UMPQUA HEALTH
HARVARD

1813 W. Harvard Ave., Suite 201
Roseburg, OR 97471
Phone: 541-440-6390
Fax: 541-440-6392

Welcome to our Practice

We have found it much easier for our patients to complete the enclosed forms in the comfort of their own home. If you run across a question that you have trouble answering, just leave it blank. Our staff will assist you in completing this at the time of your appointment.

The enclosed **Records Releases must be returned before your scheduled appointment**, when possible. This enables us to obtain and review records prior to your scheduled appointment. We will need the full name and phone/fax number of your last medical provider to obtain these prior records.

Items to bring to your appointment:

- Forms included in this packet
- Your updated and current health insurance cards
- All medications/vitamins/supplements that you are taking. Simply **put all of your pill bottles in a bag and bring them into your appointment.**

Your appointment is with:

- Dr. James Hoyne, DO
- Dr. Scott Mendelson, MD, Ph.D
- Andrea Nutt, DNP
- Jared Juett, LCSW
- Christine Garwood, FNP
- Dr. Laurance Choate
- Kathleen Waybrant, FNP
- Jena Cottrell, FNP

On_____ at _____
(Date) (Time)

If you are unable to keep this appointment for any reason, please contact our office 24 hours in advance.
We will contact you two days prior to your appointment to confirm the appointment. If we leave a message or are unable to contact you, we will make a second attempt the day prior. If we are unable to confirm, the appointment will be cancelled.

UMPQUA HEALTH HARVARD

PATIENT INFORMATION FORM

PATIENT INFORMATION

Patient's Name _____ ☐ Male ☐ Female
Last First Middle Int.

Mailing Address _____
Box/Street City State Zip

Street Address _____
Box/Street City State Zip

Date of Birth _____ SS# _____ Marital Status: S / M / D / W / Other

E-mail address: _____

Race: White / Hispanic / American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander

Ethnicity: Hispanic or Latino / Not Hispanic or Latino Preferred Language_____

Home Phone _____ Message Contact _____ Phone _____

Emergency Contact Name _____ Relationship _____ Phone _____

RESPONSIBLE PARTY for the patient

Please circle one: Self / Spouse / Parent / Stepparent / Legal Guardian / Power of Attorney / In-law ____

Name _____DOB_____ Responsible Party's Phone _____

Mailing Address _____
Box/Street City State Zip

Employer _____ Work Phone _____ Ext _____

Additional Guardian Information _____ Cell Phone _____

OTHER RESPONSIBLE PARTY for the patient

Please circle one: Self / Spouse / Parent / Stepparent / Legal Guardian / Power of Attorney / In-law ____

Name _____ Responsible Party's Phone _____

Mailing Address _____
Box/Street City State Zip

Employer _____ Work Phone _____ Ext _____

Additional Guardian Information _____ Cell Phone _____

UMPQUA HEALTH HARVARD

PATIENT INFORMATION FORM

PRIMARY INSURANCE for the patient

Please circle one: Self / Spouse / Parent / Stepparent / Legal Guardian / Power of Attorney / In-law ____

Insured / Employee's Name _____
Last First Middle Int.

Insurance Name _____ Group Name / Employer _____

Group # _____ Policy ID# _____ Effective Date _____

Insured's Date of Birth _____ Insured's SS# _____

SECONDARY INSURANCE for the patient

Please circle one: Self / Spouse / Parent / Stepparent / Legal Guardian / Power of Attorney / In-law ____

Insured / Employee's Name _____
Last First Middle Int.

Insurance Name _____ Group Name / Employer _____

Group # _____ Policy ID# _____ Effective Date _____

Insured's Date of Birth _____ Insured's SS# _____

THIRD PARTY PAYOR

Please circle one: Auto / Worker's Comp / Home Owner's Policy / Other _____

Date of Injury _____ Place of Injury _____ Claim# _____

Insurance Company _____ Employer / Owner _____

Insurance Phone _____ Claim Representative _____

UMPQUA HEALTH HARVARD

PATIENT INFORMATION FORM

ADDITIONAL INFORMATION

Please provide a list of all the parties we may speak with or leave a message with regarding the patient's medical care, appointment scheduling, or payment information.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

May we leave a message on your answering machine, if so at what phone number? ☐ Yes ☐ No

Phone number:_____

May we contact you at work? ☐ Yes ☐ No

The undersigned patient or individual acting on the behalf of the patient agrees as follows:

1. Authority is granted to Umpqua Health - Harvard to render needed treatment to the above named patient.
2. I authorize Umpqua Health - Harvard to release information regarding my treatment to my insurance company for billing purposes.
3. I authorize payment of medical benefits to Umpqua Health - Harvard for services rendered.
4. I understand that I am responsible for all charges incurred through Umpqua Health - Harvard.
5. Authorization Period: ☐ One year OR ☐ Lifetime

I request that payment under the medical insurance program be made to the provider named above on any bills for services furnished me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original. If this becomes necessary to effect Collection of my account the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and court costs.

Signature _____ Date _____

Signature _____ Date _____

UMPQUA HEALTH
HARVARD

Cancellation and Missed Appointment Agreement

Umpqua Health - Harvard strives to provide each patient with quality personal attention and the best care possible. Patients who cannot make an appointment should call and cancel at least 24 hours in advance. This opens appointments for other patients needing prompt medical care. Whenever one patient "no shows", another sick patient cannot be seen in his/her place.

As a courtesy, Umpqua Health - Harvard confirms each appointment two days in advance.

However, it is the patient's responsibility to make or cancel appointments and to ensure current insurance information, mailing addresses and phone numbers are provided.

After two "no show" appointments or cancelled appointments without 24 hour notice, patients will no longer be able to schedule appointments. Patients will be on a work in basis and will be worked into the provider's schedule if time allows. Patients may also be considered for discharge from the practice.

My signature below represents that I have read, understand, and agree to the terms of the Cancellation and Missed Appointment Policy.

_____

Patient's Printed Name

_____ _____

Patients, Parent, or Guardian Signature Date

1813 W. Harvard Ave., Suite 201, Roseburg, OR 97471
Phone: 541-440-6390
Fax: 541-677-6048

UMPQUA HEALTH
HARVARD

ACKNOWLEDGMENT AND CONSENT

I understand that Umpqua Health - Harvard, referred to below as ("This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____ Date: _____
(Patient)

Patient's printed name _____

-OR-

By: _____ Date: _____
(Patient representative)

Description of Representative's Authority:

New Patient History Form

Name: _____ Date of Birth: _____

Occupation: _____

Age: _____ Sex: M or F Marital Status: M S W D O

Chief Complaint: _____

Current Medications	Dosage	Frequency/How Often

Family History:

Father: ☐ Alive ☐ Deceased
Cause of Death _____
Mother: ☐ Alive ☐ Deceased
Cause of Death _____
Siblings Total #____ #Alive____ #Deceased ____
Cause of Death : _____
Cause of Death : _____
Cause of Death : _____
Spouse's Name: _____

Do you have a family history of:

Heart Disease	Yes	or	No
High Blood Pressure	Yes	or	No
Diabetes	Yes	or	No
Stroke	Yes	or	No
Cancer	Yes	or	No
Site _____			
Thyroid Disease	Yes	or	No
Other Disease	Yes	or	No
Depression/Anxiety	Yes	or	No

Review of your Body Systems:

Do you have now or have you ever had any of the following?

	YES	NO	Please Explain
Ulcers	___	___	_____
Colitis	___	___	_____
Rectal Bleeding	___	___	_____
Change in Bowel Habits	___	___	_____
Black Tarry Stools	___	___	_____
Heart Disease	___	___	_____
High Blood Pressure	___	___	_____
Chest Pain	___	___	_____
Cough Blood	___	___	_____
Shortness of Breath	___	___	_____
Thyroid Disease	___	___	_____
Lung Disease	___	___	_____
Cancer	___	___	Site:_____
Asthma or Emphysema	___	___	_____

New Patient History Form

Name: _____ Date of Birth: _____

Hepatitis	___	___	_____
Gallbladder Disease	___	___	_____
Venereal Disease	___	___	_____
Kidney Stones	___	___	_____
Blood in Urine	___	___	_____
Epilepsy/ Seizures	___	___	_____
Swollen or Painful Joints	___	___	_____
Arthritis	___	___	_____
Nervous Disorder	___	___	_____
Depression/Anxiety	___	___	_____
Diabetes	___	___	_____
Stroke	___	___	_____
Headache/Migraines	___	___	_____
Back Disorder	___	___	_____
Blood Disease or Anemia	___	___	_____

Hospitalizations:

Illness _____ Year _____ Hospital _____
Illness _____ Year _____ Hospital _____
Illness _____ Year _____ Hospital _____
Surgery _____ Year _____ Hospital _____
Surgery _____ Year _____ Hospital _____
Surgery _____ Year _____ Hospital _____

Your Children: Number living _____ Number Deceased _____
List any serious diseases in your children:_____

Your Personal Habits

	YES	NO	Please explain
Regularly exercise (3 or 4 times/wk)	_____	_____	_____
Wear Auto Seat belts (90% of time)	_____	_____	_____
Use Illegal Drugs	_____	_____	_____
Medical Marijuana Cardholder	_____	_____	_____
Use Alcohol	_____	_____	_____
Were you ever a heavy drinker?	_____	_____	_____
Use Tobacco	_____	_____	_____

Religious Preference: _____

Advance Directives: Yes or No POLST? Yes or No

Women Only----------

Menstrual Period Age at onset _____ Date of last period _____
□ Regular □ Irregular □ Difficulty with periods

Number of Pregnancies: _____No. of live births: _____
C-Sections ____ Miscarriages ____ Stillborns____ Premature _____

New Patient History Form

Name: _____ Date of Birth: _____

*Describe any complications*_____

UMPQUA HEALTH

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize the following health care provider(s) to use, share and disclose medical information of the patient named below, as follows:

Health care provider who is disclosing information:

_____
Name of provider, clinic or hospital

_____
Street Address

_____
City, State, Zip

_____
Phone Fax

Person or organization who is receiving information:

UMPQUA HEALTH, LLC.
Name (if an individual, include affiliated institution, if any)

1813 W. HARVARD AVE, STE 201
Street Address

ROSEBURG, OR 97471
City, State, Zip

541-440-6390 **541-464-4641**
Phone Fax

Patient Name:	Date(s) of Service, if applicable:	Patient ID Number:
Date of Birth:	Other Names Used:	Patient's or Personal Representative's Phone Number:

Describe each purpose of disclosure, or indicate that the disclosure is at the request of the individual:

_____ At the request of the individual (initial in the space provided); or

_____

_____

By initialing the spaces below, I authorize the use and/or disclosure of the following:

_____Entire medical record (except the Specially Protected Information identified by asterisk below)
_____Partial record, including (check all that apply):

_____Clinic records
_____Transcribed hospital reports
_____Progress notes
_____Emergency and urgent care records
_____Photographs and Videotapes
_____Demographic sheet/face sheet
_____Other: _____

_____Dental records
_____Laboratory reports
_____Pathology reports
_____Diagnostic imaging reports
_____Billing statements

*Specially Protected Information: Except as specifically permitted by law, the following types of information will not be disclosed unless I authorize the disclosure by **placing my initials** in the space(s) next to type of information to be disclosed:

_____*HIV-positive test results and HIV diagnosis
_____*Mental health information and/or records
_____*Genetic testing information and/or records (Oregon ONLY)
_____*Other sexually transmitted diseases (Washington ONLY)
_____*Drug/alcohol diagnosis, treatment or referral information.

UMPQUA HEALTH

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal and state law. However, I also understand that federal or state law may restrict redisclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services unless authorization is required to bill my insurance company. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. Revocation shall be sent to _____ (contact person) at _____ (address), identifying you by name and by birth date or patient identification number, and stating that you are revoking this authorization.

If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire one year from the date of signing on _____, or as otherwise identified here: _____.

_____ _____

Signature of Patient** or Patient's Legal Representative*** Date

_____ _____

Print Name of Legal Representative (if applicable) Relationship to Patient

**Patients of the following ages must sign this form to release their PHI to any person or facility, except when release to a parent or guardian is permitted by law or regulation:
14 years of age and above: All medical conditions (Washington); mental health and chemical dependency (Oregon)
15 years of age and above: All other medical conditions (Oregon)

***If you are not the patient's parent, please attach documentation of your authority.

☐ Legal Representative's authority to act as Representative verified

☐ Patient's or Legal Representative's Personal Identification Verified Records Copied by: _____

Instructions for completion of
"Authorization To Use And/Or Disclose Protected Health Information"

If you are requesting information to be released to someone other than yourself, complete all sections of this form as directed.

1. Print the name and address of the health care provider, clinic or hospital that is to release information.

2. Print the name and address of the person or entity that is to receive your information, under "To use/disclose medical information to."

3. Print the full name of the patient, including middle initial in "Patient Name" box.

4. Identify the date(s) of service of the health care information you would like released.

5. Identify the reason for the requested release in the "Purpose" box.

6. Print the patient's social security number (optional).

7. Print the patient's Date of Birth.

8. Print other names used by the patient.

9. Include the patient's or personal representative's phone number.

10. Initial in the space provided for each type of medical record/information you wish to disclose to the recipient. Initial next to any specially protected records that you would like disclosed (Specially protected information is identified with an asterisk).

11. Fill in an expiration date or event. An example of an event is, "while I am receiving services at this facility." If left blank, authorization will expire one year from the date of signing the form.

12. Sign your name if you are the patient or the patient's legal representative on the "Signature" line.

13. Indicate the date you are signing the form.

14. Print the patient's name or name of legal representative if applicable.

15. Write your relationship to the patient if you are not the patient.

16. Retain a copy of the authorization for yourself.

If you are the legal representative for the patient please attach a copy of the Power of Attorney, Death Certificate or Probate form.

Effective Date: May 15, 2019

NOTICE OF PRIVACY PRACTICES

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

If you have any questions about this notice, please contact our Privacy Officer at 541-229-7035.

We understand that your health information is personal, and we take the privacy of our patients and others we serve very seriously. The law requires us to (1) protect the privacy of the health information we create or receive; (2) provide you with this notice describing how we may use and share your health information; and (3) follow the terms of this notice.

This notice applies to health care providers affiliated with Umpqua Health, LLC, including **Umpqua Health - Harvard, LLC, Umpqua Health Newton Creek**, **LLC**, and all of their employees, volunteers, and service providers, including clinicians, who have access to the health information we have received while caring for you.

A. Use and Disclosure of Health Information Without Your Permission.

We may use or share your health information without your permission in the following circumstances:

1. *Treatment*. We may use your health information to provide you with health care services and to coordinate and manage your care. We may share your health information with doctors, nurses, technicians, and others involved in your care, including third parties such as hospitals, pharmacies, or home health agencies.

Example: A doctor treating your injury may need to review your medical history to know if you have other health conditions that may complicate your treatment. The doctor may also share your treatment plan with a physical therapist involved in your care.

2. *Payment*. We may use and share your health information so that we, or others, may bill and be paid by you, your insurance company, or a third party for the health care services provided to you. We may also tell your health plan about a treatment you are going to receive, to obtain your plan's prior approval or learn if your plan will pay for the treatment.

Example: We may provide information to your health plan about the services we provided to treat your injury, so that the health plan will pay us or reimburse you for those services.

3. *Operations*. We may use and share your health information to run the necessary administrative, educational, quality assurance, and business functions at our clinics.

Example: We may use your health information to evaluate the performance of our staff in caring for you or to help us determine what additional services we should offer and how we can improve efficiency or quality of care.

4. *Information Exchange.* We utilize an electronic health record system that is maintained by an Umpqua Health affiliate and is shared by multiple health care providers and organizations in the Douglas County community. We also participate in a health information exchange managed by Mercy Medical Center that permits health care providers to electronically exchange health information. Your health information may be shared with other providers and organizations when necessary and as appropriate for our and their treatment, payment, and health care operations purposes.

5. *Organized Health Care Arrangement.* We participate in a clinically integrated network that engages in certain health care quality and efficiency initiatives and is supported by ACE Network, LLC. Participants of the clinically integrated network have formed an organized health care arrangement ("OHCA"). As our business associate, ACE Network, LLC facilitates information sharing among the OHCA participants in furtherance of the OHCA's health care quality and efficiency-related activities. Your health information may be shared by ACE Network, LLC with other OHCA participants.

6. *Appointment Reminders.* We may use and share your health information to contact you as a reminder that you have an upcoming appointment for treatment or related services.

7. *Treatment Alternatives and Related Services.* We may use and share your health information to tell you about or recommend possible treatment options, alternatives, or health and related benefits or services that may be of interest to you.

8. *Public Health*. We may share your health information for public health activities, such as preventing or controlling disease, injury, or disability; reporting births, deaths, suspected abuse or neglect, domestic violence, or non-accidental physical injuries; reporting reactions to medications or problems with products; and helping with product recalls.

9. *Health Oversight.* We may share your health information with health oversight agencies for activities authorized by law, such as audits and investigations.

10. *Legal Proceedings*. We may share your health information in response to any court order, administrative order, or subpoena that requires us to share your information, if certain requirements are met.

11. *Law Enforcement*. We may share your health information with law enforcement officials, as appropriate, to report a crime or assist in the investigation of a crime.

12. *Public Safety.* We may share your health information to prevent a serious threat to anyone's health or safety.

13. *Employment*. We may share your health information with employers, insurers, and others to comply with laws related to workers' compensation and employment safety.

14. *Organ Donation*. We may share your health information with organ procurement organizations or organ donation banks to facilitate organ, eye, or tissue donation or transplantation.

15. *Death*. We may share your health information with coroners, medical examiners, or funeral directors if you die.

16. *Research.* We may use or share your health information for research purposes under certain limited circumstances.

17. *Special Circumstances*. We may share your health information for specific government functions, such as national security, military activities, the operation of correctional facilities, and government benefit programs.

18. *Required by Law*. We will share your health information as required by federal, state, or local laws.

B. Disclosure of Health Information to Family and Friends.

1. We may share your health information with your family, close friends, or others involved in your care or the payment of your care if you tell us we can do so or if we can assume, based on the circumstances and our professional judgment, that you do not object. If you are unable to approve or object (for example, if you are unavailable or unconscious), we may share your health information that is related to the particular person's involvement in your care only if we feel it is in your best interest.

2. We may also share your health information to notify, or assist in notifying, your family, close friends, or others involved in your care of your location or general condition. For example, in a natural disaster or other emergency, we may share your health information with a disaster relief organization to assist in notifying your family of your location and general condition.

C. Use and Disclosure of Health Information for Fundraising Activities.

We may use and share a limited amount of your health information to contact you in connection with fundraising efforts. Any fundraising communications you receive from us will include information about how you can elect not to receive any further fundraising communications.

D. Use and Disclosure of Your Health Information Requiring Written Permission.

Other than for the purposes described above in Sections A-C, we will not use or share your health information for any purpose unless you give us specific written permission to do so. Special circumstances that require your written permission include:

1. *Psychotherapy Notes*. In most cases, we may not share your psychotherapy notes without your written permission.

2. *HIV Test Results.* In certain circumstances, disclosure of your test results for human immunodeficiency virus (HIV) requires your written permission.

3. *Sale of Health Information*. We will not sell your health information without your written permission.

4. *Marketing*. We will not use or share your health information for marketing purposes that encourage you to buy a product or service, unless we have your written permission.

If you provide written permission, you can revoke it at any time by contacting the Privacy Officer in writing. If you revoke your permission, we will no longer use or disclose your health information as allowed by the written permission, except to the extent we have already relied on it.

E. Your Rights Regarding Your Health Information.

You have the following rights with respect to your health information. If you want to exercise these rights, you must do so in writing by completing a form you can obtain from the Umpqua Health Compliance & Privacy Office. In some cases, we may charge you for the costs of providing materials to

you. You can get more information about how to exercise your rights and any costs that we may charge for materials by contacting the Umpqua Health Compliance & Privacy Office.

1. *Request Restrictions*. You can ask us in writing to limit how we use or share your health information for treatment, payment, or our operations. We are not required to say "yes" to your request, and we may say "no" if it would affect your care. Please ask a staff member for the Request for Restriction of Health Information form.

If you or someone else, other than your health plan, pays for a procedure, service, or test out-of-pocket and in full, you can ask that we not share that information with your insurer for payment or health care operations purposes. We will say "yes" to your request, unless the law requires us to share that information.

2. *Access*. You can ask to see or get an electronic or paper copy of your medical record and other health information. We will provide you with a copy or summary of your health information, usually within 30 days of your request. We may say "no" to your request in certain circumstances, but if we do, you may ask that the decision be reviewed.

3. *Amend*. If you believe your health information is incorrect or incomplete, you can ask us in writing to correct the information. We may deny your request in certain circumstances, but we will tell you why in writing, usually within 60 days of your request. Please ask a staff member for the Request for Amendment of Protected Health Information form.

4. *Accounting of Disclosures*. You can ask us for a list of when we shared your health information, who we shared it with, and why. We will include all disclosures except:

- Disclosures made for treatment, payment, and our operations;
- Certain other disclosures, such as disclosures made to you or made with your permission; and
- Disclosures made more than six years before your request.

5. *Confidential Communications*. You can ask us to contact you in a certain way or at a certain location. For example, you may ask us to contact you at work or by mail. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

6. *Notice of Privacy Practices*. You can ask for a paper copy of this notice, even if you agreed to receive this notice electronically.

7. *Notice of Breach*. We must provide you with written notice if we discover a breach that may have compromised the privacy or security of your unsecured health information.

F. Changes to This Notice.

We can change the terms of this notice, and the terms will apply to all health information we already have about you, as well as any information we receive in the future. The new notice will be available on our website, in our clinics, and upon request.

G. Questions or Complaints.

If you have any questions about this notice or believe your privacy rights have been violated, please contact our Privacy Officer at 541-229-7035 or compliance@umpquahealth.com.

You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by following the instructions at https://www.hhs.gov/hipaa/filing-a-complaint.

We will not penalize or retaliate against you for filing a complaint.