Patient Name: _____ Patient DOB: _____

After completing the form, click the 'Save Form' button to save the form to your computer. If using Google Chrome, right-click the form and select 'Save As...' Send the form in an email to the following address: medicalrecords@ganephrology.com.

Print Form

Save Form

Reset Form

MEDICAL HISTORY

Please mark YES or NO and fill in appropriate blanks as needed

Kidney Disease

Chronic Kidney Disease Yes ☐ No ☐

If yes, year diagnosed _____

Previous Nephrologist _____

Transplant Yes ☐ No ☐

If yes, date _____

Donor type Living ☐ Deceased ☐

Related ☐ Unrelated ☐

Frequent Infections Yes ☐ No ☐

Polycystic Kidney Disease Yes ☐ No ☐

Any other kidney history we should know?

Diabetes

Do you have Diabetes? Yes ☐ No ☐

If yes, type? Type 1 ☐ Type 2 ☐

Medication taken Insulin ☐ Oral ☐ Both ☐

Last HgbA1C _____

Who manages your diabetes? _____

High Blood Pressure

High blood pressure? Yes ☐ No ☐

If yes, year diagnosed? _____

Monitored at home? _____

Average reading? _____ / _____

Who manages BP? _____

EENT

Blindness Yes ☐ No ☐ Hearing Problems Yes ☐ No ☐

Cataracts Yes ☐ No ☐ Glaucoma Yes ☐ No ☐

Patient Name: _____ Patient DOB: _____

Heart

Heart Disease	Yes ☐	No ☐		AICD	Yes ☐	No ☐	
Atrial Fibrillation	Yes ☐	No ☐		Valvular Disease	Yes ☐	No ☐	
Pacemaker	Yes ☐	No ☐		Congestive Failure	Yes ☐	No ☐	
High Cholesterol	Yes ☐	No ☐		Mitral Valve Prolapse	Yes ☐	No ☐	
Irregular Heartbeat	Yes ☐	No ☐		Murmur	Yes ☐	No ☐	

If yes to any, who manages your heart disease? _____

Have you ever had cardiac surgery? Yes ☐ No ☐

Respiratory

COPD	Yes ☐	No ☐		Pneumonia	Yes ☐	No ☐	
Chronic Bronchitis	Yes ☐	No ☐		Tuberculosis	Yes ☐	No ☐	
Asthma	Yes ☐	No ☐		Sleep Apnea	Yes ☐	No ☐	
Emphysema	Yes ☐	No ☐		Pulmonary Hypertension	Yes ☐	No ☐	

Do you use a C-PAP? Yes ☐ No ☐

Do you wear chronic oxygen? Yes ☐ No ☐

Do you see a lung doctor? Yes ☐ No ☐

If so, who? _____

Gastrointestinal (GI)

GERD			Yes ☐	No ☐			
Inflammatory Bowel Disease			Yes ☐	No ☐			
Stomach/Bowel Ulcers			Yes ☐	No ☐			
Irritable Bowel Syndrome			Yes ☐	No ☐			
Gallbladder Disease	Yes ☐	No ☐		Gluten Intolerance	Yes ☐	No ☐	
Hepatitis	Yes ☐	No ☐		Lactose Intolerance	Yes ☐	No ☐	

Had a Colonoscopy? Yes ☐ No ☐ If yes, year? _____

Had an Upper Endoscopy? Yes ☐ No ☐ If yes, year? _____

See a stomach doctor? Yes ☐ No ☐ If so, who? _____

Genitourinary

Kidney Stones	Yes ☐	No ☐
Polycystic Kidney Disease	Yes ☐	No ☐
Frequent Urinary Tract Infections	Yes ☐	No ☐
Solitary Kidney	Yes ☐	No ☐
Prostate problems	Yes ☐	No ☐
Do you see a urologist?	Yes ☐	No ☐

If so, who? _____

Patient Name: _____ Patient DOB: _____

Musculoskeletal

Gout Yes ☐ No ☐ Osteoporosis Yes ☐ No ☐

Osteoarthritis Yes ☐ No ☐ Scoliosis Yes ☐ No ☐

Back/Spinal Injury Yes ☐ No ☐

Neurological

Stroke Yes ☐ No ☐ Parkinson's Yes ☐ No ☐

Neuropathy Yes ☐ No ☐ Dementia Yes ☐ No ☐

Seizures Yes ☐ No ☐ Memory Issues Yes ☐ No ☐

Do you see a Neurologist? Yes ☐ No ☐ If so, who? _____

Psychiatric

Depression Yes ☐ No ☐ Anxiety Disorder Yes ☐ No ☐

Endocrine

Hypothyroidism Yes ☐ No ☐ Hyperthyroidism Yes ☐ No ☐

Hyperparathyroidism Yes ☐ No ☐ Adrenal Insufficiency Yes ☐ No ☐

Obesity Yes ☐ No ☐

Do you see an endocrinologist? Yes ☐ No ☐

If so, who? _____

Hematology

Cancer Yes ☐ No ☐

If yes, type? _____ Year _____

Treatment type _____

Sickle Cell Trait Yes ☐ No ☐ Sickle Cell Disease Yes ☐ No ☐

Blood Transfusion Yes ☐ No ☐ Thalassemia Yes ☐ No ☐

Anemia Yes ☐ No ☐ Blood Doctor? _____

Autoimmune

Lupus Yes ☐ No ☐ Rheumatoid Arthritis Yes ☐ No ☐

Multiple Sclerosis Yes ☐ No ☐ Vasculitis Yes ☐ No ☐

Do you see a Rheumatologist? Yes ☐ No ☐

If so, who? _____

HIV/AIDS Yes ☐ No ☐ When diagnosed? _____

If so, on medication? Yes ☐ No ☐ Who manages? _____

Miscellaneous

Chronic Pain Yes ☐ No ☐

If yes, who manages? _____

Functional Disability Yes ☐ No ☐ Mental Disability Yes ☐ No ☐

Patient Name: _____ Patient DOB: _____

Additional Medical History

Surgical History

Appendectomy	Yes ☐	No ☐		Hysterectomy	Yes ☐	No ☐	
CABG	Yes ☐	No ☐		Nephrectomy	Yes ☐	No ☐	
Carotid Endarterectomy	Yes ☐	No ☐		Cardiac Valve Replacement	Yes ☐	No ☐	
Thyroidectomy	Yes ☐	No ☐		D&C / C-Section	Yes ☐	No ☐	
Tonsillectomy	Yes ☐	No ☐		Gallbladder Removal	Yes ☐	No ☐	
Cataract Surgery	Yes ☐	No ☐		Gastric Bypass	Yes ☐	No ☐	
AV Fistula	Yes ☐	No ☐		Hemorrhoidectomy	Yes ☐	No ☐	
AV Graft	Yes ☐	No ☐		Hernia Repair	Yes ☐	No ☐	
PD Catheter	Yes ☐	No ☐		Hip Replacement	Yes ☐	No ☐	
Knee Replacement	Yes ☐	No ☐		Other:			

Family History

Kidney Disease	Father ☐	Mother ☐	Sister ☐	Brother ☐
High Blood Pressure	Father ☐	Mother ☐	Sister ☐	Brother ☐
Heart Disease	Father ☐	Mother ☐	Sister ☐	Brother ☐
Diabetes	Father ☐	Mother ☐	Sister ☐	Brother ☐
Cancer	Father ☐	Mother ☐	Sister ☐	Brother ☐
Stroke	Father ☐	Mother ☐	Sister ☐	Brother ☐
Gout	Father ☐	Mother ☐	Sister ☐	Brother ☐
Autosomal Dominant Polycystic Kidney Disease	Father ☐	Mother ☐	Sister ☐	Brother ☐
Dementia	Father ☐	Mother ☐	Sister ☐	Brother ☐
Autoimmune disorder	Father ☐	Mother ☐	Sister ☐	Brother ☐

Father Living Age: _____ Deceased Age: _____

Mother Living Age: _____ Deceased Age: _____

Patient Name: _____ Patient DOB: _____

Social History

Marital Status	Married ☐	Single ☐	Separated ☐		
	Widowed ☐	Divorced ☐			
Living Arrangement	Alone ☐	Spouse ☐			
	Family Member ☐	In-home Caregiver ☐			
	Assisted Living ☐	Name: _____			
	Nursing Home ☐	Name: _____			
Occupation	Retired ☐	Previous Occupation: _____			
	Employed ☐	Current Occupation: _____			
	Student ☐	Unemployed ☐			
Functional/ Cognitive	None ☐	Memory Deficit ☐	Hearing Loss ☐		
	Poor vision ☐	Blindness ☐	Limited Mobility ☐		
	Transportation Challenges ☐				

Habits

		Never	Former	Current	Amount
Tobacco	Cigarettes	☐	☐	☐	_____
	Pipes	☐	☐	☐	_____
	Snuff	☐	☐	☐	_____
	Cigars	☐	☐	☐	_____
	Chew	☐	☐	☐	_____
Alcohol	< 1 Week	☐	☐	☐	
	1 per week	☐	☐	☐	
	2-3 per week	☐	☐	☐	
	1 per day	☐	☐	☐	
	> 1 per day	☐	☐	☐	

Recreational Drug Use	Never	Former	Current
Marijuana	☐	☐	☐
Heroin	☐	☐	☐
Cocaine	☐	☐	☐
Amphetamines	☐	☐	☐
Ecstasy	☐	☐	☐
Barbiturates	☐	☐	☐
LSD	☐	☐	☐
Opium	☐	☐	☐
Other	☐	☐	☐

Patient Name: _____ Patient DOB: _____

OFFICE POLICIES AND PROCEDURES

Cancellation / No Show Policy

At Georgia Nephrology, we do our best to schedule your appointment in a timely manner. We ask that you notify our office more than 24 hours prior to your scheduled appointment if you must cancel. It is our office policy to charge $50 for a new patient and $25 for established patients that no show for their appointment or do not provide more than 24 hours cancellation notice.

Arrival Time / Late Policy

We make every attempt to see you at your appointed time. To ensure that we run on time, we ask that new patients arrive 30 minutes and established patient arrive 15 minutes prior to appointment time. If you are running late we may need to reschedule your appointment. If your provider does agree to see you late, you will be handled as a work-in appointment and will be seen when the schedule allows so that other patients' appointments remain on time.

Patient Information / Patient Portal

In order to maintain accuracy in your patient record, we require that you give our office current information at every visit. This includes your name, changes to address or telephone number, changes to your insurance, changes in your health status, and information about other health services that you may have received. Our office uses a patient portal to enhance communication with our patients. At your visit, we will ensure that you have access to our portal. You may contact your doctor's medical assistant through the portal with health questions or medication refill requests. In addition, a summary of your visit and the results of any labs drawn in our office are available through the portal.

Insurance and Payments

Georgia Nephrology will file claims with most insurance companies. We ask that you pay any and all required payments at the time of service. Required payments may include your copay or the full visit charge if you do not carry insurance. If you have an outstanding balance, our staff will notify you prior to your appointment. If your insurance company requires a referral for you to see us, we will attempt to obtain this referral prior to your visit. If your Primary Care Physician does not provide a referral, we will contact you for your assistance or to reschedule your appointment. If you have questions about what you will be expected to pay or whether a referral is needed, please contact our billing department prior to your appointment. We accept the following forms of payments: cash, check or credit card (including MasterCard, Visa, Discover, and American Express).

Medication Refill Policy

We require that you bring all of your medications, including any over-the-counter medications, to your appointment. At your appoint-ment, we will provide you with enough medication to last until your next appointment. If you need a refill between these visits, you must ask your pharmacist to submit an electronic refill request, or you may submit a request to our office through our patient portal (do not call for refills!). We will address refill requests within 48 hours. If you request or require an urgent refill (same day response), we will charge $20 in advance to complete the refill. If you call after hours or on weekends, the on-call physician will only refill your prescription for up to 5 days. We will refill controlled medications only during appointments – no exceptions. If the medication you take requires renewal of a prior authorization, your refill may be delayed. Our office is not responsible for the timing of prior authorization approvals by your insurance company.

Family Medical Leave Act (FMLA) Forms

If you have a FMLA form to be completed, please allow up to 10 working days for completion. Due to the complexity of these forms, we charge a fee of $25 that must be paid prior to form completion. Georgia Nephrology does not complete long-term disability forms.

Refund Policy

If you are due a refund on your account, and you have not received payment in a timely fashion, please call our billing department to assure that we have your account posted correctly.

SIGNATURE: _____ **DATE:** _____

Patient Name: _____ Patient DOB: _____

NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document a patient's acknowledgement of receipt of our Privacy Practices or our good faith, but unsuccessful effort to obtain that acknowledgement. We are not obligated to attempt to obtain this acknowledgement in an emergency treatment situation.

PATIENT NAME: _____

TO THE INDIVIDUAL: Please complete the following acknowledgement.

I acknowledge that I received the Privacy Practices Notice this health care provider.
(Please sign in the space indicated below).

If the individual refused or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice, please check appropriate box below. Describe your good faith effort to obtain the individual's signed acknowledgement and the reason you were unsuccessful.

Individual refused or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice.

Individual received our Privacy Practices Notice in connection with an emergency treatment situation.
We are, therefore, not required to obtain an acknowledgement.

THIS FORM HAS BEEN SIGNED BY: (please check one)

PATIENT ☐

PATIENT'S REPRESENTATIVE ☐

I attest that the above information is correct.

_____ _____
Signature Date

_____
Printed Name

_____
Witness signature

Patient Name: _____ Patient DOB: _____

Consent for Release of Medical Records

Name of Patient: _____ Date of Birth: _____

The patient above is requesting a copy of his/her records to be sent to:

Name of Doctor/Hospital/Facility: Georgia Nephrology-Medical Records Department
Address: 595 Hurricane Shoals Road NW, Suite 100, Lawrenceville. GA 30046
Fax: 678.990.5259

I, _____am authorizing my medical records to be released to the above-mentioned Doctor/Hospital/Facility.

I do hereby consent and authorize the office to release copies of my medical records, including current and previous medical records to other practices and practitioners, hospitals, and/or clinics which are a part of my medical records. PLEASE NOTE: This authorization includes consent for release of alcohol, drug, psychiatric and psychological information and any other information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and AIDS-related syndromes. I agree that a copy of this release or fax of this release shall be as valid as the original release. Please send copy of all required information as soon as possible via fax or to the address listed above.

Patient's Signature: _____ Date: _____

Patient Name: _____ Patient DOB: _____

PATIENT COMMUNICATION PREFERENCES

Our office will need to contact you to schedule and/or reschedule appointments, relay lab and/or test results and other such administrative issues. To ensure that your privacy is maintained to the fullest extent possible, please select the method(s) by which our office may contact you.

NAME: _____ **DOB:** _____

	May we leave you a message?	May we leave results?
Home Phone: _____	Yes ◯ No ◯	Yes ◯ No ◯
Work Phone: _____	Yes ◯ No ◯	Yes ◯ No ◯
Cell Phone: _____	Yes ◯ No ◯	Yes ◯ No ◯
Fax: _____	Yes ◯ No ◯	Yes ◯ No ◯
Email: _____	Yes ◯ No ◯	Yes ◯ No ◯

I give authorization for Georgia Nephrology to discuss my medical records with: (example: spouse, child, friend, caregiver. Please do not list your other physicians as we do not need permission to discuss your care with them. You may choose to leave this area blank if you do not wish for us to discuss your information with anyone but you).

Name: _____ Relationship: _____

Phone #(s): _____

Name: _____ Relationship: _____

Phone #(s): _____

Name: _____ Relationship: _____

Phone #(s): _____

SIGNATURE: _____ **DATE:** _____

Patient Name: _____ Patient DOB: _____

After completing the form, click the 'Save Form' button to save the form to your computer. If using Google Chrome, right-click the form and select 'Save As...' Send the form in an email to the following address: medicalrecords@ganephrology.com.

Print Form

Save Form

Reset Form

CURRENT MEDICATION LIST

Name: _____ DOB: _____ Date: _____

Drug Name	Strength	Frequency

Drug Allergies: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____

MEET THE MEDICAL TEAM – ADVANCED PRACTICE PROVIDERS

At Georgia Nephrology, we pride ourselves on providing quality care at all levels within our practice. Our medical team includes board-certified nephrologists, advanced practice providers (APPs), and certified medical assistants.

The APP medical team consists of nurse practitioners (NPs) and physician assistants (PAs). Each of our APPs has earned an advanced degree: either a master's degree in the field of nursing or a master's degree as a physician's assistant. This team conducts physical examinations, diagnoses illnesses, writes prescriptions, develops treatment plans, and instructs/counsels patients. Each of our APPs is trained to recognize when a patient needs the attention of a supervising physician or another specialist.

As a patient at Georgia Nephrology, you may be scheduled with an APP for the following appointment types:

- Hospital follow-up appointments
- Follow-up visits
- Nephrology education visits

For follow-up visits, it is the policy of Georgia Nephrology that you will see a physician and an APP on alternating visits. In other words, when you check-out after your visit with your physician, you will be scheduled to see a member of our APP team on your next visit.

YOU ARE IN GREAT HANDS WITH GEORGIA NEPHROLOGY'S MEDICAL TEAM!

_____ _____

Patient's Signature Date

HIPAA NOTICE OF PRIVACY PRACTICES
GEORGIA NEPHROLOGY, LLC

Effective Date: April 14, 2003

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.

WHO WILL FOLLOW THIS NOTICE:

This notice describes the privacy practices of Georgia Nephrology, LLC and its organized health care arrangement, which consists of:

- Any health care professional authorized to enter information into your medical chart, including members of the Georgia Nephrology, LLC Medical Staff.
- All affiliates, departments and units of Georgia Nephrology, LLC, including its outpatient facilities and physician practices.
- Any member of a volunteer group we allow to help you while you are in the office.
- All employees, staff and other Georgia Nephrology, LLC personnel.

All these entities, sites, locations, and persons operate as an "organized health care arrangement" and are presenting this document as a joint notice of privacy practices. In addition, these entities, sites, locations, and persons may share medical information with each other for treatment, payment or health care operations purposes described in this notice. While the independent physicians and other health care providers who are members of Georgia Nephrology, LLC's Medical Staff are part of Georgia Nephrology, LLC's organized health care arrangement under federal law for the specific purpose of sharing patient information, some healthcare providers, including independent Medical Staff members, are not Georgia Nephrology, LLC employees or agents and remain independent contractors who exercise their own independent medical judgment in caring for patients and they are solely responsible for their own actions and compliance with the privacy laws.

For purposes of this notice, "we", "us", and "our" refers to Georgia Nephrology, LLC and its organized health care arrangement.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at a Georgia Nephrology, LLC facility. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Georgia Nephrology, LLC, whether made by Georgia Nephrology, LLC personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of these categories.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different Georgia Nephrology, LLC departments or units also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people not affiliated with Georgia Nephrology, LLC who may be involved in your medical care after you leave a Georgia Nephrology, LLC facility, such as family members, clergy or others involved in providing services that are part of your care.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect from you, your insurance company, or a third-party payer. For example, we may need to give your health plan information about your surgery so that they will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: We may use and disclose medical information about you for our operations. These uses and disclosures are necessary for us to operate and make sure that all of our patients receive quality care. For example, in the course of quality assurance and utilization review activities, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. Some of these reviews may be conducted by independent physicians who are members of the medical staff, but not Georgia Nephrology, LLC employees. We may also combine medical information about many of our patients to decide what additional services we should offer and what services are not needed. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the medical

information we have with medical information from other healthcare providers to see where we can make improvements. We may remove information that identifies you from this set of medical information to protect your privacy.

Appointment Reminders: We may use and disclose medical information and the contact information you have provided to contact you with appointment reminders. If we do not reach you, we may leave a message with an individual who answers the phone or leave a voicemail message. While e-mail and text messaging may not be a secure method of transmitting information, if you elect for us to do so — we may also send appointment reminders via text message or email. The appointment reminders may include your name, the date, time, and location of the appointment, the name of the facility or entity, the name of the physician or other health care provider you have the appointment with and general information about the upcoming appointment. We may also send you an appointment reminder in the mail.

Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Fundraising Activities: We may use medical information about you to contact you in an effort to raise money for Georgia Nephrology, LLC and its subsidiaries and affiliates. We may disclose medical information to a foundation related to Georgia Nephrology, LLC so that the foundation may contact you in raising money for Georgia Nephrology, LLC. We would only release contact information, such as your name, address, and telephone number and the dates you received treatment or services at a Georgia Nephrology, LLC facility. You may opt out of being contacted for fund-raising purposes. If you do not want Georgia Nephrology, LLC to contact you for fundraising efforts, please notify us via email at info@ganephrology.com or 404-645-7150.

Directory: We may include certain limited information about you in the directory while you are a patient. This information may include your name, location, your general condition (e.g., fair, stable, etc.) and your religious affiliation. Unless there is a specific written request from you to the contrary, this directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don’t ask for you by name. This information is released so your family, friends and clergy can visit you in the and generally know how you are doing. If you do not want your information to be listed in the directory, please ask to be listed as a “No-Information” patient.

Individuals Involved in Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. We generally will obtain your written authorization to use your medical information for research purposes. There may be limited circumstances when access to your information for research purposes may be allowed without your specific consent. These will be limited to cases when use or disclosure was approved by an Institutional Review Board or Privacy Board.

Business Associates: There are some services provided to or on behalf of Georgia Nephrology, LLC by third parties known as "business associates". One example is the copy service we use when making copies of your health record. We may disclose your healthcare information to our business associates so that they can perform the job we have asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

As Required by Law: We will disclose medical 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 medical 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.

Marketing and Sale of Health Information: We must obtain your written authorization prior to most uses of your health information for any marketing purposes or disclosures that constitute a sale of your health information.

Psychotherapy Notes: Most uses and disclosures of psychotherapy notes will only be made with your written authorization.

Other Uses and Disclosures: Other uses and disclosures of your health information not covered by this Notice will be made only to you or with your written authorization.

SPECIAL SITUATIONS

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: We may release medical 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 medical 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 the abuse or neglect of children, elders and dependent adults;
- 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;

Health Oversight Activities: We may disclose medical 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 medical information about you in response to a court or administrative order. We may also disclose medical information about you 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 (which may include written notice to you) or to obtain an order protecting the information requested.

Law Enforcement: We may release medical 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;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at a Georgia Nephrology, LLC 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.

Coroners, Medical Examiners and Funeral Directors: We may release medical 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 may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you 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) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

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

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. If you are a current inpatient, you should notify your primary nurse and complete the required form. If you are an outpatient or discharged patient, you should contact the Director of Health Information Services in writing, at the appropriate service location to obtain and complete the required form. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. 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. Another licensed health care professional chosen by Georgia Nephrology, LLC will review your request and the denial. The person conducting the review will not be the person who denied your request. 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 the information is kept by or for Georgia Nephrology, LLC. If you are a current inpatient, you should notify your primary nurse and complete the required form. If you are an outpatient or discharged patient, you should contact the Director of Health Information Services in writing, at the appropriate service location to obtain and complete the required form. 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 Georgia Nephrology, LLC;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment, and health care operations, as those functions are described above. To request this list or accounting of disclosures, you should contact the Director of Health Information Services in writing, at the appropriate service location to obtain

and complete the required form. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list 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.

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. Because any restrictions of your information may hinder the quality of care provided at our facilities, according to the law, we reserve the right to deny such request. In addition, because of the many health care providers participating in the Georgia Nephrology, LLC organized health care arrangement, we generally cannot agree to special requests. If we do agree, we will comply with such request unless the information is needed to provide you emergency treatment. You have the right to request that we restrict information from being disclosed to a health plan if the information is related to services for which you have paid for the service in full out of pocket.

To request restrictions, you should contact the Director of Health Information Services in writing, at the appropriate service location to obtain and complete the required form. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse. **To be binding, any agreement to comply with special restrictions must be in writing signed by the Director of Health Information Services.**

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:

Georgia Nephrology, LLC
Attn: Privacy Officer
595 Hurricane Shoals Drive NW
Suite 100
Lawrenceville, GA 30046

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to be Notified of a Breach. You have the right to be notified if there is any impermissible use of disclosure of your health information that compromises the privacy or security of your health information.

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. You may obtain a copy of this notice at our website, www.ganephrology.com. To obtain a paper copy of this notice, you may contact:

Georgia Nephrology, LLC
Attn: Privacy Officer
595 Hurricane Shoals Drive NW
Suite 100
Lawrenceville, GA 30046

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for medical information we already have about you as well as any information we receive in the future. The current notice will be posted in our facilities and on our website www.ganephrology.com, and you may request a copy of our current notice at any time.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Georgia Nephrology, LLC Privacy Officer whose contact information is below or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical 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 medical 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 medical 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 our records of the care that we provided to you.

Georgia Nephrology, LLC
Attn: Privacy Officer
595 Hurricane Shoals Drive NW
Suite 100
Lawrenceville, GA 30046

Effective Date: April 14, 2003. **Revised:** August 15, 2003; November 6, 2019