PEDIATRIC HEALTH HISTORY FORM

Child/Adolescent Name	Birth Date	Age	Gender	Grade	School/Teacher

Street Address	Mailing Address (PO Box)	City	Zip Code	

Race (Optional) ❒ White ❒ Black ❒Asian ❒American Indian ❒ More Than One ❒ Other

Ethnicity (Optional) ❒ Non-Arabic/Non-Hispanic ❒Hispanic ❒Arabic

Mother/Parent Name	Mother/Parent Birth Date	Occupation	Phone Number

Father/Parent Name	Father/Parent Birth Date	Occupation	Phone Number

Preferred Telephone Number	May We Leave a Message? Yes No	Best Time of Day to Be Contacted?

Guardian Last Name (if different than mother/father)	Guardian First Name	Guardian Telephone Number	Relationship To Student

Name of Emergency Contact (other than parent/guardian)	Relationship	Telephone Number

Name of Student's Physician or Clinic	Physician or Clinic Telephone Number	

HEALTH INSURANCE (Please complete all information)

❒ None (uninsured) Please contact me about MI Child/Healthy Kids health insurance for my child. ❒ Yes ❒ No

❒ Medicaid/Medicaid HMO Child's Card Number _____

❒ Blue Cross/Blue Shield
❒ Blue Care Network
❒ Priority Health
❒ TriCare
❒ Other:_____

Name of Policy Holder
_____

Insurance Policy Number
_____

Insurance Group Number
_____

Birth Date of Policy Holder
_____

Relationship of Policy Holder to child?
_____

Does your insurance pay for immunizations? ❒ Yes ❒ No

alcona citizens for health, inc.
dba
alcona health centers
"Your family health center"

BEHAVIORAL HEALTH TREATMENT CONSENT FORM

Alcona Health Center (AHC) is offering behavioral health services (BHS) at **OTTAWA SCHOOL**. These services will be provided by Laura Jeffries, LMSW a State of Michigan licensed Master Social Worker employed by AHC as a behavioral health therapist. As a condition for offering these services to your child, AHC is requiring that a parent or legal guardian must give written, informed consent, as outlined below. This consent may be revoked at any time.

As the parent or legal guardian of _____ DOB:_____

1. I understand Behavioral Health Services will include a behavioral health assessment of my child, during which I may be asked to provide information about my child's emotional needs and behavior at home and school. I may be invited to be actively involved in the treatment planning for my child. My acceptance of counseling services for my child is on a voluntary basis, and I may terminate these services at any time.
2. I understand that Laura Jeffries, LMSW maintains professional liability coverage and follows federal and state laws protecting client's rights to confidentiality of personal information. I understand these laws allow the exchange of Protected Health Information with others only when the parent/guardian signs a release of information naming a specific person(s) or entity with whom the information is to be exchanged.
3. I understand that counseling is a fee for service agreement and that my insurance company will be billed for services. I further understand that I will be responsible for any portions of fees and/or additional fees not covered by my insurance provider. AHC encourages parents/guardians to contact their child's insurance company directly so you are informed about Behavioral Health services coverage for your child. It is a parent/guardian responsibility to know your insurance benefits. Alcona Health Center will not be contacting your insurance company directly to inquire about Behavioral Health services coverage in order to begin services with your child. You may be eligible for AHC's Sliding Fee program. Ask your therapist for details. Services will not be denied based on the inability to pay.
5. I understand that AHC has taken steps to minimize exposure to COVID-19 in all school locations based on CDC guidelines. I understand that if my child appears in poor health, I may be contacted to reschedule their appointment until symptoms are evaluated by a medical professional. If I have any concerns regarding COVID-19, I will contact my child's therapist prior to their scheduled appointment.
6. I understand that federal and state regulations protect the confidentiality of my child's records maintained by this program, except when the following conditions exist:
   a. There is suspected evidence of child abuse, neglect, or danger to my child; or
   b. The Michigan Department of Health and Human Services, Child Protective Services requests Behavioral Health information by directly submitting the DHS-1163-P form to Alcona Health Center and/or this Behavioral Health Therapist; or
   c. A medical emergency that may require a referral to medical personnel or
   d. "Duty to Warn(homicide threat/injury to another person) or Duty to Protect (suicide threat/injury to oneself)" or,
   e. If your child displays signs, symptoms and/or verbal confirmation of recent use of alcohol or another substance use that is causing some type of observable impairment.

I HAVE READ AND UNDERSTAND THE CONDITIONS OUTLINED ABOVE, AND BY SIGNING BELOW AUTHORIZE Laura Jeffries, LMSW TO OFFER BEHAVIORAL HEALTH SERVICES TO MY CHILD. I acknowledge this consent will remain active until rescinded or the student reaches age 18.

_____ _____
Signature of Parent(s) or Legal Guardian Signature of Witness
Date: ____/_____/_____ Date: ____/_____/_____

_____ My initials indicate that I have been offered a copy of AHC's Notice of Privacy Practices.
https://www.alconahealthcenters.org/patient-privacy/

CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION

Michigan Department of Health and Human Services

Use this form to give or take away your consent to share information about your:

- Mental and behavioral health services. This will be referred to as “behavioral health” throughout this form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as “substance use disorder” throughout this form.

This information will be shared to help diagnose, treat, manage, and pay for your health needs.

Why This Form Is Needed

When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care, or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

Instructions

- To **give** consent, fill out Sections 1, 2, 3, and 4.
- To **take** away consent, fill out Sections 5.
- Sign the completed form, then give it to your health care provider. They can make a copy for you.

Section 1: About You * Child's information provided below

First Name	Middle Initial	Last Name	Date of Birth	Date Signed

Section 2: Who Can See Your Information and How They Can Share It

Section 2a: Sharing Information Between Individuals and Organizations

Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

1. Ottawa Elementary School Staff
2. Physician's Name:
3. Char-Em
4.
5.
6.

Section 2b: Sharing Information Electronically

Health information exchanges or networks share records back and forth electronically. This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer, and more complete care for you. Your health care provider and health plan may have already listed these organizations below.

Choose only one option:

☐ Share my information through the organizations listed below. This information will be shared with the individuals and organizations listed under Section 2a.

☐ Do not share my information through the organizations listed below.

☐ Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

For Health Care Provider or Health Plan Use Only. List all health information exchanges or networks:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Section 3: What Information You Want to Share

Choose one option:

☐ Share **all** my behavioral health and substance use disorder records. This does not include "psychotherapy notes."

☒ Share **only** the types of behavioral health and substance use disorder records listed below. For example, what I am being treated for, my medications, lab results, etc.

1. Scheduling, attendance, engagement 4. _____
2. Care Plan as needed for support 5. _____
3. _____ 6. _____

Section 4: Your Consent and Signature

Read the statements below, then sign and date the form.

By signing this form below, I understand:

- I am giving consent to share my behavioral health and substance use disorder records. This includes referrals and services for alcohol and substance use disorders, but other information may also be shared.
- I do not have to fill out this form. If I do not fill it out, I can still get treatment, health insurance or benefits. But, without this form, my provider or health plan may not have all the information needed to treat me.
- My records listed above in Section 3 will be shared to help diagnose, treat, manage, and pay for my health needs.

- My records may be shared with the people or organizations as stated in Section 2.
- Other types of my health information may be shared along with my behavioral health and substance use disorder records. Under existing laws, my health care provider and health plan do not need my consent to share most types of my health information to treat me, coordinate my care or get paid for care.
- This form does not give my consent to share "psychotherapy notes".
- I can remove my consent to share behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form. Or it has been read to me in a language I can understand. My questions about this form have been answered. I can have a copy of this form.
- This signature is good for **1 year** from the date signed. Or I can choose an earlier date or have it end after the event or condition listed below. (For example, at the end of my treatment.)

  Date, event, or condition: _____

State your relationship to the person giving consent and then sign and date below:

☐ Self

☐ Parent (Print Name) _____

☐ Guardian (Print Name) _____

☐ Authorized Representative (Print Name) _____

Signature	Date
Witness Signature (If Appropriate)	Date

TAKE AWAY YOUR CONSENT

Complete Section 5 if you no longer want to share your records listed above in Section 3.

Section 5: Who Can No Longer See Your Information

I no longer want to share my records with those listed in Sections 2a and 2b. I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person withdrawing consent, then sign and date below.

☐ Self

☐ Parent (Print Name) _____

☐ Guardian (Print Name) _____

☐ Authorized Representative (Print Name) _____

Signature	Date
Witness Signature (If Appropriate)	Date

FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY

Verbal Withdrawal of Consent

☐ The individual listed above in Section 1 has taken away his/her consent.

List the individual who requested the withdrawal below, then sign and date below.

☐ Individual listed above in Section 1.

☐ Parent (Print Name) _____

☐ Guardian (Print Name) _____

☐ Authorized Representative (Print Name) _____

Signature of Person Who Received the Verbal Withdrawal	Print Name	Date

Other Information for Health Care Providers and Health Plans

This form cannot be used for a release of information from any person or agency that has provided services for domestic violence, sexual assault, stalking, or other crimes. See the FAQ for providers and other organizations at michigan.gov/bhconsent.

Additional Identifiers (Optional)

Medicaid Last 4 of the Social Security Number

Form Copy (Optional, Choose One Option)

☐ The individual in Section 1 **received** a copy of this form.

☐ The individual in Section 1 **declined** a copy of this form.

AUTHORITY:	This form is acceptable to the Michigan Department of Health and Human Services as compliant with 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq. and PA 129 of 2014, MCL 330.1141a.
COMPLETION:	Is Voluntary, but required if disclosure is requested.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

alcona citizens for health, inc
alcona health center
"Your family health center"

School Based Health & Wellness Centers

HEALTH HISTORY FORM

Ottawa Elementary School-Laura Jeffries, LMSW

Patient Name: _____ Date of Birth: _____

Please check yes or no.

Bee sting allergies	☐yes ☐ no	Seizures (epilepsy)	☐yes ☐no	Psychological disorder	☐yes ☐no
Anemia	☐yes ☐no	Stomach problems	☐yes ☐no	Thyroid disease	☐yes ☐no
Seasonal allergies	☐yes ☐no	Heart problems	☐yes ☐no	Frequent sore throats	☐yes ☐no
Asthma	☐yes ☐no	Bladder problems	☐yes ☐no	Nosebleeds	☐yes ☐no
Diabetes	☐yes ☐no	Cancer	☐yes ☐no	Backaches	☐yes ☐no
Eczema/rashes	☐yes ☐no	Headaches/migraines	☐yes ☐no	Frequent urination	☐yes ☐
no					
ADD/ADHD	☐yes ☐no	High blood pressure	☐yes ☐no	Kidney disease	☐yes ☐no
Sickle cell disease/trait	☐yes ☐no	Fainting	☐yes ☐no	Shortness of breath	☐yes ☐no
Pounding of heart	☐yes ☐no	Pneumonia	☐yes ☐no	Learning Disability	☐yes ☐no
Depression	☐yes ☐no	Anxiety	☐yes ☐no		

Does anyone smoke in the household? ☐yes ☐no

If additional space needed for below questions, please use the back of the form.

1. Student's Daily Medications? _____
2. Condition for Medications? _____
3. Any Medication Allergies? _____
4. Any Food Allergies? _____
5. Any Surgeries? _____
6. Any Hospitalizations? _____
7. Other health problems? _____

Family Medical History Check any illnesses that relatives (i.e. mother, father, aunt, uncle, grandparents, sibling) and note which relative has them	
☐ Heart Problems	☐ Cancer
☐ Cholesterol	☐ Diabetes (high blood sugar)
☐ High Blood Pressure	☐ Stroke
☐ Asthma/Emphysema/Bronchitis	☐ Seizures
☐ Death under age 50 – Cause:	☐ Kidney or Thyroid Disease
☐ Sickle Cell Anemia/Blood problems	☐ Other

Signature (Parent/Guardian): _____ Date: _____

School-Based Health Care

Client Rights and Responsibilities

YOUR RIGHTS:

1. You have the right to receive services in our clinic: regardless of race, religion, national origin, gender, sexual orientation, handicap or ability to pay.
2. You have the right to be treated with respect and dignity.
3. You have the right to receive the best possible care and have all options for care explained to you.
4. You have the right to privacy.
5. You have the right to discuss any questions or problems you may have about your care provider.
6. You have the right to refuse any services you do not want or do not understand.
7. You have the right to make a complaint if you are not satisfied with your care.

YOUR RIGHT TO CONFIDENTIAL SERVICES:

1. You have the right to confidential services.
2. You have the right to confidential services without a parental consent for these services:
    a) Behavioral Health services for students age 14 and older
    b) Sexual and Reproductive Health Services for students age 12 and older (Note: birth control devices and prescriptions, abortions and abortion referrals are restricted services and not provided).
    c) Substance abuse screening, brief intervention and referral for students age 12 and older
3. You have the right to OK or refuse the release of confidential information unless law requires otherwise.*
4. Confidentiality may be broken when we are concerned about your safety or the safety of others.

*If you are under age 18, parents and legal guardians do have the right to see your record, except for information identified as confidential above. When we receive a request from a parent or guardian to view your record, we will meet with you first and will also be available to review the information together with you and your parent/legal guardian. *School staff may be notified of the time you are with us for your appointment, if this information is needed for attendance purposes.*

YOUR RESPONSIBILITIES:

You are responsible for:

1. Participating in the development of your individual treatment plan.
2. Working towards your treatment goals and objectives.
3. Treating program staff with respect.
4. Showing respect and privacy for others using school-based health services.
5. Asking questions about anything you don't understand.
6. Telling program staff about any changes in your health.
7. Arriving on time for your appointments.
8. Informing staff if you can't make an appointment.
9. Giving us the correct information about your insurance, address, name, or phone number. If any of this information changes, you are responsible to tell the health center.
10. Asking any questions if you do not understand any information given to you in writing or verbally.

If you feel your rights have been violated, please inform the Behavioral Health Director:989-358-3966

The physicians and staff of Alcona Health Centers, Inc. have always held any medical or personal information gathered during the course of your care in the strictest of confidence. However, the federal government now mandates health care entities give notice of their privacy practices in writing, to all patients. The information contained here fulfils that requirement and contains a few changes from our previously applied policies and procedures.

This Notice describes how information about you may be used and disclosed and how you can get access to this information. Please read it carefully. You may contact our Privacy Officer at (989) 736-8157 for further information about this Privacy Notice and the complaint process. This notice was first published in December of 2002 and was reviewed and revised in 2014. This policy was last revised on August 31, 2018.

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 this office. We need this record to provide you with quality care and to comply with certain legal requirements. This Privacy Notice applies to all the records of your care generated by this practice, whether made by office personnel; or your personal doctor, physician assistants, nurse practitioner, dentist, hygienist, dental assistant or behavioural health therapist. Physicians, physical assistants, nurse practitioners, dentist, hygienist and behavioural health therapist are referred to as providers in this Notice.

Understanding Your Health Information

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or healthcare operations and for other purposes permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information and images that may identify you and that relate to your past, present or future physical or mental health or condition and related healthcare services. We are required to abide by the terms of this Notice of Privacy Practices. A current Notice will remain permanently posted in the patient lobby and paper copies will be available upon request. We may change the terms of our Notice, at any time.

The new Notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based upon Your Written Acknowledgement:

You will be asked to sign a one-time acknowledgement form. Alcona Citizens for Health Inc, hereafter referred to as AHC, will use or disclose your protected health information as described in this Section. 1. Your protected health information may be used and disclosed by your provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you. Your protected health information may also be used and disclosed to receive payment for your healthcare series to support the operations of the Alcona Citizens for Health, Inc.

Following are examples of the types of uses and disclosures of your protected healthcare information that AHC is permitted to make once you have been provided with the Notice of Privacy Practice brochure.

Treatment: We will use and disclose your protected health information to provide coordination, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that has already obtained your permission to have access to your protected health information. For example, we will disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose your protected health information to medical equipment suppliers and third party payors (for example, insurance companies and Medicare) for treatment or payment purposes. We will also disclose protected health information to other providers who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be faxed to a physician or healthcare provider to which you have been referred to ensure they have the necessary information to diagnose or treat you. We may use a sign-in sheet at the reception desk where you will be asked to sign your name and indicate the reason for your visit. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you or remind you of your appointment.

In addition, we may disclose your protected health information from time-to-time to another physician or healthcare provider (e.g., a specialist or laboratory) that, at the request of the provider, becomes involved in your care by providing assistance with our healthcare diagnosis or treatment to our provider.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health care plan may undertake before it approves or pays for the healthcare services we recommend for you such as; making a determination of eligibility of coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We will only use or disclose your protected health information to the extent necessary for AHC to operate. The uses and disclosure are necessary to run AHC and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many AHC patients to decide what additional services AHC should offer, what services are not needed, and whether certain new treatments are not effective. We may also disclose information to doctors, nurses, technicians, students and other AHC personnel for review and learning purposes. We may also combine the medical information we have with medical information from other facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it study health care and health care delivery without learning who the specific patients are.

We will share your protected health information with the third party "billing associates" that perform various activities (e.g., billing, transcription services) for AHC. We will have a written agreement that will protect the privacy of your protected health information whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information.

We may use or disclose your protected health information as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also send you information about products or services that we believe may be beneficial to you. You may notify our PRIVACY OFFICER, the individual at AHC who is responsible for healthcare privacy matters, to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time,

in writing, except to the extent that your provider or AHC has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object.

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your healthcare will be disclosed.

Registries: Unless you object, we may disclose protected health information to registries such as the (PECS) Patient Electronic Care System; or Michigan Childhood Immunization Registry (MCIR). If you do not wish to participate in a registry, send a written letter to our Health Information Supervisor

Health Information Exchange (HIE): Unless you object, the HIE records and transmits health information, including prescription information, electronically. Health information is shared and protected electronically through local, state and national health information exchanges. This organization participates in the Great Lakes Health Connect (GLHC) information network. GLHC has rules regarding how health information can be accessed through GLHC, and limits on use or disclosures of that information. For more information about GLHC, and your rights associated with transmission of your information through this and other health information exchanges, please contact our Privacy Officer. If you do not wish to participate in an HIE, send a written letter to our Health Information Supervisor.

Appointment Reminders and Messages: Unless you object, we may leave appointment reminders and messages on the answering machine at the home telephone number that you have provided. If you do not want reminders or messages left on your home recorder send a written letter to the Health Information Supervisor.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your healthcare. If you are unable or object to such a disclosure, we may disclose such information as necessary if we determine that is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, legal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens your provider shall try to obtain your consent as soon as reasonably practical after the delivery of treatment. If your provider or another provider in the practice is required by law to treat you and the provider has attempted to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your provider or another provider in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the provider determines, using professional judgment, that your intent is to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency that is authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose our protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been the victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to make sure repairs or replacements, or conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), We may, in certain conditions, disclose protected health information in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on premises of AHC, and (6) medical emergency (not on AHC premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the corner or medical examiner to perform other duties authorized by law.