	
3	
4	

List any reactions to bug bites or stings _____

_____

_____

Adult Immunizations – Check the box next to or list all immunizations received including the most recent date received.

	Date Received	Others	Date Received
❑ Tetanus			
❑ Flu			
❑ Pneumonia			
❑ HPV			
❑ Hepatitis B			

Screenings – List the most recent date and doctor for the following screenings:

	Date	Doctor/Practice/Facility Name
Complete Medical Physical		
Full panel of lab work		
Cholesterol (lipid) screening		
Chest X-ray		
Treadmill Stress Test		
Other heart tests		
Colonoscopy		
Mammogram		
Bone Density		

GREENVILLE HEALTH SYSTEM

Today's Date _____ Patient Name_____ DOB _____

Hospitalization & Surgical History – List all hospital admissions and operations you have had.

	Reason for Hospitalization/Surgery	Year
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

❑ Yes ❑ No Did you have any problems with anesthesia? If yes, please describe.

_____

Social History

❑ Yes ❑ No Do you currently smoke or use other tobacco products? If yes, how many per day? _____

❑ Yes ❑ No Have you smoked or used other tobacco products in the past? If yes, how many per day? _____

How many years since you last smoked? _____

❑ Yes ❑ No Do you drink caffeinated beverages? If yes, what type, how often, how much? _____

❑ Yes ❑ No Do you drink alcohol? If yes, what type, how often, how much? _____

❑ Yes ❑ No Do you exercise regularly? If yes, what type? _____

How often and how long? _____

Family Medical History – Check the box next to any medical condition below that has affected any of your immediate family members (parents, brothers, sisters), state your relationship and their age at onset.

	Relationship	Age at onset
❑ High Blood Pressure		
❑ High Cholesterol		
❑ Heart Disease		
❑ Stroke		
❑ Migraines		
❑ Seizures/Convulsions		
❑ Diabetes		
❑ Bleeding/Blood-clotting Disorder		
❑ Allergies		
❑ Asthma		
❑ Thyroid Problems		
❑ Osteoporosis		
❑ Psychiatric Disorder/Mental Illness		
❑ Alzheimer's/Dementia		
❑ Cancer - type:		
❑ Other:		

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

THE INFORMATION PROVIDED IN THIS FORM WILL BE RELIED UPON BY ALL HEALTH CARE PROVIDERS OF GREENVILLE HEALTH SYSTEM UNLESS REVOKED OR MODIFIED BY THE PATIENT IN WRITING.

Patient Name (PRINT) _____

(For Office Use Only)
MRN_____

DOB _____

Authorization for Disclosure of Medical Information: The privacy of your medical information is important. We will discuss your medical condition with person(s) you designate.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? (*Check and complete one*)

☐ The following family members or other individuals may receive information regarding my medical condition:
*Print first and last name(s)*_____
_____

OR

☐ Any family member or other individual inquiring about my medical condition may receive information from my provider, EXCEPT the following individuals: *Print first and last name(s)*_____
_____

You may revoke/cancel or modify/change the above designation, but the revocation or modification must be in writing.

NOTE: This designation does not give the above named individuals the right to make health care decisions for you. If at any time you are unable to consent to care or treatment, we will follow the procedure set forth in the South Carolina Adult Health Care Consent Act.

Confidential Communication: Please provide phone number(s) where we can reach you:
☐ Home:_____ ☐ Work:_____ ☐ Cell Phone:_____ ☐ Other_____

Messages: A request for return calls may be left on the following answering machine or voice mail: (*Check all that apply*)
☐ Home ☐ Work ☐ Cell Phone ☐ I do not authorize

I authorize my medical information to be left on the following answering machine or voice mail: (*Check all that apply*)
☐ Home ☐ Work ☐ Cell Phone ☐ I do not authorize

If we are unable to reach you or leave a message at the above phone number(s), please indicate with whom we may leave a message for you to call our facility.
Name _____ Phone Number _____
Name_____ Phone Number _____
Note: *An automated appointment reminder system may call the number listed in our data base.*

Signature: I hereby authorize the disclosure of my medical condition and information as described above.
Patient/Patient's Representative Signature:_____ Date: _____Time:_____
PRINT Name (if Patient's Representative): _____
Relationship to Patient (if Patient's Representative):_____

GHS Representative:_____Date: _____ Time:_____
Form Create Date: December 30, 2013

GREENVILLE HEALTH SYSTEM

Authorization for Release of Medical Information

One Per Request

Patient Full Name **(Print)** _____ MRN (office use) _____ DOB _____

is requesting that the Greenville Health System release health information

(check one) ☐ To or obtain ☐ From the person/company/agency/facility listed below.

Name, Position, or Department: _____

Name of Organization: _____

Address of Organization: _____

Phone number of Organization: _____

The information to be disclosed relates to service dates beginning _____ and ending _____

- ❑ Entire Medical Record
- ❑ Demographic Information
- ❑ History & Physical
- ❑ Medical/Surgical History
- ❑ Physician Office Visits
- ❑ Medication List
- ❑ Immunizations
- ❑ Test Results (lab, X-ray, etc.)
- ❑ Other Assessments
- ❑ Discharge Summary
- ❑ Physical Therapy Notes
- ❑ Occupational Health Record
- ❑ Other: (specify) _____
- ❑ Other: (specify) _____
- ❑ Other: (specify) _____

The purpose of the disclosure: *("Request of the Individual" is sufficient for patient-initiated releases)*

- ❑ Request of Individual
- ❑ Referral to Specialist
- ❑ Continuing Care
- ❑ Change of Doctor
- ❑ Insurance
- ❑ Workers' Comp
- ❑ Legal Investigation
- ❑ Other: (specify) _____

Conditions and Notifications:
This authorization for release of information expires 12 months from the date of patient's signature. You may revoke this authorization at any time by writing to the Office Supervisor/Manager. However, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation. You may inspect or request a copy of the health information to be used or disclosed, consistent with federal law. This authorization is being given to the GHS University Medical Group, to GHS, and each practice and entity affiliated with it including GHS Partners in Health.
Note: There may be a processing fee charged to the patient to cover labor, copying, and supplies used to reproduce medical records.

Signatures:
I hereby authorize the use or disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary, and that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

Signature of Patient/Personal Representative: _____ Date: _____

Print Name of Personal Representative: _____

Relationship of Representative to Patient: _____

Released by: _____ Date: _____
(Department Representative Name)

****Additional Form Required for Each Provider****

GREENVILLE HEALTH SYSTEM

Financial Policy

Please read this financial policy carefully. If you have any questions about this policy, any member of our staff will be glad to assist you.

The following are the conditions for services provided to the patient by Greenville Health System, GHS Partners in Health, and the various entities and providers affiliated with them each individually and collectively referred to as Greenville Health System or GHS.

Payment for Service: Each office will inform you of co-pay and deductible amounts at check in or check out. These amounts are due at the time of service. As a courtesy to you, we will file your insurance claims if you provide us with a copy of your current insurance card. We require that you pay your deductible, co-payment, and/or any charges not covered by insurance.

Method of Payment: You may pay your bill with cash, personal check, certain credit cards, or debit card.

Returned Checks: A $25.00 service charge will be added on all checks returned to us for insufficient funds.

Non-appointment Prescription Refills: A $15.00 charge per incidence may be added for non-appointment prescription refills.

Non-appointment Prescription: A $25.00 charge may be billed to you for new prescriptions filled via phone.

Completion of Medical Forms: There may be a charge for completion of forms such as disability, camp physicals, etc.

Copies of Medical Records: There may be a charge for completion of this process; SC Sec. 44-7-325 for Health Care Facilities

- $.65 per page for the first 30 pages
- $.50 per page for all other pages
- Clerical fee not to exceed $25.00
- Plus actual postage

No-show Appointments: A fee of $25.00 for a follow up visit and $50.00 for a new patient visit or endoscopy procedure may be charged for all missed appointments not canceled at least 24 hours prior to the appointment time. You will be financially responsible for the fee, as insurance plans do not cover these charges. You may notify our office of any cancellations by calling during normal office hours.

Payment for Services Provided by Certain Providers: If you are having laboratory and/or diagnostic services by providers other than this office or other practices doing business as GHS University Medical Group, you may be billed separately by that service provider. This includes services provided by Greenville Health System.

Collection Policy: Delinquent accounts will be forwarded to a collection agency. We will inform you of your account status on your statement. If you are unable to pay your balance promptly, please call us at 864-454-2000 or 1-888-284-6024 to make payment arrangements. We will attempt to contact you by letter before your account is forwarded.

Questions: We are here to help should you have any questions regarding your statement or insurance.

Consents/Registration
Greenville Health System

GREENVILLE HEALTH SYSTEM (GHS) PATIENT PORTAL ACCESS

A. Patients 16 years old or older or Emancipated Minors

I desire to participate in the Patient Portal. Email address:_____

Signature of Patient_____Date/Time_____

I authorize proxy access to my Patient Portal to another person. (*if applicable to specific portal)*

Name of Proxy:_____Relationship:_____

Email address:_____DOB:_____

Signature of Patient:_____Date/Time_____

B. Patients 12 to 15 years old

My parent/legally authorized representative and I desire to participate in the Patient Portal.

Patient hereby assents to the terms and conditions for participation in the Patient Portal and to allowing a parent (or legally authorized representative) to be granted proxy access.

Patient's email address:_____DOB:_____

Signature of Patient_____Date/Time_____

Name of parent/legally authorized representative:_____

Email address:_____Relationship:_____DOB:_____

Signature:_____Date/Time_____

C. Patients under 12 years old

I desire to participate in the Patient Portal for my child/ward.

Name of parent/legally authorized representative:_____DOB:_____

Email address:_____Relationship:_____

Signature:_____Date/Time_____

D. Patients unable to consent/assent

I desire to participate in the Patient Portal for the above named patient who is unable to consent/assent.

Name of Proxy:_____Relationship to patient:_____

Email address:_____DOB:_____

Signature:_____Date/Time_____

Appropriate Documentation has been presented to GHS Staff to indicate that the legally authorized representative has authority to sign for the patient.

GHS Staff Signature:_____Printed Name:_____Date/Time:_____

For new information or updates, please fax to 864-454-2539*

CHILDREN'S HOSPITAL SPARTANBURG NIGHT CLINIC NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND RELEASED AND HOW YOU CAN GET THIS INFORMATION. PLEASE READ IT CAREFULLY.

Children's Hospital Spartanburg Night Clinic makes every effort to keep your health information private. Each time you visit Children's Hospital Spartanburg Night Clinic, a record is made. This health or medical record often includes your symptoms, exams and tests, diagnoses, treatment, and care plan. We need this record to give you high-quality care and to meet legal requirements. This Notice applies to all health records produced at Children's Hospital Spartanburg Night Clinic, including those received from other providers. It outlines how we may use and give out information about you for treatment, payment, or healthcare operations and other purposes granted or required by law. It also describes your rights to get and control your record, and legal requirements we have on its use and release. The law requires Children's Hospital Spartanburg Night Clinic to do the following: (1) Keep your health record private (2) Describe our legal duties and privacy obligations related to your health information (3) Follow the current Notice of Privacy Practices

We reserve the right to change practices and terms of this Notice and the changes will be effective for the information we already have about you and any information we receive in the future. The Notice will list the start date in the top right-hand corner of the first page. Each time you register at Children's Hospital Spartanburg Night Clinic, you may receive a copy of the notice. We will post it in our facilities and on our Web site (www.ghs.org). You may also call our Privacy Office at 864-455-3711 for a copy.

ROUTINE USES AND DISCLOSURES OF YOUR HEALTH RECORD The following sections describe how we use and release medical information. Each section explains what we mean and gives a few examples. (Note: These examples are not all-inclusive.)

Treatment. We use medical information about you to provide, coordinate, and manage your treatment or services. We may give this information to doctors, nurses, technicians, and students of affiliated healthcare programs, volunteers, or other staff who care for you. Various units may share information about you to coordinate your needs, such as lab work or drugs.

We may give details about you to people who are involved in your care, such as a specialist, spouse, or friend. Children's Hospital Spartanburg Night Clinic medical personnel and employees, using their best judgment, may release to a relative, close friend, or other person information about your health related to that person's involvement in your care. Here is how your health record might be used for treatment reasons: We may send your record to specialists our doctors want to consult. (1) Your record may be sent to a doctor to whom you have been referred. (2) You may plan for a friend to pick you up after a procedure. A Children's Hospital Spartanburg Night Clinic representative may believe it is in your best interest to tell your friend what drug you must take that night and what will speed your recovery at home. (3) We may use and release your health record to provide material on treatment options.

Payment. We use and release health information so that treatment and services you receive may be billed to and payment collected from you, an insurance company, or a third party. Here is how your health record might be used for payment purposes. (1) We may call your health plan for pre-approval of a service. (2) We may give your health plan details about your surgery, so it will pay us or reimburse you. (3) If someone else is responsible for your payment, we will contact that person.

Healthcare Operations. We may use and release your record to support our business functions (for example, administrative, financial, and legal activities). These uses and disclosures are needed to run the practice; support treatment and payment, and help patients receive high-quality care. Activities may include measuring quality, reviewing employee performance, and training students. Here is how your health record might be used for business operations. (1) We may call you to confirm your appointment. (2) We may ask you to list your name and your doctor's name when you arrive for a visit. We may also call you by name in a waiting area. (3) We may use health information to review our treatment and services. (4) We may combine information on Children's Hospital Spartanburg Night Clinic patients to decide what services to offer. (5) We may give information to doctors, nurses, technicians, students, and other staff for review and learning purposes. (5) We may combine our records with those from other hospitals or practices to compare how we are doing and where we can improve.

Facility Directory. Unless you object in writing, we include certain facts about you in our directory while you are a patient at Children's Hospital Spartanburg Night Clinic. These facts may include your name, location, and general condition (for example, fair, serious, undetermined).

People Involved in Your Care or Payment for Your Care. Unless you object, Children's Hospital Spartanburg Night Clinic health experts may tell a family member, friend, or other person you identify, or that we have a reasonable basis to believe is involved in your medical care, details about you that relate to that person's involvement in your care. If you cannot physically or mentally agree or object to a disclosure, we may supply information as needed. We may also give information to someone who pays for your care. Finally, we may share facts with someone helping in a disaster relief effort so that family can know of your condition, status, and location.

Business Associates. Business associates of Children's Hospital Spartanburg Night Clinic provide some services related to treatment, payment, and business operations. Examples include medical supplies, transcription, medical record storage, and some aspects of billing. We have a written contract that requires associates to protect your record in the course of performing their job.

SPECIAL USES AND DISCLOSURES OF YOUR HEALTH RECORD

Emergencies. We may use or release your health information during emergencies.

Communication Barriers. We may use or release your record if we try to get your consent but cannot because of major communication barriers and the doctor or staff decides that you intend to consent to use or release such information.

Research. Children's Hospital Spartanburg Night Clinic may release your record for research approved by the Greenville Health System's Institutional Review Committee (IRC). The IRC reviews proposals and protocols to ensure privacy. We may share information about you with researchers starting a project to help them find patients with specific needs (the information will not leave Greenville Health System).

Fundraising Events. We may use your name, address, and dates that you received treatment for Greenville Health System-supported fundraising events. Any fundraising material sent to you will include information telling you what to do to keep from receiving any future communications.

Workers' Compensation. We may release information about you to comply with workers' compensation laws or similar programs.

Legal Proceedings. We may release health information about you for the following reasons: Court or administrative order, and/or subpoena, discovery request, or other lawful process.
Legal Requirements. We will give out medical information about you when required to do so by federal, state, or local law.

Serious Threat to Health or Safety. We may use and release information about you to prevent a serious threat to your health and safety or the health and safety of others.

Health Oversight Activities. We may supply information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure. These activities help the government oversee healthcare systems, benefit programs, and civil rights laws.

Public Health Risks. We may release information about you to local, state, or federal public health agencies (such as the Food and Drug Administration and the Department of Health and Environmental Control) for reasons such as: (1) To prevent or control disease, injury, or disability (2) To report births and deaths (3) To report adverse events, product defects or problems, or drug reactions (4) To note product recalls (5) To notify a person who may have been exposed to a disease or may be at risk for getting or spreading one (6) To alert a government agent if we believe a patient is the victim of abuse, neglect, or domestic violence.

Coroners, Funeral Directors, and Organ Donors. We may release information to coroners or medical examiners to identify a deceased person, find cause of death, or carry out duties as required by law. We may also give information to funeral directors to meet their duties and may share such information in the reasonable anticipation of death. We may supply your health record to organ donor groups as approved by you or consistent with the law.

Military, Veterans, and National Security. If you are a member of the armed forces, we may release information about you as required by military authorities. We may also share information about foreign military personnel to the appropriate foreign military authority. We may give information about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Law Enforcement. We may release your health information to a law enforcement official: (1) In response to a court order, subpoena, warrant, summons, or similar legal process (2) To identify or locate a suspect, fugitive, witness, or missing person (3) To provide information about the victim of a crime if, under certain cases, we cannot get the person's agreement or as required by law (4) In case of a death we believe may be the result of criminal conduct (5) In response to criminal conduct at this facility (6) In an emergency to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.
Inmates. If you are an inmate of a correctional institution or in custody of a law enforcement official, we may release medical information about you to that facility or person.

YOUR HEALTH INFORMATION RIGHTS

Review and Copy. You have the right to review and request a copy of your health record (this often includes medical and billing records but, under federal law, excludes psychotherapy notes). To do so, write to: Children's Hospital Spartanburg Night Clinic, 1650 Skylyn Drive, Suite 240, Spartanburg, SC 29307. There may be a fee for copying, mailing, and related supplies. We may deny your request to inspect and copy in certain cases. Then you may request a review. Another licensed healthcare professional chosen by Children's Hospital Spartanburg Night Clinic will examine your request. The reviewer will not be the person who denied your request. Children's Hospital Spartanburg Night Clinic will comply with the outcome of the review.

Amend. If you believe that information we have about you is incorrect or incomplete, you may ask us to modify or add the information. You have the right to request a change or addition for as long as Children's Hospital Spartanburg Night Clinic keeps the record. Request your change in writing to: Children's Hospital Spartanburg Night Clinic, 1650 Skylyn Drive, Suite 240, Spartanburg, SC 29307. You must give a reason that supports your request. We may deny your request if it is not in writing or does not include a reason to support the request. We may also deny a request to modify a medical record in these cases: (1) The current information is accurate and complete (2) It is not part of the medical information kept by or for Children's Hospital Spartanburg Night Clinic (3) It is not part of what you would be allowed to view and copy (4) It was not created by us. If we deny this request, you have the right to file a statement of disagreement. We may then prepare a rebuttal. We will give you a copy of the rebuttal.

Accounting of Disclosures. You have the right to request an "accounting of disclosures" (a list of disclosures made about you for reasons other than treatment, payment, Children's Hospital Spartanburg Night Clinic operations, or national security). Request this list by writing to: Children's Hospital Spartanburg Night Clinic, 1650 Skylyn Drive, Suite 240, Spartanburg, SC 29307. Your request must state a period of time, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. Additional lists may involve a charge. We will notify you of the cost, and you may cancel or adjust your request before any fees are incurred.

Request Restrictions. You have the right to request that we limit information we use or give out about you for treatment, payment, or healthcare operations. You also have the right to request a limit on what we release to someone involved in your care or payment for your care, such as a family member. For example, you could ask that we not use or give out information about a surgery that you had to your family. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the material is needed for emergency treatment. To request restrictions, submit a Restriction of Information Agreement Form to Children's Hospital Spartanburg Night Clinic registration personnel. State (1) what you want to limit; (2) if you want to limit use, release, or both; and (3) to whom the limits should apply, for example, disclosures to your family.

Request Confidential Communications. You have the right to request that we interact with you about medical matters in a certain way or place. For example, you can ask that we contact you only by mail or only at work. To request confidential communications, submit a Restriction of Information Agreement Form to Children's Hospital Spartanburg Night Clinic registration personnel. We will try to meet all reasonable requests. You must note how or where you wish to be contacted.

Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. For a paper copy, call Children's Hospital Spartanburg Night Clinic at 864-598-0460 or the Greenville Health System Privacy Office at 864-455-3711. You may also get a copy from our web site, www.ghs.org

COMPLAINTS If you believe your privacy has been violated, you may file a complaint with Children's Hospital Spartanburg Night Clinic, Greenville Health System or with the Secretary of the Department of Health and Human Services. To file a complaint, call the Practice Manager of Children's Hospital Spartanburg Night Clinic at 864-598-0460, or call our Privacy Office at 864-455-3711 or the GHS Service Excellence Department at 864-455-7975. You may also file an anonymous complaint through our Corporate Compliance Hotline at 1-888-243-3611 (1-800-297-8592 en Espanol). To ensure proper follow-up, complaints must also be submitted in writing.

OTHER USES. Other uses and disclosures of medical information not covered by this notice or relevant laws will be made only with your written consent. If you allow us to use or release health information about you, you may cancel that consent, in writing, at any time. If you revoke it, we will no longer use or release information for the reasons covered by your written consent. **Note:** We cannot take back disclosures already made with your consent.