

Confidential Client Registration Information
Informacion Confidencial del Cliente

Please print clearly and fill out all information that applies. *Por favor escriba claramente y llene toda la información apropiada.*

Last Name <i>Apellido</i>	First Name <i>Nombre</i>	Middle Initial <i>Segundo Nombre</i>
<p>A mailing address and telephone number are required in the event we need to contact you for billing or lab results. Requerimos un telefono y direccion donde le podamos escribir o llamar para sus resultados o informacion de sus pagos.</p>		
Mailing Address <i>Dirección</i>		
City <i>Ciudad</i>	State <i>Estado</i>	Zip Code <i>Código Postal</i>
Where do you prefer to be called? <i>Dónde usted prefiere ser llamado?</i>		County
First Phone Number <i>Primer Número De Teléfono</i>		Second Phone Number <i>Segundo Número De Teléfono</i>
Date of Birth <i>Fecha de Nacimiento</i>		Social Security # <i>Número de Seguro Social</i>
Sex <i>Sexo</i>	<input type="checkbox"/> Female <i>Femenino</i>	<input type="checkbox"/> Male <i>Masculino</i>
Current Method of Birth Control		
Marital Status (1) <input type="checkbox"/> Single <i>Es Usted Soltero</i> (2) <input type="checkbox"/> Married <i>Casado</i> (6) <input type="checkbox"/> Legally Separated <i>Legalmente Separado</i> (5) <input type="checkbox"/> Divorced <i>Divorciado</i> (4) <input type="checkbox"/> Widowed <i>Viudo</i> (7) <input type="checkbox"/> Long Term Partner <i>Acompañado</i>		
Emergency Contact Name <i>En caso de emergencia, llamar a</i>		Contact phone <i>Número del contacto</i>

Spanish/Hispanic/Latino Origin? <i>Hispano/Origen Latino?</i>	(1) <input type="checkbox"/> No <i>No</i>	(2) <input type="checkbox"/> Yes, Mexican, Mexican Am., Chicano <i>Sí, Mejicano, Mejicano Amer., Chicano</i>	(3) <input type="checkbox"/> Yes, Puerto Rican <i>Sí, Puerto Riqueño</i>
	(4) <input type="checkbox"/> Yes, Cuban <i>Sí, Cubano</i>	(5) <input type="checkbox"/> Yes, Other Spanish/Hispanic/Latino <i>Sí, Otro origen Hispano o Latino</i>	

Please also check one of the choices below / Por favor tambien marque una de las opciones de abajo:

Race <i>Raza</i>	(01) <input type="checkbox"/> White <i>Blanco</i>	(02) <input type="checkbox"/> Black/African American <i>Moreno</i>	(03) <input type="checkbox"/> American Indian or Alaskan Native <i>Indígena de las Americas o Alaska</i>	(04) <input type="checkbox"/> Asian <i>Asiático</i>
	(05) <input type="checkbox"/> Native Hawaiian/Pacific Islander	(06) <input type="checkbox"/> Multiracial	(90) <input type="checkbox"/> Other Spanish/Hispanic/Latino	(98) <input type="checkbox"/> Other

Weekly Household Income <i>Ingreso mensual familiar</i>	Number of persons supported by this income <i>Número de personas que dependen de este ingreso incluyendose Ud.</i>
Do you have: <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> No insurance <i>Tiene Usted: Seguro Privado Medicaid No asegurado</i>	

Referral Source <i>Cómo se enteró de nuestra clinica?</i>	(1) <input type="checkbox"/> Friend/Relative <i>Amigo/Familiar</i>	(2) <input type="checkbox"/> Another Planned Parenthood <i>Otro Planned Parenthood</i>	(3) <input type="checkbox"/> Doctor/Clinic <i>Doctor/Clinica</i>	(4) <input type="checkbox"/> Yellow Pages <i>Paginas amarillas</i>
	(5) <input type="checkbox"/> Internet <i>Internet</i>	(6) <input type="checkbox"/> TV	(7) <input type="checkbox"/> Radio	(8) <input type="checkbox"/> Newspaper <i>periódico</i>
			(9) <input type="checkbox"/> PPGO Community Education <i>PPGO Propaganda de Educacion</i>	

I accept full financial responsibility for medical services provided to me. I understand that payment is due at the time of service unless valid insurance is presented prior to receiving medical services.
Acepto responsabilidad financiera repleta para servicios médicos proporcionados a mí. Entiendo que ese pago es debido en el tiempo del servicio a menos que el seguro válido se presente antes de servicios médicos recipientes.

Signature Today's Date
Firma Fecha de Hoy

Patient Label

Patient Label

Insurance Declaration

CHOOSE ONE:

<p><input type="checkbox"/> I am NOT using insurance. I will be responsible for full payment today for this visit.</p> <p><i>If PPGO has NO contract</i> with my insurance company I will be responsible for payment in full and I will be given a receipt to send to my insurance company for reimbursement.</p> <p>_____ I understand that I will NOT be able to submit a claim directly to my insurance carrier if PPGO has a contract with my insurance carrier</p>
<p><input type="checkbox"/> I AM using insurance. I understand that payment is due at the time of service unless valid insurance is <i>presented and authorized prior</i> to receiving medical services during today's visit.</p> <p>I have insurance with _____</p> <ul style="list-style-type: none">• I have another secondary insurance plan that am using and my insurance is _____ <p><i>If PPGO has a contract</i> with my insurance company, the insurance will be directly billed for this visit. I am responsible for any <i>co-payment, deductible, or co-insurance</i> payments required by my insurance company <i>and for any services and supplies not billable to my insurance company</i>.</p> <ul style="list-style-type: none">• Your insurance coverage may not pay for our recommended laboratory tests. Patient may be responsible for payment to the laboratory.

PATIENT NAME AND SIGNATURE REQUIRED

Print Patient Name

Patient Signature Date

Name _____
Last Name M.I.

Today's Date _____
Birthdate _____
Age _____

Personal Medical History

Have you ever had any of the following conditions?

Please check all that apply

- Stroke Yes No
- Heart Attack Yes No
- High Blood Pressure Yes No
- Headaches Yes No
- Eye Problems Yes No
- Dizziness/Fainting Yes No
- Anemia Yes No
- Blood Clotting Disorder Yes No
- Blood transfusion or exposure to blood products Yes No
- Varicose Veins/Inflamed Veins (Thrombophlebitis / Blood clots) Yes No
- High Blood Fat (Cholesterol / Triglycerides) Yes No
- Heart Problems (Murmurs, Rheumatic Fever/Valve, etc.) Yes No
- Kidney Disease Yes No
- Chronic Bladder Infection Yes No
- Sexually Transmitted Infections (herpes, gonorrhea, syphilis, condyloma, chlamydia, hepatitis B) Yes No
- Have you ever been diagnosed with HIV? Yes No
- Cancer Yes No
Type: _____
- Liver Problems (Mononucleosis / Hepatitis) Yes No
- Gastrointestinal Problems Yes No
- Lung Problems (shortness of breath, asthma, tuberculosis) Yes No
- Positive Tuberculosis Test Yes No
- Gall Bladder Problems (stone or removal) Yes No
- Sensory difficulties (ie: numbness) Yes No
- Diabetes/Sugar in Urine Yes No
- Epilepsy/Seizures Yes No
- Genetic Abnormalities Yes No
Kind: _____
- Thyroid Problems Yes No
- Substance Abuse Yes No
Type: _____

- Depression/suicidal thoughts Yes No
- Sickle Cell Disease/Trait Yes No
- Leg, Chest, Arm or Abdominal Pain Yes No
- Do you need to update your immunizations? Yes No
- Tetanus Yes No
- TB Yes No
- Rubella Yes No
- Flu Yes No
- Hepatitis Yes No
- Mumps Yes No
- I was adopted Yes No
- Smoke Yes No
Pack per Day _____
- Did your mother take DES (drug to prevent miscarriage) during her pregnancy with you? Yes No
- Are you receiving treatment from another source of medical care at this time? Yes No
- Who? _____
- Date of visit: _____
- Reason for treatment: _____
- Major Surgeries: _____
- Hospitalization: _____
- Allergies: Drug/skin _____
- Current Medication: _____
- Year of last physical exam _____
- Was everything normal? Yes No
- Any other significant medical/health information?

- Are there any areas of health or well being you would like to discuss?

Family Medical

Mother, Father, Brother, Sister

- Stroke Yes No
- Heart Attack Yes No
- What Age: _____
- High Blood Pressure Yes No
- Cancer Yes No
- Type: _____
- Diabetes Yes No
- Sickle Cell Disease/Trait Yes No
- High Blood Fats (Cholesterol / Triglycerides) Yes No

Reproductive History

- Do you examine your testicles regularly? Yes No
- Have you ever had sores, lumps, or growths on your penis or testicles or scrotum? Yes No
- Do you have a discharge from your penis? Yes No
- Have you ever had an infection, injury, or surgery on your penis, testicles, or scrotum? Yes No
- Do you have any unusual genital itching? Yes No
- Do you have any pain, bleeding or other problems with intercourse or ejaculations? Yes No

MEDICAL HISTORY CHANGES / NOTES

MEDICAL HISTORY CHANGES / NOTES

Sexual History

Age of first intercourse? _____
Estimated number of current partners: _____
Lifetime _____ last 12 months _____
New partners in the past three months _____

Partners have been:

- female male both

Current pattern of sexual activity:

- vaginal anal oral
- outercourse none

Has anyone ever forced you to have sex?

- Yes No

Problems with sex relations?

Contraceptive History

Please check all birth control methods
you or your partner have used:

- Abstinence
- Condoms
- Foam, Cream, Insert
- Fertility Awareness
- Withdrawal
- Sponge
- IUD
- Pills
- Patch (Evra)
- Depo Provera
- Vaginal Ring
- Sterilization
- Diaphragm
- Other

Kind: _____

- None

What birth control method are you currently
using? _____

Do you wish to continue your current
method? _____

Social History

Number of children: _____

Ages: _____

Social History:

Occupational hazards or environmental toxin exposure? Yes No

Have you ever been hit, slapped, kicked or otherwise hurt by someone? Yes No

Has anyone ever forced you to have sex? Yes No

Partner history: uses injectable drugs Yes No

has multiple partners Yes No

bisexual Yes No

For Minor Patients Only (age 17 or less)

Patients age of 17 or less are encouraged to involve parents in the decision making
regarding sexual activity and contraceptive use.

History Review Certification:

I hereby certify that I have reviewed and updated my medical, family, contraceptive histories and
that they are correct to the best of my knowledge. I understand that any deletions or
misrepresentation of said histories may have an adverse effect upon my health and agree to
release Planned Parenthood of Greater Orlando, Inc. of any and all liability resulting from any
and all adverse consequences to my health due to such deletions or misrepresentation.

Client Signature Date

Staff Signature Date

Clinician Signature Date

Client Signature Date

Staff Signature Date

Clinician Signature Date

Client Signature Date

Staff Signature Date

Clinician Signature Date

**REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES**

DATE _____ PATIENT # _____

NAME OF PATIENT _____

DATE OF BIRTH _____ TELEPHONE # _____

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Planned Parenthood may need to refer me to another health care facility to provide the services necessary for my care.

I have been given information about the test(s), treatment(s), procedure(s), and contraceptive method(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Planned Parenthood.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in Planned Parenthood of Greater Orlando, Inc *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.

I hereby request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

I hereby acknowledge receipt of Planned Parenthood of Greater Orlando, Inc. notice of health information privacy practices.

Signature of patient _____

Date _____

I witness the fact that the patient received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.

Signature of witness _____

Date _____

	CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW
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Signature of any other person consenting _____

Relationship to patient _____

Date _____

I witness the fact that the patient's legal guardian (or person consenting in her behalf) received the above mentioned information and said she read and understood same.

Signature of witness _____

Date _____

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT
YOU MAY BE USED OR DISCLOSED BY PP OF ORLANDO, INC. AND
HOW TO ACCESS THIS INFORMATION**

Effective Date of This Notice: October 30, 2009

PLEASE REVIEW THIS NOTICE CAREFULLY

If you have any questions about this notice, please contact PP of Greater Orlando, Inc.'s Privacy Official at 407-246-1788.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

We understand that health information about you and your healthcare is personal. We are committed to protecting health information about you. We will create a record of the care and services you receive from us. We do so to provide you with quality care and to comply with any legal or regulatory requirements.

This Notice applies to all of the records generated or received by PP of Greater Orlando, Inc., whether we documented the health information, or another doctor forwarded it to us. This Notice will tell you the ways in which we may use or disclose health information about you. This Notice also describes your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

Our pledge regarding your health information is backed-up by Federal law. The privacy and security provisions of the Health Insurance Portability and Accountability Act ("HIPAA") require us to:

- Make sure that health information that identifies you is kept private;
- Make available this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we may use or disclose health information about you. Unless otherwise noted each of these uses and disclosures may be made without your permission. For each category of use or disclosure, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, unless we ask for a separate authorization, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use health information about you to provide you with healthcare treatment and services. We may disclose health information about you to doctors, nurses, technicians, health students, volunteers or other personnel who are involved in taking care of you. They may work at our offices, at a hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other healthcare provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, to have prescriptions filled, or for other treatment purposes. For example, a doctor treating you may need to know if you have diabetes because diabetes may slow the healing process. We may provide that information to a physician treating you at another institution.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, a state Medicaid agency or a third party. For example, we may need to give your health insurance plan information about your office visit so your health plan will pay us or reimburse you for the visit. Alternatively, we may need to give your health information to the state Medicaid agency so that we may be reimbursed for providing services to you. In some instances, we may need to tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Healthcare Operations: We may use and disclose health information about you for operations of our healthcare practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study healthcare delivery without learning who our specific patients are.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment. Please let us know if you do not wish to have us contact you concerning your appointment, or if you wish to have us use a different telephone number or address to contact you for this purpose.

Fundraising Activities: We may use health information about you to contact you in an effort to raise money for our not-for-profit operations. Please let us know if you do not want us to contact you for such fundraising efforts.

Research. There may be situations where we want to use and disclose health information about you for research purposes. For example, a research project may involve comparing the efficacy of one medication over another. For any research project that uses your health information, we will either obtain an authorization from you or ask an Institutional Review or Privacy Board to waive the requirement to obtain authorization. A waiver of authorization will be based upon assurances from a review board that the researchers will adequately protect your health information.

As Required By Law. We will disclose health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans. If you are a member of the armed forces or are separated/ discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose health information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify 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.

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

Law Enforcement. We may release health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- If you are the victim of a crime and we are unable to obtain your consent;
- About a death we believe may be the result of criminal conduct;
- In an instance of criminal conduct at our facility; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Such releases of information will be made only after efforts have been made to tell you about the request and you have time to obtain an order protecting the information requested.

Coroners, Health Examiners and Funeral Directors. We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have certain rights to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records. This does not include psychotherapy notes.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing on a form provided by us to: “The Privacy Official at PP of Greater Orlando, Inc.” If you request a copy of your health information, we may charge a fee for the costs of locating, copying, mailing or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may in certain instances request that the denial be reviewed. Another licensed healthcare professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your initial request. We will comply with the outcome of the review.

Right to Amend. If you feel that health 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 on a form provided by us and submitted to: “The Privacy Official at PP of Greater Orlando, Inc.”

We may deny your request for an amendment if it is not the form provided by us and 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 health information kept by or for our practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures. You have the right to request a list (accounting) of any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list of disclosures, you must submit your request on a form that we will provide to you. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003 [The compliance date of the Privacy Regulation]. The first list of disclosures you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date should not exceed a total of 60 days from the date you made the request.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health 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 health information we disclose about you to someone who is involved in your care or the payment for your care. For example, you could ask that access to your health information be denied to a particular member of our workforce who is known to you personally.

While we will try to accommodate your request for restrictions, we are not required to do so if it is not feasible for us to ensure our compliance with law or we believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request on a form that we will provide you. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain manner or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box. During our intake process, we will ask you how you wish to receive communications about your health care or for any other instructions on notifying you about your health information. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice at any time upon request. You may also obtain a copy of this Notice at our website www.pppo.org

Right to Receive Notice of a Breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

- a brief description of the breach, including the date of the breach and the date of its discovery, if known;
- a description of the type of Unsecured Protected Health Information involved in the breach;
- steps you should take to protect yourself from potential harm resulting from the breach;
- a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
- contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional information.

In the event the breach involves 10 or more patients whose contact information is insufficient or out of date we will post a notice of the breach on the home page of our Web site or in a major print or broadcast media. If the breach involves more than 500 patients in a state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to notify the Secretary of the U.S. Department of Health and Human Services. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

MINORS AND PERSONS WITH GUARDIANS

Minors have all the rights outlined in this Notice with respect to health information relating to reproductive healthcare, except for abortion and in emergency situations or when the law requires reporting of abuse and neglect. In the case of abortion, under Florida law, if you are under 18 and plan to have an abortion, at least one parent must be notified. Therefore, the parent has all the rights outlined in this Notice, including the right to access the health information relating to abortion. However, if you obtain a judicial bypass of the notification requirement, you have the same rights as an adult with respect to health information relating to your abortion. If you are a minor or a person with a guardian obtaining healthcare that is not related to reproductive health, your parent or legal guardian may have the right to access your medical record and make certain decisions regarding the uses and disclosures of your health information.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in our facility and on our website. The Notice contains the effective date on the first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact: "The Privacy Official at Planned Parenthood Greater Orlando, Inc." All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain the records of the care that we provided to you.