



Dear Parents/Guardians:

Did you know that your son or daughter can get **Health Care** at school? Roosevelt High School has a School-based Health Center (SBHC) that is located in the building and its services are available to all students. The SBHC is operated by Neighborcare Health, a community health center serving more than 70,000 people in Seattle and Vashon Island each year.

The SBHC offers a child friendly setting and all the services of a family doctor. The SBHC provides appointments before, during, and after school and offers the following services:

- Evaluation and treatment of common health problems
- Immunizations, lab tests, and medication management
- Sports physicals
- Reproductive health care
- Mental, social, and emotional health care
- Oral health care
- Preventive health care, including tobacco, alcohol, and other drug use prevention education
- Health insurance eligibility and enrollment assistance
- Referrals to other health care providers as needed

To use this service, please complete and sign the following forms in this packet:

- Health History Form (pg. 2)
- Registration Form (pg. 3)
- Consent Form (pg. 4)
- Release of Education Records Form (pg. 5) (Optional)
- Text Appointment Reminder Consent Form (pg. 6) (Optional)

Forms can be returned with the school packet or mailed to the school separately. They can also be dropped off in person at the SBHC or the school's main office.

A completed Release of Education Records form allows your child's school records to be shared with Neighborcare Health. Access to school records enables Neighborcare Health to work with teachers and staff to improve student learning, attendance, grades, and behavior.

Neighborcare Health is committed to serving all patients regardless of ability to pay. The Roosevelt High School SBHC receives support from the Families and Education Levy, but this funding does not fully cover the program's operating costs; therefore the SBHC bills insurance when appropriate. Please complete the insurance section of the registration form to ensure that we have your most current insurance information on file.

If you do not have health insurance, the SBHC can help you enroll in an insurance plan. Please check the "No Insurance" box on the registration form and a SBHC staff member will follow-up with you. You can also call the SBHC directly to request health insurance enrollment assistance.

Roosevelt High School is fortunate to have the SBHC and I hope you will take advantage of this resource for your child. If you would like more information or need assistance please call the Roosevelt High School SBHC at 206-527-8336.

Sincerely,
Brian Vance
Principal

School-based Health Centers
Health History Form

In order to help us provide the best care for your child, please fill this Health History Form as completely as possible. To schedule an appointment, please call the School-based Health Center. Thank you.

Student's Name: _____ Date of Birth: ____/____/____
(First) (Last)

(Printed Name of Person Completing Form) (Relationship to Student (if not self)) (Date Form Completed)

QUESTIONS ABOUT YOUR CHILD:

- Yes No Does your child have a Primary Care Doctor or Clinic? If Yes, please provide clinic practice name: _____
Provider Name: _____ Phone #: _____
- Yes No Has your child had a physical or full check-up in the past year?
- Yes No Would you like your child to receive a check-up with our provider?
- Yes No Has your child had a dental check-up in the past year?
- Yes No Would you like your child to receive a dental screening with our provider?
- Yes No Does your child have any MEDICATION allergies? 1) _____ 2) _____ 3) _____
- Yes No Does your child have allergies to anything else? (foods, dust, etc.)
If Yes, please List: 1) _____ 2) _____ 3) _____
- Yes No Does your child take any medications? (include vitamins and over-the-counter medications)

<small>Medication</small>	<small>Dosage</small>	<small>Reason</small>
_____	_____	_____

Has your child had any of the following (Check all that apply):

- Chronic or Ongoing Health Problems:**
- Vision Problems
 - Diabetes
 - Hearing Problems/Ear Infections
 - Asthma
 - Anemia
 - Underweight, overweight, or growth issues
 - Heart Problems
 - High Blood Pressure
 - Dental Decay/Teeth Problems
 - Other: _____

- Acute or Urgent Health Problems, including infections:**
- Bone or Joint Injury
 - Chickenpox
 - Serious accident or fall
 - Tuberculosis or TB
 - Bladder or Kidney Infection
 - Fainting or Passing Out
 - Infection
 - Other: _____

- Other Concerns about Well-Being**
- Too much worry or stress
 - Behavior or Anger Problems
 - Alcohol or Drug Misuse
 - Attention Deficit Disorder
 - My Child has been threatened or harassed by someone
 - Depression
 - Developmental Delays
 - Other: _____

- School or Learning Performance in This or Last School Year:**
- Attendance problems
 - Failing grades
 - Suspension
 - Relationship problems with students or adults
 - Worse grades
 - Is your child performing at grade level? _____

Other Health Conditions or Special Healthcare Needs or Concerns About Your Child's Care:
 Describe any: _____

- Check all items you feel are generally true for your child:**
- My child engages in behavior that supports a healthy lifestyle; eating healthy foods, being active, and keeping safe
 - My child has at least one adult in their life who cares about them and to whom they can go to for help.
 - My child has at least one friend or a group of friends with whom they are comfortable.
 - My child is helpful or active in a group in school, a faith-based organization, or the community.
 - My child is able to bounce back from life's disappointments.
 - My child has a sense of hopefulness and self-confidence.

QUESTIONS ABOUT YOUR FAMILY:

- Who lives in your home? _____
- Yes No Have there been any major changes or challenges in the past year? If yes, describe: _____
 - Yes No Does anyone living at home smoke cigarettes, cigars, or e-cigarettes?
 - Yes No Do you eat meals together as a family?
 - Frequently Sometimes Never Are you concerned there will not be enough food on the table?
 - Yes No Is there a gun in your home? : Is it locked? Yes No

FAMILY HEALTH HISTORY: (check all that apply)

	Father	Mother	Mother's side of Family	Father's side of Family
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer; Identify Type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack or Stroke before age 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or Drug Misuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression or Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden or Unexplained Death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis (TB Infection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical, Sexual or Other Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Illness or Conditions explain: _____				

*When your child comes in for care, we will ask them to complete a risk assessment that will include family health history

NEIGHBORCARE HEALTH REGISTRATION FORM - School-based Health Centers

Please help us serve you better by providing the following confidential information and updating it every year so we have the most current information on record. This consent will remain active from year to year. To withdraw consent for services, please submit your request in writing.

<u>Student's Name: Last (Sr. Jr.)</u> _____	<u>First:</u> _____	<u>Middle:</u> _____	<u>Other Names Used: (If applicable)</u> _____	<u>Nickname:</u> _____
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<u>Student's Date of Birth:</u> ____/____/____	Student's Sex listed on birth certificate (Check one): <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	Gender identified as: _____ Sexual orientation identified as: _____
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Student's Address (Street or Post Office Box): _____ _____ _____ City: _____ State: _____ Zip: _____ Phone (Student): _____ E-mail (Student): _____	Parent, Guardian, or Responsible Party: Relationship: <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Other Parent/Guardian Name: _____ Parent/Guardian Date of Birth: ____/____/____ Parent/Guardian Phone: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home Parent/Guardian Address: <input type="checkbox"/> Same as Student Street: _____ City: _____ State: _____ Zip: _____ E-mail (Parent/Guardian): _____ Best way to contact me: <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail <i>*We may contact you via email.</i>
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IN CASE OF EMERGENCY CONTACT:
 Same as Parent/Guardian Information
 Name _____ Date of Birth _____
 Relationship _____ Telephone _____
 Address _____ City _____ State _____ Zip _____

Parent, Guardian, or Responsible Party:
 Relationship: Parent Grandparent Sibling Other
 Parent/Guardian Name: _____
 Parent/Guardian Date of Birth: ____/____/____
 Parent/Guardian Phone: _____ Cell Home
 Parent/Guardian Address: Same as Student
 Street: _____
 City: _____ State: _____ Zip: _____
 E-mail (Parent/Guardian): _____
 Best way to contact me: Phone Email Mail
**We may contact you via email.*

LANGUAGE (Primary language spoken in student's home):
 AMHARIC HMONG SAMOAN
 ARABIC KOREAN SOMALI
 CAMBOADIAN/KHMER LAOTIAN SPANISH
 CANTONESE MANDARIN TAGALOG
 ENGLISH MIEN THAI
 FARSI OROMO TIGRINYA
 FRENCH RUSSIAN VIETNAMESE
 OTHER Preferred Language: _____

Student Status
 Student ID: _____ Grade: _____
 School: _____
 Are you on the Free or Reduced Price Meals Program? YES NO

ADDITIONAL QUESTIONS:

Disabled/Handicapped: Does the patient have an ongoing condition preventing daily activities? YES NO
Immigrant/Refugee: Is the patient an immigrant or refugee or new arrival to this Country? YES NO
Total Number in household: Number of family members reported on Federal Income Tax Return: _____
Household Status: Patient lives with: Single Parent (Male) Single Parent (Female) Both Parents
Housing Status: Not Homeless Public Housing Doubling Up Shelter Street Transitional Other Unknown/Unreported
Farm Worker Status: Migrant Seasonal Not a Farm Worker
Interpreter Required: Is an Interpreter needed for this Patient? YES NO LANGUAGE: _____
Veteran Status: YES NO
Income: What is your gross annual household income? \$ _____

STUDENT RACE:
 AMERICAN INDIAN/ALASKA NATIVE OTHER PACIFIC ISLANDER
 ASIAN WHITE
 BLACK/AFRICAN AMERICAN MORE THAN ONE RACE
 NATIVE HAWAIIAN DECLINE TO SPECIFY

STUDENT ETHNICITY:
 HISPANIC OR LATINO
 NOT HISPANIC OR LATINO

INSURANCE
 No insurance; please contact me with additional information on insurance coverage options
Primary Insurance Name: _____
 Subscriber Name: _____ Relationship: _____ Subscriber Gender: _____ Subscriber Date of Birth: ____/____/____
 Identification/Policy # _____ Plan # (if applicable): _____ Group # (if applicable): _____
 Group Name (if applicable): _____ Effective Date: ____/____/____ Insurance Phone #: _____

PRIVACY PRACTICE NOTICE, RELEASE AND CONSENT SIGNATURE

CERTIFICATION OF INFORMATION AND CONSENT FOR CARE: I certify that the registration information that I have reported to this clinic is currently correct and understand that any deliberate misrepresentation of the information may cause me to be responsible for full charge of services delivered. I grant permission to the Medical, Mental Health, and Dental staff of the above named clinic to employ such established treatments and therapies deemed professionally and medically necessary or advisable in the diagnosis and treatment of my child's health problems. I understand that the medical care may be given by a Physician, Nurse Practitioner, Physician Assistant or other licensed staff. I understand that the mental health care may be given by licensed Mental Health Therapist or other staff. I understand that dental care may be given by licensed Dentists, Dental Hygienists, Dental Assistants, Dental or Hygien students or trained volunteers in accordance with the Washington State Dental Practice Act. This authorization shall remain in effect unless the consent is cancelled by written notice to the Medical/Dental Director. The assignment and release authorizes Neighborcare Health to release to my insurance company, CMS or DSHS any information needed to determine the benefits payable for related services. I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those health care provider who have rendered services to me. I agree to pay all charges that are not paid in full by assigned insurance.

NOTICE OF PRIVACY PRACTICES: I have received Neighborcare Health's **Notice of Privacy Practices** that describes how my health information may be used and disclosed and how I can access my information.

SIGNATURE **RELATIONSHIP TO STUDENT** **DATE**

Neighborcare Health School-Based Health Centers Consent for Health Services

Neighborcare Health's School-based Health Centers are located in Seattle Public Schools. Neighborcare Health must have signed consent from a parent or legal guardian before providing services to the student, except in situations where federal and/or state laws allow the student to access such treatment without parent/guardian consent. If the student is enrolled in school but is not enrolled in a School-based Health Center (SBHC), he/she can continue to receive school nurse services.

I hereby request and authorize that:

Print Student's Name: _____ / /
First Name Middle Initial Last Name Date of Birth

receive health care services available from and deemed necessary by the Neighborcare Health SBHC staff. These services may include, but are not limited to: mental health counseling, routine medical exams, naturopathy, sports physicals, well-child or teen care, evaluation and treatment of acute illness and injuries, immunizations, blood studies, photographs, X-rays, dental and fluoride treatment services. SBHC staff encourage family involvement in the care they provide to students. However, if I am unable to be present, authorization is given for my child to receive services in my absence. Consent is also given for referral of care and, if needed, emergency transportation to other physicians, health care professionals, hospitals, clinics, or health care agencies as deemed necessary by the Neighborcare Health SBHC staff. This authorization does not allow services to be rendered without the student's consent, unless she/he is unable to consent. Neighborcare Health is committed to creating a health care home and encouraging long-term relationships between patients and providers that includes medical, dental and mental health care. Neighborcare Health collaborates with other providers in the community that may also be seeing the patients we serve to ensure care is coordinated.

In accordance with state and/or federal law, when consent is provided for care, healthcare information is kept confidential. A few exceptions exist. For example:

1. Permission is given by the patient or parent/guardian through a signed release of information form.
2. The patient indicates risk of imminent harm to self or others.
3. The patient has a life-threatening health problem and is under the age of 18.
4. There is reason to suspect abuse or neglect.
5. Certain communicable diseases must be reported to public health authorities.

Consent is given to share necessary information with the health care providers at the SBHC, including exchange of information between the mental health therapist, nurse practitioner or physicians assistant and the school nurse, for the purpose of providing the best care for the above named student. To facilitate coordination of care, the student's SBHC medical record will be accessible to Neighborcare Health staff at the SBHC. Consent is granted for the school nurse to administer over-the-counter medications (for example, Ibuprofen, Tylenol, Tums, etc.) as prescribed by the medical provider of the SBHC.

Students may also receive health services independently at any of Neighborcare Health's medical or dental clinics. With this consent, services can be received at any of the following other Neighborcare Health medical and dental clinics:

High Point Medical-Dental Clinic: 206-461-6966
45th Street Medical Clinic: 206-633-3350
Meridian Medical-Dental Clinic: 206-296-4990
Columbia City Medical Clinic: 206-461-6957
Central District Dental Clinic: 206-461-7801

Rainier Beach Medical-Dental Clinic: 206-722-8444
Pacific Tower Dental Clinic: 206-548-5850
Lake City Medical Clinic: 206-417-0326
Georgetown Dental Clinic: 206-461-6943

Consent is authorized for services provided by Neighborcare Health during the length of time the student is enrolled in a school with a Neighborcare Health SBHC or for the length of time services are provided at another Neighborcare Health clinic. Withdrawal of this consent can be done at any time by writing to the SBHC.

Student Signature: _____ Date: ____/____/____

Parent/Guardian Signature: _____ Date: ____/____/____

Name of Legally Responsible Guardian (Print): _____ Relationship: _____

IMPORTANT ADDITIONAL INFORMATION ON MINOR CONSENT

Under Washington State law, the SBHC will provide and assist students in accessing outside care if necessary. Under Washington State law, youth may independently access reproductive health care at any age without parent/guardian consent. Youth (age 13 and older) may independently receive drug and alcohol services and mental health counseling without parent/guardian consent. The SBHC encourages each student to involve his/her parents or guardians in health care decisions whenever possible. When applicable, the SBHC will assist the student in discussing these situations with parents/guardians.

Because youth are able to provide consent for treatment, their consent is legally required for release of information about pregnancy and sexually transmitted diseases (including HIV/AIDS testing). Consent from students age 13 and older, and parent/guardian consent for students age 12 and younger, is legally required for release of information about alcohol and drug or mental health counseling. For more information on minor consent visit: www.washingtonlawhelp.org and search "Minor Consent".



Community Based Organization Parent/Guardian Consent Form 2017-2018 Approval

Public Health – Seattle & King
County
School-Based Partnerships Program
401 5th Ave #1000
Seattle, WA 98104
206.263.8350

Neighborcare Health
1200 12th Ave S, STE 901
Seattle, WA 98144-2712
206-461-6935

Consent to Release of Education Records Under the Family Education Rights and Privacy Act (FERPA)

I consent to the release of my child’s education records from the Seattle School District to the above listed agencies. I understand that education records include, but are not limited to:

1. Student name, DOB and contact information
2. Student Demographics: including Special Education status and 504 Status and race/ethnicity
3. Attendance History
4. Discipline History
5. Coursework and grades History
6. Test Scores History
7. Enrollment History
8. Assignment Grades
9. Upcoming & Missed Assignments

This release includes permission for agency staff to access my child’s academic records using an automated data feed through Seattle Public Schools.

I understand that the purpose of sharing these records with the above-mentioned entities is to keep my child’s school-based health center medical and/or mental health provider informed of his/her academic program and progress. In collaboration with Public Health - Seattle & King County, Neighborcare Health staff will work with my child and/or his/her school in an effort to improve my child’s success at school. I acknowledge that I may revoke this consent by sending a written notification to the Seattle School District’s School & Community Partnership Department, MS: 32-159 P.O. Box 34165 Seattle, WA 98124.

This Release of Information will make the above-listed educational records, which includes historical student data, available to agency staff from the date of consenting signature until December 31, 2018. I consent to Seattle School District releasing information to the above listed agencies (please print clearly):

Parent/Guardian Signature (if youth is 17 or younger): _____

Parent/Guardian Printed Name: _____

Student’s Signature (if youth is 18 or older): _____

Today’s Date: _____

PRINT Student’s Name (First and Last name)

Student Date of Birth

****Student School District ID #**

Student’s School

***Student ID # can be found on student ASB card, report card, official school mailing, or by contacting your student’s school*



PATIENT CONSENT FOR TEXT COMMUNICATIONS

Neighborcare Health understands that students would like to receive appointment reminders via text communication. Prior to using text communications that may contain your appointment reminders, Neighborcare Health advises students that there may be some level of risk that information in an unencrypted text message could be read by a third party. Neighborcare Health will not be responsible for any unauthorized access of your appointment reminders in the form of text communication.

Neighborcare Health **will not** respond to any text messages sent to the health center's appointment reminder cell phone. Text message communication will solely be used for appointment reminders. If you have any follow-up questions or concerns, please visit your health center.

I, the undersigned, consent to text communications with Neighborcare Health about my health center appointments. I understand, both my parent/legal guardian and I are required to sign this consent form in order to receive health center appointment reminders. I understand the risks associated with using text communications. Standard carrier message and data rates may apply. I will inform Neighborcare Health in writing if I no longer wish to receive health center appointment reminders from Neighborcare Health via text.

Patient Name (Print)

Patient DOB

Patient Signature

()

Patient Cell phone Number & Carrier

Parent or Legal Guardian Name

Cell Carrier/Provider

Parent Signature

Relationship (parent or legal guardian)

Date

Time



NOTICE OF PRIVACY PRACTICES

THIS NOTICE EXPLAINS HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND GIVEN OUT. IT ALSO EXPLAINS HOW YOU COULD GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Neighborcare Health respects your privacy. We understand that your personal health information is very sensitive. We will not give out your information to others unless you tell us to, or unless the law allows or requires us to do so.

We are required by law to keep your Protected Health Information (**PHI**) private, to give you this Notice, and follow the terms of this Notice. We also have the right to change our practices. If we make changes to this Notice, you will receive the updated Notice upon your next visit. If we change this Notice, we will post the revised notice in the waiting area of our office and on our web site at www.neighborcare.org.

PHI is any information that includes your personal information, as well as health and billing information. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. USING AND RELEASING PROTECTED HEALTH INFORMATION

A. Without Your Written Permission. We have the right to use and share your health information for the following reasons:

1. **Treatment:** Information obtained by a nurse, physician, or other members of our health care team, recorded in your medical record, may be used to help decide your future care. We may also share information to others providing you care. This will help them stay informed about your care.

2. **Payment:** We request payment from your health insurance plan. Health plans need information from us about your medical care. Information shared with health plans may include your diagnoses, procedures performed, or future recommended care.

3. **Health Care Operations:** We may use and share PHI for our health care operations, such as quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff.

4. **Required or Permitted by Law:** We may share PHI when we are required or permitted to do so by law. For example, we may release PHI to proper authorities if we believe that you are a possible victim of abuse, neglect, or domestic violence. We may also share PHI necessary to stop a serious threat to the health or safety of you or others. Other releases could include: public health activities; requests from state or federal agencies; law enforcement; court order or other lawful process; approved research; workers' compensation claims; military or national security agencies, coroners, medical examiners, and correctional institutions.

B. Without Your Permission, And You May Object.

1. **Fundraising:** We may use PHI to contact you in an effort to raise money for our operations. We may also release PHI to a foundation that is related to us so that the foundation may contact you in an effort to raise money for its operations. Any fundraising communications with you will include a description of how you may opt out of receiving any further fundraising communications

2. **Family and Other Persons Involved in Your Care.** Unless you object, we may share your PHI with a family member, relative, close friend, or any other person you identify is involved in your medical care. We may share information to notify the person of your location, general condition or payment related to your care.

3. **Disaster Relief Efforts.** We may share your protected PHI to a public or private entity authorized by law or its charter to assist in disaster relief efforts for coordinating notification of family members of your location, general condition, or death.

C. Needs Your Written Permission.

1. Psychotherapy Notes. We must get your permission to use or release psychotherapy notes, unless the psychotherapy notes are:

- (1) By the creator of the psychotherapy notes for treatment purposes,
- (2) For our own training programs in which mental health students, trainees or practitioners learn to improve their counseling skills,
- (3) To defend ourselves in a legal proceeding initiated by you,
- (4) To a health oversight agency for oversight of the creator of the psychotherapy notes,
- (5) To a coroner or medical examiner; or
- (6) To prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.

2. Minors. We will follow Washington State law when using or sharing PHI of minors. Minors who receive health care services related to HIV/AIDS; STDs, mental health treatment, alcohol/drug testing, and treatment or reproductive health may request that another person receive that information on their behalf. If the minor does not give permission in writing to anyone, we will only give information to the minor.

3. Marketing Communications: Sale of PHI. We must have your written permission before using or sharing PHI for marketing or the sale of PHI, consistent with the related definitions and exceptions set forth in HIPAA.

Other Uses and Releases. Any requests for information besides those described in this Notice will need your written permission. For example, you will need to sign a permission form before we can send PHI to your life insurance company or to your attorney. You may revoke your permission at any time by providing us with a written request.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy. You may request to see your medical records billing records in order to inspect and/or request copies of the records. All requests to view records must be made in writing. Under limited circumstances, we may deny access to your records. We may charge a fee for the cost of copying and sending records you request.

B. Right to Alternative Communications. You may request in writing to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions. You have the right to limit PHI we use or share for treatment, payment, or health care operations. You must request limitations in writing addressed to **Neighborcare Health's Privacy Officer**. We are not required to agree to limitations you request, **unless** your request is to limit releasing PHI to a health plan for payment or health care operations and that PHI directly relates to a health care item or service that you or another person or entity on your behalf paid in full.

D. Right to Accounting of Releases. You may request in writing an accounting of releases of PHI made by us in the last six years, subject to certain restrictions and limitations.

E. Right to Request Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to **Neighborcare Health's Privacy Officer, at (206) 548-3026** at any time.

G. Right to Receive Notification of a Breach. We are required to notify you if we discover a breach of your unsecured PHI, according to requirements under federal law.

H. Questions and Complaints. If you have questions about your privacy rights, or are concerned that we have violated your privacy rights, you may contact **Neighborcare Health's Privacy Officer, at (206) 548-3026**. You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or with our office.

III. EFFECTIVE DATE

A. Effective Date. This Notice is effective on **September 23, 2013**.