Wynd Counts, MD
Wendy Cruz, MD
Kristina Eaton, MD

WOMEN'S CARE OF ALASKA

2741 DeBarr Rd, Suite C205
Anchorage, AK 99508

Katie Ulmer, ANP
Migel Hadley, ANP
Rhianne Christopherson, ANP

PLEASE FILL OUT FORM AS COMPLETELY AS POSSIBLE

PATIENT:

Patient Name _____ DOB _____ SS# _____

Preferred Ph# _____ Choose Other # _____ Choose Email _____

Mailing Address _____ City _____ State ____ Zip _____

Employer Name _____ Occupation _____

Employer Addr _____ City _____ State ____ Zip _____

Relationship Status Choose Gender Identity Choose Sexual Orientation Choose Race Choose Ethnicity Choose

How did you hear about our practice? _____

PARTNER:

Partner Name _____ DOB _____ SS# _____

Preferred Ph# _____ Choose Other # _____ Choose Email _____

Mailing Address _____ City _____ State ____ Zip _____

Employer Name _____ Occupation _____

Employer Addr _____ City _____ State ____ Zip _____

IF PATIENT IS A MINOR

Who may authorize treatment? _____ *Relationship* _____ *Contact#:* _____ Choose

INSURANCE:

PRIMARY INSURANCE COMPANY: _____

Subscriber Name _____ DOB _____ SS# _____

Subscriber ID# _____ Group# _____ Relationship to Patient _____

Employment Status _____ Occupation _____ Employer Name _____

Employer Addr _____ City _____ State ____ Zip _____

SECONDARY INSURANCE COMPANY: _____

Subscriber Name _____ DOB _____ SS# _____

Subscriber ID# _____ Group# _____ Relationship to Patient _____

Employment Status _____ Occupation _____ Employer Name _____

Employer Addr _____ City _____ State ____ Zip _____

EMERGENCY CONTACT:

Emergency Contact Name _____ Relationship _____ Ph# _____ Choose

Emergency Contact Name _____ Relationship _____ Ph# _____ Choose

AUTHORIZATION (Please ✔ check each statement, after you have read it, then sign the bottom of the form)

- ☐ I hereby authorize release of any information required to process insurance claims related to my medical and/or surgical care.
- ☐ I authorize direct payment to the provider(s) for my medical and/or surgical care.
- ☐ I understand that I am responsible to pay any non-covered charges or services.
- ☐ I understand that if I am uninsured, I am responsible to pay for any services provided.
- ☐ I have read and agree to the PATIENT FINANCIAL POLICY for Women's Care of Alaska.

_____ _____

Patient Signature Date

Wynd Counts, MD
Wendy Cruz, MD
Kristina Eaton, MD

WOMEN'S CARE OF ALASKA
2741 DeBarr Rd, Suite C205
Anchorage, AK 99508

Katie Ulmer, ANP
Migel Hadley, ANP
Rhianne Christopherson, ANP

Patient Name: _____ DOB: _____ Date: _____

What brings you to our office today? _____

If we need to contact you, regarding any future appointments or to give you test results, may we leave a message?

☐ Yes ☐ No Please specify the preferred phone number: (____)_____

ALLERGIES

LIST DRUG, ENVIRONMENTAL AND FOOD ALLERGIES	REACTION

CURRENT MEDICATIONS

DRUG NAME	DOSE	DRUG NAME	DOSE

GYN HISTORY

- Date last menstrual period began:_____
- Date of last PAP:_____ ☐ Normal ☐ Abnormal
- Date of last Mammogram:_____ ☐ Normal ☐ Abnormal
- Age when periods started?_____
- Menstrual bleeding is: ☐ Light ☐ Moderate ☐ Heavy
- Periods last: _____ days
- Cramps are: ☐ Mild ☐ Moderate ☐ Severe
- Cramps last: _____days
- Spotting occurs between periods: ☐ Yes ☐ No
- Spotting occurs after intercourse: ☐ Yes ☐ No

- **Have you ever had any of the following procedures?**

☐ Colposcopy - Date:_____ ☐ Cryosurgery - Date:_____ ☐ LEEP - Date: _____

STD HISTORY

Have you ever been treated for any of the following conditions?

☐ Chlamydia ☐ Gonorrhea ☐ Genital Warts ☐ Herpes ☐ Trichomonas ☐ Syphilis ☐ PID

Have you ever tested positive for HIV? ☐ Yes ☐ No

SEXUAL HISTORY

Are you currently sexually active? ☐ Yes ☐ No ☐ Have Never Been Sexually Active

Did you begin sexual activity before 16 y/o? ☐ Yes ☐ No If yes, what age started? _____

Have you had > 5 sexual partners in your lifetime? ☐ Yes ☐ No If yes, how many? _____

CONTRACEPTION

Current Birth Control Method: ☐ Condoms ☐ Birth Control Pills ☐ Tubal Ligation ☐ Vasectomy

☐ Depo Provera ☐ Natural / Rhythm ☐ IUD ☐ Nexplanon® ☐ Other _____

PREGNANCY HISTORY

Total Times Pregnant		Full term deliveries		Elective Abortions	
Miscarriages		Cesarean sections		Living children	

PERSONAL MEDICAL HISTORY

YES	CONDITION	YES	CONDITION	YES	CONDITION
	Diabetes		Heart disease		Anxiety
	High Blood Pressure		Hepatitis		Seizures
	GI Reflux Disease		Liver Problems		Asthma
	Other GI Disease		Kidney Infections/stones		Lung Disease
	Fibroids		Arthritis		Tuberculosis
	Endometriosis		Joint Pain		Thyroid Disease
	Osteopenia		Fracture		Clotting Disorder
	Osteoporosis		PCOS		Ovarian Cyst
	Cancer (type)		Migraine		Other
	High Cholesterol		Depression		

SURGICAL HISTORY

SURGERY	YEAR	SURGERY	YEAR

FAMILY HISTORY

YES	CONDITION	YES	CONDITION	YES	CONDITION
	Diabetes		Heart Disease		Depression
	High Blood Pressure		High Cholesterol		Lung Disease
	GI Reflux		Liver Problem		Asthma
	Fibroids		Kidney Infections/Stones		Tuberculosis
	Endometriosis		Arthritis		Thyroid Disease
	Osteopenia		Cancer - Type: Relation:		Clotting Disorder
	Osteoporosis		Joint Pain		Other

SOCIAL HISTORY / HABITS / PERSONAL SAFETY

Education Level: ☐ High School ☐ College ☐ Graduate Degree ☐Other

Special Diet? ☐ Yes ☐ No Type: _____

Do you exercise? ☐ Never ☐ Rarely (1-2x/yr) ☐ Occasionally (1-2x/month) ☐ Often (1-2x/wk) ☐ Regularly (3-5x/wk)

Smoking: ☐ Yes ☐ No ☐ Former Packs/day:_____ Number of years: _____ Quit Date:_____

Alcohol: ☐ Yes ☐ No ☐ Former Drinks/day:_____ Drinks per week: _____ Quit Date:_____

Drug Use: ☐ Yes ☐ No ☐ Former Type:_____ Number of Years?_____ Quit Date:_____

Caffeine: ☐ Yes ☐ No Cups per day:_____ Cups per week:_____

Has anyone close to you ever threatened to hurt you? ☐ Yes ☐ No

Has anyone ever hit, kicked, choked or hurt you physically? ☐ Yes ☐ No

Has anyone, including your partner, ever forced you to have sex? ☐ Yes ☐ No

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

WOMEN'S CARE OF ALASKA, PC
2741 DeBarr Road, Suite C205
Anchorage, AK 99508
Wynd Counts, MD * Wendy Cruz, MD * Kristina Eaton, MD

OBSTETRIC MEDICAL HISTORY

Name:
LAST FIRST MIDDLE

Date Form Completed: – –

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

Personal Health History

1. ☐ Yes ☐ No Have you ever had an allergic reaction to a medication or vaccine component?

If yes, please list: _____

_____

Any other allergies or reactions? _____

_____

2. Please mark any condition that you have or have had in the past:

- ☐ Epilepsy
- ☐ Headaches
- ☐ Thyroid Disorder
- ☐ Breast Disease
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Anemia
- ☐ von Willebrand disease or other bleeding disorders
- ☐ Blood Clotting Disorder (eg, Phlebitis/Thrombophilia)
- ☐ Blood Transfusion
- ☐ Gastrointestinal Illness
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Recurrent Urinary Tract Infections
- ☐ Gestational Diabetes
- ☐ Diabetes (Type 1 or Type 2)
- ☐ Arthritis or Lupus
- ☐ Skin Disorders
- ☐ Prior Preterm Birth
- ☐ Group B Streptococcus In Prior Pregnancy
- ☐ Herpes
- ☐ Sexually Transmitted Infections
- ☐ HIV/AIDS
- ☐ Frequent Infections
- ☐ Psychiatric Illness
- ☐ Depression/Postpartum Depression
- ☐ Eating Disorder
- ☐ Other: _____

Describe, if needed: _____

_____

3. Please indicate any surgery or hospitalization that you have had and the date:

4. Please describe any health problems or symptoms that you are having at this time:

5. ☐ Yes ☐ No Do you or any family member have a history of problems with anesthesia?

If yes, please describe: _____

6. ☐ Yes ☐ No Do you have any objections to any form of medical treatment (eg, blood transfusion)?

If yes, please describe: _____

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Exposures Affecting Health

1. ☐ Yes ☒ No Do you currently or have you in the past year smoked, chewed, used any type of nicotine delivery system (ENDS), or vaped?
   If yes, how many packs per day? _____ If former smoker/user, when did you quit? _____

2. ☐ Yes ☐ No Do you drink alcoholic beverages now or did you before you became pregnant?
   If yes, please indicate number of drinks per week: _____
   What type of drinks? _____

3. Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, and any herbal medicines:
   _____
   _____

4. ☐ Yes ☐ No Have you used any street drugs since your last menstrual period (eg, cocaine, marijuana, opioids)?
   If yes, please indicate number of uses per week: _____
   What type of drugs? _____

5. ☐ Yes ☐ No Do you have any reason to believe you or your partner may have been exposed to HIV/AIDS? This may include a history of blood transfusion, IV drug use, sex with gay or bisexual men, or sex with someone who has used IV drugs?

6. ☐ Yes ☐ No Have you been exposed to chemicals (eg, pesticides, lead, hazardous material/agents) or radiation (eg, X-rays) since you became pregnant?
   If yes, please describe: _____

7. ☐ Yes ☐ No Are you on a restricted diet?
   If yes, please describe: _____

8. ☐ Yes ☐ No Have you or your partner recently traveled outside of the United States?
   If yes, please describe: _____

Gynecologic Health History

1. When was your last Pap test? _____

   ☐ Yes ☐ No Have you ever had an abnormal pap test?
   If yes, when and how were you treated? _____
   _____
   What was the diagnosis? _____

   ☐ Yes ☐ No Did you have any procedures on your cervix for treatment (eg, LEEP [loop electrosurgical excision procedure] or cold knife or laser conization)?

   ☐ Yes ☐ No Have you ever had HPV?

   ☐ Yes ☐ No Have you received all three doses of the HPV vaccine?

2. ☐ Yes ☐ No Have you ever had ☐ Gonorrhea ☐ Chlamydia ☐ Pelvic Inflammatory Disease
   If yes, when, how, and where were you treated? _____

3. ☐ Yes ☐ No Have you ever had herpes?
   If yes, where do you have outbreaks? _____
   If yes, how often do you have outbreaks? _____

   ☐ Yes ☐ No Have you ever had syphilis?
   If yes, how, when, and where were you treated? _____

4. ☐ Yes ☐ No Have you ever used an intrauterine device (IUD) for contraception?
   If yes, please indicate when: _____

   ☐ Yes ☐ No Did you have any problem with the IUD?
   If yes, please describe: _____

5. ☐ Yes ☐ No Have you been treated for infertility?
   If yes, please describe when and treatment received: _____
   _____

6. ☐ Yes ☐ No Do you have any other concerns related to your past health history?
   If yes, please list: _____
   _____

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Family History & Genetic Screening

1. What is your ethnicity? _____ What is the ethnicity of the baby's father? _____

2. ☐ Yes ☐ No Have you or has the baby's father had a child born with a birth defect?
   If yes, please describe: _____

3. ☐ Yes ☐ No Did either you or the baby's father have a birth defect?
   If yes, please describe: _____

4. Please describe any special needs that have occurred in children of your family or the baby's father's family (eg, cognitive impairment/intellectual disability, birth defects, early infant death, deformities, or inherited diseases, such as hemophilia, muscular dystrophy, or cystic fibrosis):
   _____
   _____
   How is this child/person related to you? _____

5. ☐ Yes ☐ No Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillbirths)?
   If yes, have either of you had genetic counseling? ☐ Yes ☐ No
   If yes, have either of you had chromosomal testing? ☐ Yes ☐ No
   Where and what were the results? _____

6. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby's father is, of one of these backgrounds:

   ☐ Yes ☐ No Eastern European Jewish (Ashkenazi) Ancestry
   If yes, have you had tay–sachs screening tests? ☐ Yes ☐ No
   If yes, have you had a canavan screening test? ☐ Yes ☐ No
   If yes, have you had familial dysautonomia screening? ☐ Yes ☐ No
   Date: _____ /_____ /_____ Result: _____

   ☐ Yes ☐ No African American
   If yes, have you had sickle cell screening? ☐ Yes ☐ No
   Date: _____ /_____ /_____ Result: _____

   ☐ Yes ☐ No Mediterranean Ancestry or Southeast Asian Ancestry
   If yes, have you had screening for inherited forms of anemia such as Thalassemia? ☐ Yes ☐ No

   ☐ Yes ☐ No French Canadian or Cajun Ancestry
   If yes, have you had Tay–Sachs screening tests? ☐ Yes ☐ No

7. ☐ Yes ☐ No Have you had cystic fibrosis screening?

8. ☐ Yes ☐ No Have you had any other genetic carrier screening, such as an expanded carrier screening?
   Screening: _____ Date: _____ /_____ /_____ Result: _____

9. Please list any other concerns you have about birth defects or inherited disorders:
   _____
   _____
   _____

10. ☐ Yes ☐ No Do you want a test that will tell you about your risk to have a baby with Down syndrome?

11. ☐ Yes ☐ No Is the father 45 years or older?

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Psychosocial Screening*

1. ☐ Yes ☐ No Do you have any problems (eg, job, transportation) that prevent you from keeping your health care appointments?
2. ☐ Yes ☐ No Do you feel unsafe where you live?
3. ☐ Yes ☐ No Are you exposed to second-hand smoke? ☐ Yes ☐ No In the past 2 months, have you used any form of tobacco, including smoked, chewed, any type of nicotine delivery system (ENDS), and vaped?
4. ☐ Yes ☐ No In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks)?
5. ☐ Yes ☐ No In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?
6. ☐ Yes ☐ No Has anyone forced you to perform any sexual act that you did not want to do?
7. On a 1–5 scale, how do you rate your current stress level? Low 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ High
8. How many times have you moved in the past 12 months? _____
9. If you could change the timing of this pregnancy, would you want it ☐ earlier ☐ later ☐ not at all/NA

*Modified with permission from Florida's Healthy Start Prenatal Risk Screening Instrument. Florida Department of Health. DH 3134. September 1997.

_____
PATIENT SIGNATURE

_____
PRINT NAME

_____
DATE

Notes

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Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Height: _____ Weight: _____ Age of First Period: _____ Your Age When First Child Delivered (If applicable): _____ Age of Your Mother: _____

Are you Menopausal: _____ Have you ever used hormone replacement therapy? Please circle **Yes** or **No** If Yes, how long have you been it? _____

Has anyone in your family had genetic testing for hereditary cancer syndrome (Ex: BRCA or LYNCH)? Please circle **Yes** or **No** If Yes, what was the result? _____

Best Contact Phone Number(s): _____ Email: _____

Please mark below if there is a **personal or family history** of any of the following cancer and **indicate family relationship** and **their AGE at diagnosis** in the appropriate column. Consider parents, children, siblings, grandparents, aunts, uncles, and cousins.

Please Check			You (age at diagnosis)	Siblings/Children (Who + age at diagnosis) *Ex: Brother, 36 yrs*	Your Mother's side (Who + age at diagnosis) *Ex: Aunt, 44 yrs*	Your father's side (Who + age at diagnosis) *Ex: Grandpa, 65 yrs*
Y	**N**	Breast cancer				
Y	**N**	Breast cancer in both breasts or multiple primary breast cancers				
Y	**N**	Ovarian cancer				
Y	**N**	Male breast cancer				
Y	**N**	Are you of Ashkenazi Jewish descent				
Y	**N**	Uterine (endometrial) cancer (*NOTE: do not include cervical cancer*)				
Y	**N**	Colon cancer				
Y	**N**	Stomach, kidney/urinary tract, brain, or small bowel/intestinal cancer *(NOTE: Please circle or write appropriate cancer in column)*				
Y	**N**	10 or more colon polyps found in a lifetime				
Y	**N**	Prostate cancer				
Y	**N**	Pancreatic cancer (Col/BRCA)				
Y	**N**	Malignant melanoma				

Patient's Signature: _____ **Date:** _____

For Office Use Only

BRCA/Lynch/myRisk Testing Indicated? **Yes** **No**

Patient offered hereditary cancer testing? **Yes** **No** If YES: **ACCEPTED** **DECLINED:**_____

Follow-up appointment scheduled? **Yes** **No** Date of Appointment: _____

Provider Signature: _____ **Date:** _____

BRCA - Personal or Fam History

One person with (out to 2nd degree)

- Breast cancer at 45 or younger
- Ovarian cancer at any age
- Male breast cancer at any age
- Breast cancer + Jewish Heritage
- Bilateral Breast cancer at 50 or younger
- Triple negative breast cancer at any age
- Family history of known BRCA1 or BRCA2 mutations

BRCA - Personal or Fam History

Two persons with (out to 3rd degree)

- 2 breast cancers w/ 1 ≤ 50 yrs
- Breast & ovarian cancer (any age)

Three persons with (out to 3rd degree)

- Breast and/or Ovarian and/or Pancreatic (any age) and/or aggressive prostate cancer

Lynch Syndrome (Colon/Endometrial)

Personally affected with:

- Colon and/or Endometrial cancer at ≤ 50 yrs
- Family history of known Lynch mutations

Family History of Colon, Endometrial, or Lynch Cancers (out to 2nd degree) (ie. Gastric, ovarian, brain, kidney, small bowel)

- 1 or more Lynch cancers, 1 dx ≤ 50 yrs

WC AK Women's Care of Alaska
2741 DeBarr Rd, Suite C205 • Anchorage, Alaska 99508 • (907) 279-2273 • Fax (907) 258-7705

PROTECTED HEALTH INFORMATION (PHI) DISCLOSURE RECORD

PATIENT NAME: _____ **DOB: _____/_____/_____**
Month Day Year

AUTHORIZED METHODS OF COMMUNICATION
(√ Check all that apply)

☐ **RESIDENCE TELEPHONE**	☐ **CELL PHONE**	☐ **WORK TELEPHONE**
Number: _____	Number: _____	Number: _____
☐ Leave a call back number only. Do NOT leave a message	☐ Leave a call back number only; Do NOT leave a message	☐ Leave a call back number only; Do NOT leave a message
☐ OK to leave detailed message with person	☐ OK to leave detailed message with person	☐ OK to leave detailed message with person
☐ OK to leave detailed message on voicemail	☐ OK to leave detailed message on voicemail	☐ OK to leave detailed message on voicemail

Do you authorize us to speak with another individual, such as a spouse or other relative, regarding your PHI? If so, please indicate their name at the bottom of this form. Forms of PHI include, but are not limited to, the following examples:

(T) Treatment
Test results
Prescriptions/refills
Treatment Options

(P) Payment
Insurance questions/problems
Account balance/payment options

(O) Healthcare Operations Activities
Appointment reminder, Messages returned
Referral options/appointments, Records release
Messages that results are available

Name: _____/_____ (T) (P) (O) Circle all that apply
PLEASE PRINT (RELATION TO PATIENT)

Name: _____/_____ (T) (P) (O) Circle all that apply
PLEASE PRINT (RELATION TO PATIENT)

Name: _____/_____ (T) (P) (O) Circle all that apply
PLEASE PRINT (RELATION TO PATIENT)

Name: _____/_____ (T) (P) (O) Circle all that apply
PLEASE PRINT (RELATION TO PATIENT)

PATIENT SIGNATURE: _____ **DATE:_____/_____/_____**

2741 DeBarr Road, Suite C-205
Anchorage, Alaska 99508
(907) 279-2273 * fax (907) 258-7705

Effective Date: January 23, 2014

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. If you have any questions about this notice, please contact our Office Manager, Carolann Weir, at 279-4307.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use the disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological car you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved In Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we my use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transportation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be a result of criminal conduct; 5) about criminal conduct on our premises; and 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.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be necessary; 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copay. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Women's Care of Alaska, at the address listed on page one. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If you're protected health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your protected health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Women's Care of Alaska, at the address listed on page one.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of your Health Information for purposes other than treatment, payment and health care operations or for which you provid3ed written authorization. To request an accounting of disclosures, you must make your request, in writing to Women's Care of Alaska at the address listed on page one.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Women's Care of Alaska on

our Disclosure Form. We are not required to agree to your request unless you are asking us to restrict the use and dis closure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or, in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not to be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For Example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing to our office, at the address listed on page one. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please ask any of our receptionists to make you a copy.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Carolann Weir, Office Manager, at (907) 279-4307. All complaints must be made in writing. **You will not be penalized for filing a complaint.**