HEALTH HISTORY QUESTIONAIRE

**Welcome to our practice. Please fill this questionnaire as thoroughly as possible and bring it with you at the time of your appointment. Please remember to bring with you any pertinent insurance information. We look forward to seeing you.*

Full Legal Name: _____ Date: _____
The name by which you would like to be called: _____
Age: _____Date of birth: _____ Place of birth: _____
Cell Phone: _____ Occupation: _____
Who may we contact in case of an emergency? _____ Phone: _____
Please check your marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
State your partners name: _____ Partners DOB: _____
How did you hear about our practice? _____

OB-GYN HISTORY

Age of first period: _____ When did your last period start? _____ When did your previous period start? _____
Number of days between periods? _____ How long are your periods? _____
Do you have bleeding between periods? ☐ Yes ☐ No Bleeding since last period? ☐ Yes ☐ No
Have you recently had a positive pregnancy test? ☐ Yes ☐ No If Yes, when? _____ Where? _____
Have you ever been treated for infertility? ☐ Yes ☐ No If Yes, when and how? _____

Most recent birth control method? _____ Duration of use: _____
When did you last use contraception? _____

Date of last PAP smear? _____ Have you ever had an abnormal PAP smear? ☐ Yes ☐ No
If Yes, when? _____ What was the result? _____ How was it treated and by whom? _____
_____

Have you been instructed in performing a breast-self exam? ☐ Yes ☐ No
When was your last mammogram? _____ Where was it done? _____
Have you ever had abnormal mammogram results? _____

Total # of pregnancies including the present one, if pregnant: _____ # of deliveries before 37 weeks: _____ Miscarriages: _____
Terminations: _____ Tubal/Ectopic pregnancies: _____ Multiple births: _____ Stillbirths: _____ Living children: _____

List pregnancies in order including miscarriages, terminations, stillbirths and tubal/ectopics:

Date	Weeks	Length of labor	Sex: M/F Name	Delivery type	Epidural? Yes/No	Place of delivery and Provider's name	Preterm Labor? Yes/No	Complications? Diabetes or High Blood pressure?

Have you had any difficult vaginal deliveries? ☐ Yes ☐ No : _____
_____
Have you carried pregnancies with any birth defects? ☐ Yes ☐ No : _____
_____

Please check if you have had any of the following (include dates, if known):

☐ Diabetes/Gestational diabetes	☐ Cancer Type: Age:	☐ Ovarian cyst(s)	☐ Hypertension
☐ Kidney stones	☐ Anemia (low blood count)	☐ Heart murmur	☐ Mental health problems
☐ Sickle cell screening	☐ Irregular heartbeat	☐ Nausea/vomiting	☐ Negative blood type
☐ Chest pains	☐ Breast disease	☐ Asthma	☐ Shortness of breath
☐ More than 2 pregnancy losses	☐ Visual problems	☐ Heart surgery	☐ Hepatitis/liver disease
☐ Headaches	☐ Rheumatic fever	☐ Varicose veins	☐ Dental problems
☐ Mitral valve prolapse	☐ Thyroid disease	☐ Bowel problems	☐ Accidents/injuries
☐ Bladder/kidney infections	☐ Uterine fibroids	☐ Seizures	☐ Blood transfusions
☐ Gallbladder disease	☐ Removal of skin moles	☐ Phenylketonuria	☐ Hepatitis/liver disease

List members of your immediate family (parents and grandparents, aunts, uncles, brothers, sisters, children) with:

	Relative (sister, uncle, etc.)	Maternal side	Paternal side	Age at Diagnosis	Deceased from this disease? If yes, at what age?	Age Now
Breast Cancer						
Ovarian Cancer						
Uterine Cancer						
Colon Cancer						
Pancreatic Cancer						
Other Cancer (include type)						
Bleeding Disorder						
Tuberculosis						
Birth Defects						
Diabetes						
Heart Disease						
Neurological Disorder						
Glaucoma						
Sickle Cell						
Muscular Dystrophy						
Huntington Disease						
Mental Retardation						
Ashkenazi (Eastern European Jewish)						
Cystic Fibrosis						
Other						

Allergies to medications? ☐ Yes ☐ No; if yes, medication name(s) and reaction(s): _____

_____

Allergy to latex? ☐ Yes ☐ No

Any allergies to adhesives or soaps such as Betadine or Iodine? ☐ Yes ☐ No

Which prescription medications are you taking normally and their dosages?

Date started	Medication & Dose	Directions	Reason for Taking	Prescribed by

List any medications taken since your last period not included above

Date started	Medication & Dose	Directions	Reason for Taking	Prescribed by

List all non-prescription drugs, herbs or supplements

Date started	Medication & Dose	Directions	Reason for Taking	Prescribed by

Have you had a rash, viral illness, or fever since your last period? ☐ Yes ☐ No

Please check if you have had any of the following (include date and treatment, if known):

☐ Hepatitis	☐ Gonorrhea	☐ Chlamydia	☐ Polio	☐ Herpes simplex	☐ HIV
☐ Syphilis	☐ Venereal warts	☐ German measles	☐ Tuberculosis	☐ MRSA	☐ Zika

Have you been immunized for the following (include date of immunization, if known)?
☐ COVID-19 _____ COVID booster? _____ ☐ HPV _____
☐ Hepatitis B _____ ☐ Rubella (MMR) _____ ☐ Tetanus and Pertussis (Tdap) _____ ☐ Tuberculosis _____

When was your last tuberculosis test? _____ What was the result? _____

List any operations, date they were done, why they were done, and any complications: _____
_____
Have you had any problems after having anesthesia for surgery? ☐ Yes ☐ No

Have you been exposed to any x-rays since your last period? ☐ Yes ☐ No
Do you work with farm animals, have cats as pets, or eat raw or uncooked meat of any kind? ☐ Yes ☐ No

How many times each week do you exercise? _____ What types of exercise do you do? _____
Do you use a hot tub or sauna? ☐ Yes ☐ No

Do you currently smoke? ☐ Yes ☐ No How many cigarettes per day do you smoke? _____ How many years? _____
Are you a former smoker? ☐ Yes ☐ No If Yes, # of cigarettes per day?____ # of years? _____ Date you quit? _____

Do you drink alcohol? ☐ Yes ☐ No If Yes, how often? ☐ monthly or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more

Have you used drugs other than those for medical reasons in the past 12 months? ☐ Yes ☐ No : _____
Do you use marijuana? ☐ Yes ☐ No; if yes, how often? _____

Caffeine intake? ☐ Yes ☐ No; how many cups per day? _____

How much weight have you gained or lost in the last year? _____

To which countries do you travel? _____

Do you have any physical limitations or needs? _____
Are you currently under the care of any other physicians? ☐ Yes ☐ No :_____

Are there any issues you wish to discuss not previously mentioned?
_____
**Thank you for your patience filling out this questionnaire. The information will be kept in the strictest confidence.*

Center for Midwifery and Women's Health

PATIENT INFORMATION

Personal Information*

Prefix: Mr./Mrs./Other:_____ Patient*:_____ Suffix: Jr./Sr./Other: _____
(Last / First / Middle Initial)

Previous Name:_____ Preferred Name: _____

Mailing Address*: _____
(Street Address / City / State / Zip)

Home #:_____ Cell #:_____ Work #:_____ Ext: _____

Method of Contact for Appointment Reminders: ☐ Text Message ☐ Home Phone ☐ Cell Phone

Primary Care Provider (PCP):_____ Address:_____ Phone #: _____
(First / Last)

Referring Provider:_____ Address:_____ Phone #: _____
(First / Last)

Date of Birth*:_____ Sex*:_____ Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
(mm/dd/yyyy)

Social Security #:_____-_____-_____ Employer Name:_____ Occupation:_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ N/A

Additional Information*

Email: _____

Race*: ☐ Caucasian/White ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Other: _____

Ethnicity*: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other: _____

Language*: ☐ English ☐ Spanish ☐ Other: _____

Pharmacy Name*:_____ Address:_____ Phone #:
(Street Address / City / State / Zip)

Emergency Contact*

Name:_____ Relationship: _____
(Last / First)

Address: _____
(Street Address / City / State / Zip)

Home #:_____ Work #:_____ Cell #: _____

Parent / Guardian Information* - Required if the patient is under 18 years of age

Name:_____ Date of Birth:_____ Sex:_____ Social Security #:_____-_____- _____
(Last / First / mm/dd/yyyy)

Address: _____
(Street Address / City / State / Zip)

Home #:_____ Cell #:_____ Work #:_____ Ext: _____

Primary Insurance Information*

Insurance Name:_____ Member ID #:_____ Relationship to Insured:_____

Employer:_____ Group #:_____ Effective Date: _____
(mm/dd/yyyy)

Insured's Information* - (if not self)

Name:_____ Date of Birth:_____ Sex:_____ Social Security #:_____-_____- _____
(Last / First / mm/dd/yyyy)

Relationship to Insured:_____ Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address: _____
(Street Address / City / State / Zip)

Home #:_____ Work #:_____ Cell #: _____

Secondary Insurance Information

Insurance Name:_____ Member ID #:_____ Relationship to Insured:_____ Group #:_____ Effective Date: _____

Secondary Insured's Information - (if not self)

Name:_____ Date of Birth:_____ Sex:_____ Social Security #:_____-_____- _____
(Last / First / mm/dd/yyyy)

Relationship to Insured:_____ Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address: _____
(Street Address / City / State / Zip)

Home #:_____ Work #:_____ Cell #: _____

CONSENT INFORMATION

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC or any of its affiliates. I also authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration. **X_____ (Please initial)**

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

If any LMG health professional, worker or employee should be directly exposed to your blood or your body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1- 45.1(A), you are deemed to have consented to the release of the test results to the person exposed. **X_____ (Please initial)**

If you should be directly exposed to blood or body fluids of a LMG health care professional, worker or employee in a way that may transit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test. **X_____(Please initial)**

MEDICATION HISTORY CONSENT

I give permission for Loudoun Medical Group to access my pharmacy benefits data electronically through RXHub/SureScript. This consent will enable Loudoun Medical Group to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan. Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.
- Also, this is notice that Loudoun Medical Group has consent to utilize the Virginia Prescription Monitoring Program on
- all patients prescribed controlled substances.
- In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RXHub and Virginia Prescription Monitoring Program. **X_____(Please initial)**

_____ _____

Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis Date

_____

Relationship (if any)

Center for Midwifery and Women's Health

24430 Stone Springs Blvd. • Suite 550 • Dulles • VA • 20166
Ph: (571) 209-1800
Fax: (703) 665-2374

Telephone Communications

Patient Name: _____

Date of Birth: _____

I wish to be contact in the following manner (please check all that apply):

HOME Phone #: _____

_____ OK to leave a detailed message on home answering machine (this includes test results, pre-op info, follow-up info, etc.)

_____ Leave message with call back number only

_____ Do not call my home phone

CELL Phone #: _____

_____ OK to leave a detailed message

_____ Leave message with call back number only

_____ Do not call my cell phone

WORK Phone #: _____

_____ OK to leave a detailed message

_____ Leave message with call back number only

_____ Do not call my work phone

Check the best method to contact you: ☐ Home ☐ Cell ☐ Work

I understand that I may change my methods of contact any time by written consent only.

Patient Signature: _____ Date: _____

Center for Midwifery and Women's Health

24430 Stone Springs Blvd. • Suite 550 • Dulles • VA • 20166
Ph: (571) 209-1800
Fax: (703) 665-2374

Permission to Disclose Information

I, _____, acknowledge that I was made aware of Center for Midwifery & Women's Health/Loudoun Medical Group's Privacy Policy and a copy was made available to me for my review.

I authorize Center for Midwifery & Women's Health to disclose my protected health information to the following person(s) and entities:

Name	Date of Birth	Relationship to You

Printed Patient Name: _____ Date: _____

Patient Signature: _____

Printed Name of Personal Representative: _____

Relationship to Patient: _____

24430 Stone Springs Blvd, Suite 550
Dulles, VA 20166
Phone (703) 957-1245
FAX (703) 665-2374

Authorization for Release of Medical Information

to Center for Midwifery & Women's Health

Print Patient Full Name _____ Date of Birth _____

Address _____ Social Security Number _____

City / State / Zip _____ Phone Number (Best number to reach you) Home / Cell _____

INFORMATION RELEASE FROM:

PRACTICE / PRACTITIONER _____ ***FAX NUMBER (required)*** _____

RELEASE TO: Center for Midwifery & Women's Health - 24430 Stone Springs Blvd, STE 550, Dulles, VA 20166
FAX: (703) 665-2374 or ContactCFM@lmgdoctors.com

At the request of the individual, I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. *

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

Signature of individual or guardian or Personal Representative of patient's estate _____ Date _____

OFFICE USE ONLY

RECORDS REQUESTED:

_____ Discharge Summary	_____ Pathology Reports	_____ Emergency Reports
_____ History & Physical	_____ Laboratory Reports	_____ OB Records
_____ Progress Notes	_____ Radiology Reports	_____ Sonogram Reports
_____ Operative Notes	_____ ECG/EEG/Cardiac Cath	_____ Other _____

PURPOSE OF DISCLOSURE:

_____ Referral to Specialist	_____ Insurance	_____ Workers Comp	_____ Change of Doctor/Provider
_____ Legal Investigation	_____ Disability Determination	_____ Personal	_____ Continuing Care
_____ Other (please specify)			

LOUDOUN MEDICAL GROUP
Receipt of Notice of Privacy Practices Acknowledgement

_____
Patient's Name

I have a received a copy of Loudoun Medical Group's Notice of Privacy Practices and understand that the notice describes how my/the patient's medical information may be used and how access to this information may be obtained. I have also been given an opportunity to ask questions about the information provided in the Notice.

_____
Signature

Date:_____

_____
Relationship to Patient (if Acknowledgement Form is executed by someone other than the Patient)

FOR OFFICE USE ONLY

I attempted to obtain the patient's/representative's signature in acknowledgement of this Receipt of Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Staff Initials	Reason
		Refused to sign (circle if applicable) **Other:**

LOUDOUN MEDICAL GROUP PC
NOTICE OF PATIENT PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions or comments about this Notice please contact:

Loudoun Medical Group, PC
224-D Cornwall St. N.W., Suite 403
Leesburg, VA 20176

Our Privacy Officer is: Clara McAuley Nussbaum, Director of Compliance, 703-737-6010

Who Does this Notice Apply to?

Loudoun Medical Group, PC ("LMG"), has published this Notice. It applies to everyone who works for Loudoun Medical Group, PC, including our employees, contractors, and volunteers.

Why Do We Publish this Notice?

LMG understands that information about you and your health is sensitive and personal. We are required by law to maintain the privacy of information we gather and use about our patients, and provide them with notices of our legal duties and privacy practices with respect to their information. We are also required to notify affected individuals of any breach of unsecured protected health information.

While we are committed to the privacy of our patients' information, in order to serve them we need to gather, keep and use records of this information. We sometimes also need to share information with other parties. This Notice is intended to let you know how we use and disclose your information.

This Notice is also to let you know about certain legal rights you have with respect to the information we hold about you. You have certain rights to review and obtain a copy of our records of information about you. You may also request that we amend these records, and may ask us to account for certain disclosures we may have made of information about you. Requests for amendments and requests for accountings must be made in writing and directed to the Privacy Officer.

When Is This Notice Effective?

We are required to comply with the terms of this Notice while it is in effect. We reserve the right to change the terms of this Notice, and make the new terms effective for all information to which this Notice applies. This Notice will be in effect from _____ until the date we publish an amended Notice. If we do publish an amended Notice, we will notify you at your next visit. We will also publish the amended Notice in our offices, and will publish it on our web site if we maintain one.

What Information Does this Notice Cover?

This Notice covers all information in our written or electronic records which concerns you, your health care, and payment for your health care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing care, or manage some of our administrative operations.

When Can We Use or Disclose Information About You?

- ***Treatment***. We may use or disclose information about you for treatment purposes to doctors, nurses, technicians, medical students or other individuals who work in our practice who are involved in providing you with health care. We may also disclose information about you to organizations and individuals involved in your care who are outside of our practice, such as consulting physicians, laboratories, social workers, and so on.

  For example, if we refer you to another physician or a hospital for specialty services, we will provide that physician or hospital with all clinical information, which might be necessary or helpful to help them provide you with the right care. Or, if we need to send a sample of your blood to a laboratory for analysis, we will provide the laboratory with the information they need to process your blood correctly.
  These are only examples, and we may use or disclose information about you to provide you proper treatment in many other ways.

- ***Payment***. We may use or disclose information about you for payment purposes to our clerks and officers involved in billing and claims payment. We may also disclose such information to your health plan or other party financially responsible for your care, or to claims and billing services if necessary.

  For example, if you are covered by a health plan we cannot get paid for the services we provide you unless we submit information in a claim. This might include detailed clinical information, depending on the kind of plan and claim. This is only an example, and there may be many other ways in which we may use or disclose information about you in

connection with payment for your care.

- ***Health care operations***. We may use or disclose information about you for operations in connection with our practice. These activities might include practice quality improvement, training of medical students, insurance underwriting, medical or legal review, and business planning or administration of our practice.

  For example, we may wish to review the quality of care you receive, in order to help us deliver the best care we can. Or, we may audit our management practices so we can become more efficient. These are only examples, and we may use or disclose information about you for health care operations in many other ways.

We may also use and disclose information about you in the following situations, without your prior authorization:

- To a public health agency, for purposes such as controlling disease.
- In case of suspected child abuse, to the appropriate governmental authority.
- In other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if you are incapacitated or it appears necessary to prevent serious harm to you or others.
- Unless you object, to friends or family members who are involved in your medical care.
- Unless you object, to notify, or to assist in notifying, a family member or friend of your location or condition.
- To health oversight authorities, for regulatory, licensing and other legal purposes.
- In litigation and legal proceedings, subject to certain requirements controlling the terms of the disclosure.
- To law enforcement agencies, subject to applicable legal requirements and limitations.
- We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.
- To Funeral Directors/Medical Examiners/Coroners in the event of your death.
- When required by Federal, State or Local law.
- For medical research purposes, subject to your authorization or approval by an institutional review board or privacy board.
- If you are in the United States military, national security or intelligence, Foreign Service, to your authorized superiors or other authorized federal officials.

We may contact you for information to support your health care, including appointment reminders, information about alternative treatments, and health-related services, which may be of interest to you. We will routinely contact patients via telephone at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appoint-ments. *Please advise us if you do not wish to receive such communications*, and we will not use or disclose your information for such purposes. If you wish not to receive this kind of communication, you must advise the Privacy Officer in writing at the address given above.

Most uses and disclosures of psychotherapy notes and most uses and disclosures of your information for marketing purposes will require your written authorization. Further, LMG would typically be required to obtain your written authorization in order to sell your information. Except for uses and disclosures described in this notice, we may not use or disclose information about you for any other purpose without your written authorization.

What Legal Rights Do You Have In Connection With Your Information?

- Right to Inspect and Copy. You have the right to inspect or obtain copies of your medical information. To inspect and copy medical information, you must submit your request in writing to the Privacy Officer at the address set forth above. If you request a copy of the information, there will be a charge based on our costs.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed by another licensed health care professional. We will comply with the outcome of the review.

- Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information.

  To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address set forth above. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support

the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for LMG;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

You will be informed of the decision regarding any request for amendment of your medical information and, if we deny your request for amendment, we will provide you with information regarding your right to respond to that decision.

- Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures we have made of your medical information. The accounting of disclosures typically would not list disclosures we made of medical information about you that were made for purposes of treatment, payment, or health care operations and that were made in response to a specific authorization from you.

  To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address set forth above. Your request must state a time period for which you want the accounting (which may not be longer than six years prior to the request).

- Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to a requested restriction, unless (i) you are requesting that we not disclose information to a health plan for payment or health care operations of the health plan, and (ii) the information pertains solely to an item or service for which you or someone other than the health plan has already paid in full. If we do agree to a requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment. Additionally, even when we do not agree to a requested restriction, health information about you may only be disclosed to family or friends if, in the exercise of professional judgment, we believe it is in your best interest to have such information disclosed. However, under such circumstances, where practical, you will be given the opportunity to object to any such disclosure.

  To request restrictions, you must make your request in writing to the Privacy Officer at the address set forth above.

- 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 at work or by mail.

  To request confidential communications, you must make your request in writing to the Privacy Officer at the address set forth above. Your request must specify how or where you wish to be contacted.

- 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.

- Complaints. If you believe your privacy rights have been violated, you may file a complaint with LMG or with the Secretary of the Department of Health and Human Services. To file a complaint with LMG, contact the Privacy Officer at the phone number or address set forth above. All complaints to the Department of Health and Human Services must be submitted in writing. We will not retaliate against you for filing a complaint.