JACKSON-HINDS COMPREHENSIVE HEALTH CENTER

Please Check One: ❑ *New Patient* ❑ *Existing Patient*

Patient Information (Please print clearly)

Legal Name: _____
Last First Middle Initial

Preferred Name: _____

Pronouns:
❑ He, Him, His ❑ She, Her, Hers ❑ They, Them, Theirs ❑ Other _____

Legal Sex (please check one) *
❑ Male
❑ Female

*While Jackson Hinds Comprehensive Health Center recognizes a number of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know

Date of Birth (mm/dd/yy) _____/_____/_____ **Social Security #** _____-_____-_____ **Mother's Maiden Name:** _____

Contact Information

Mailing Address **City** **State** **Zip**

Physical Address (if different from above) **City** **State** **Zip**

Home Phone: _____
Ok to leave a voicemail?
❑ Yes ❑ No

Cell Phone: _____
Ok to leave a voicemail?
❑ Yes ❑ No

Work Phone: _____
Ok to leave a voicemail?
❑ Yes ❑ No

Email address: _____
Would you like to sign up for the Patient Portal?
❑ Yes ❑ No

Communication Preferences:
Check all that apply
❑Mail ❑Patient Portal
❑Email ❑ Primary phone

Emergency Contact

Name _____
Address: _____
Phone_____ Relationship _____
For after-hour assistance, please call (601)362-5321. An On-Call Representative will assist you.

Preferred Language:
❑English ❑Spanish ❑ Chinese
❑ French ❑ Japanese ❑ Korean
❑ Vietnamese ❑Other _____
❑ Need an Interpreter

Demographic Information

Marital Status:
❑ Married ❑ Partnered
❑ Single ❑ Divorce
❑ Separated ❑ Widow

Race:
❑ Black/African American ❑ White
❑ Hispanic ❑ Asian
❑ Pacific Islander ❑ Native Hawaiian
❑ American Indian/Alaskan Native ❑ More than one race
❑ Other _____

Ethnicity:
❑ Hispanic or Latino
❑ Not Hispanic or Latino
❑ Unknown
❑ Decline to specify
❑ Other _____

Veteran Status:
❑ Active Duty
❑ Inactive Duty
❑ Reservist
❑ Veteran
❑ Not a Veteran

Sexual Orientation & Gender Identification

Sexual Orientation
❑ Lesbian ❑ Choose not to disclose
❑ Gay ❑ Don't Know
❑ Straight/Heterosexual
❑ Bisexual
❑ Other _____

Gender Identity
❑ Male ❑ Choose not to disclose
❑ Female ❑ Other _____
❑ Genderqueer
❑ Transgender Female
❑ Transgender Male

Sex Assigned at Birth
❑ Female
❑ Male
❑ Unknown

Employment

Employment Status
❑ Employed full-time ❑ Employed part-time
❑ Student full-time ❑ Student part-time
Employer: _____
School Name: _____

How did you hear about us?

❑ Website/Search Engine ❑ Social Media ❑ Radio
❑ Community/Area Event ❑ Flyer/Registration form
❑ Friends or Family ❑ Other _____

Advanced Directive

Do you have an Advance Directive?
❑ Yes
❑ No, but would like additional information
❑ No, I am not interested

Insurance Information

What Health Insurance Coverage Do You Have? Please check all that apply.

❑ **Medicaid** ❑ **Medicare** ❑ **Private Health Insurance** ❑ **Dental** ❑ **Uninsured**

Primary Insurance Name _____ Policy Number: _____ Group # _____

Secondary Insurance Name _____ Policy Number: _____ Group # _____

Dental Insurance Name _____ Policy Number: _____ Group # _____

Medicaid Number: _____ Medicare Number: _____

Please provide the following information on the responsible party to be billed, if not the patient.

Parent or Guardian: _____ **Phone No.** _____ **Social Security No.**_____ **Birth Date** _____

ASSIGNMENT AND RELEASE: I, the patient or parent/guarantor, hereby authorized any holder of information about me to release to Medicaid, Medicare or Insurance provider, any information needed for settlement of my claims. I understand approved claims will be deducted from my allocated benefits whether they are rendered in one of our clinics or mobile health facilities. I am requesting that all health insurance benefits be made payable to Jackson Hinds Comprehensive Health Center.

Signature of Patient or Legal Guardian: _____ **Date:** _____

JACKSON-HINDS COMPREHENSIVE HEALTH CENTER

SLIDING FEE DISCOUNT PROGRAM

Part of being your indispensable healthcare partner means offering a patient-friendly Sliding Fee Discount. JHCHC maintains a standard procedure for qualifying patients for sliding fee discounts for services provided. Sliding fee discounts are available to patients with all incomes at or below 200% of the federal poverty guidelines. Sliding fee discounts apply to all directly provided JHCHC's services, and for all in-scope services. Opportunities for assistance are available to all qualifying patients – regardless of whether you have insurance. Please complete the application and BE SURE TO ATTACH ALL REQUESTED DOCUMENTATION. Applications lacking required proof of income will be voided and you will be responsible for any subsequent visits at Jackson-Hinds.

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ SSN#: _____

Address: _____

(Street Address) (City) (State) (ZIP Code)

PLEASE INDICATE YOUR CURRENT LIVING ARRANGEMENTS

- ❑ Own/Rent
- ❑ Homeless Shelter Name of Shelter_____
- ❑ Transitional (Live in halfway house) Name of Transitional Home _____
- ❑ Doubling up (Live with relative or friend)
- ❑ Street

LIST ALL PERSONS LIVING IN HOUSEHOLD

NAME	RELATIONSHIP TO PATIENT	AGE	INCOME Please circle one: Weekly, Bi-Weekly, Monthly, Yearly	SOURCE OF INCOME Job, SSI, SNAP benefits, etc.
	SELF			
Total Household Annual Income				

****ALL FAMILY MEMBERS OVER THE AGE OF 21 LISTED ABOVE MUST PRESENT INCOME OR A NOTARIZED LETTER STATING HE/SHE HAS NO INCOME AND LIVE WITH YOU FREE OF CHARGE****

Please read carefully before signing:

I hereby certify that I have examined the contents of this form and to the best of my knowledge and belief, the said contents are true and correct statements of my family income and size. Also, I understand that I must provide this information at least yearly to receive sliding fee discount for services. I understand that if I am applying for financial assistance and do not have any source of income or do not have proof of income with me today, Jackson-Hinds will discount my services for today's visit only**. However, I will be totally responsible for any subsequent visits at Jackson-Hinds, if I do not bring proof of income**. I understand that certain payments may be required at the time of, or in advance of, services being provided. I also understand I will be billed for any charges not paid by my insurer, and I will be responsible for paying them. Any false statements, documents or concealment of a material fact will disqualify me from receiving sliding fee discounts.

_____ _____

Signature of Patient or Legal Guardian **Date**

FOR OFFICE USE ONLY: _____ Partial Attestation (one visit per calendar year) OR _____ Full Sliding Fee (year)

JACKSON-HINDS COMPREHENSIVE HEALTH CENTER

GENERAL CONSENT FOR DIAGNOSIS AND TREATMENT

GENERAL CONSENT TO CARE:

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, having registered at Jackson-Hinds Comprehensive Health Center (JHCHC) for the purpose of obtaining health services, do hereby voluntarily consent to such diagnosis and treatment service, as ordered by a provider, dentist or other qualified health care provider of JHCHC. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

I recognize that I have the right to refuse any specific diagnostic or treatment service without jeopardizing my right to receive services at the heath center. I also recognize that I will be asked to sign a specific consent, as needed, for surgical and other special procedures including general and/or extensive local anesthesia.

I recognize that, according to the laws of the State of Mississippi, parental consent is not required in the case of a minor seeking treatment of a sexually transmitted infection or a female, regardless of age or marital status, seeking diagnostic or treatment services in connection with pregnancy or childbirth.

I agree and acknowledge that JHCHC is not liable for the actions or omissions of, or the instructions given by the physician, dentist or other qualified health care provider of JHCHC. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at JHCHC facilities. Further, I authorize the health center to furnish requested patient information to requisite legal, health, social and government entities, as needed.

AFTER HOUR ASSISTANCE

For after hour assistance, please call **(601) 362-5321.** An On-Call Representative will be available to assist you.

JHCHC's NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of JHCHC's Notice of Privacy Practices, which describes how medial information about me may be used and disclosed and how I can get access to this information.

USE AND DISCLOSE OF INFORMATION

I understand that JHCHC will use and disclose my health information for the purposes of treatment, payment, and healthcare operations. I understand, acknowledge and consent to the release of my personal health information for the purposes outlined in this section, as described in the Notice of Privacy Practices which has been offered to me, and as may otherwise be permitted by law. I understand and acknowledge that JHCHC may record medical and other information related to my treatment in paper, electronic, photographic, video and other formats and that such information will be used in the course of my treatment, for payment purposes and to support healthcare operations. I give consent for my treating physicians and other health care providers to exchange information with other health care professionals and providers about my prior and current health conditions to facilitate treatment. I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.

PATIENT RIGHTS AND RESPONSIBILITITES

I understand that I have the right, and the responsibility, to participate in my care and treatment. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my health history and presenting complaint, to agree upon a treatment plan, and follow that plan. I agree to participate and cooperate in my own care and treatment. I understand that my health care providers will treat me with respect, and I agree to do the same for them. Further information can be found in the Patient Rights and Responsibilities pamphlet, which has been offered to me.

RESPONSIBILITY FOR PAYMENT

In consideration of the services provided to me by JHCHC, I agree to pay JHCHC professionals involved in my care for all services and supplies provided to me. If private health insurance, Medicare, Medicaid, other governmental or other insurance programs cover my treatment, I authorize JHCHC to bill any such insurer for all charges incurred by me in connection with my diagnosis, care and treatment. My insurance coverage may provide that some amount of the bill will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered by my health insurance, Medicare, Medicaid or any other programs for which I am eligible. I understand that certain payments may be required at the time of, or in advance of, services being provided. I also understand I will be billed for any charges not paid by my insurer, and I will be responsible for paying them.

PATIENT CERTIFICATION

I HAVE READ, UNDERSTOOD AND FULLY AGREE TO the above General Consent to Diagnosis and Treatment. This consent shall go into effect upon my signature/electronic signature date and remain in effect as long as the above named patient utilizes JHCHC services, unless revoked in writing and submitted to JHCHC. I hereby sign my signature/electronic signature below as my free and voluntary act.

Signature Patient or Legal Guardian	Relationship to the Patient	Date

JACKSON-HINDS COMPREHENSIVE HEALTH CENTER
CONSENT TO E-PRESCRIBING

E-Prescribing is defined as a physician's ability to electronically send error free, accurate, and understandable prescriptions directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Jackson-Hinds Comprehensive Health Center can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all the above, I hereby provide informed consent to Jackson-Hinds Comprehensive Health Center to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

PREFERRED PHARMACY

Name_____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____

PATIENT CERTIFICATION
I HAVE READ, UNDERSTOOD AND FULLY AGREE TO the above Consent to E-Prescribing. This consent shall go into effect upon my signature/electronic signature date and remain in effect as long as the above-named patient utilizes JHCHC services, unless revoked in writing and submitted to JHCHC. I hereby sign my signature/electronic signature below as my free and voluntary act.

Print Patient Name _____ **Patient Date of Birth** _____

_____	_____	_____
Signature of Patient or Legal Guardian	**Relationship to the Patient**	**Date**

CENTRAL MISSISSIPPI CIVIC IMPROVEMENT ASSOCIATION, INC.
D/b/a JACKSON-HINDS COMPREHENSIVE HEALTH CENTER
NOTICES 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.

A federal regulation, known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Rule), requires all medical records and individually identifiable health information used or disclosed by Jackson-Hinds Comprehensive Health Center (JHCHC) in any form, whether electronically, in writing, or orally, are kept confidential. The HIPAA Privacy Rule gives you, the patient, the right to understand and control how your health information is used, collect and stored in a medical record. JHCHC is the parent organization to 11 health centers and 27 school base sites. This is your medical record; which is the property of JHCHC, but the information in the medical records belong to you. Your records are a requires us to address many specific things in this notice.

OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU

In this notice, JHCHC describe the ways that JHCHC may use and disclose health information about our patients. The HIPAA Privacy Rule requires that JHCHC protect the privacy of health information that identifies a patient or may be used to identify a patient. This information is called "Protected Health Information" or "PHI." This notice describes your rights as our patient and our obligations regarding the use and disclosure of PHI. JHCHC is required by law to:

- Maintain the privacy and security of PHI about you.
- Give you this Notice of our legal duties and privacy practices with respect to PHI.
- Comply with the terms of our Notice of Privacy Practices that is currently in effect.

JHCHC is required to abide by the terms of this notice, which JHCHC may change from time to time. Any new notice will be effective for all PHI that JHCHC maintains at that time. JHCHC will also provide you with a copy of the revised notice upon your request.

HOW JHCHC MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

For uses and disclosures relating to treatment, payment, or health care operations, JHCHC does not need an authorization to use and disclose your medical and behavioral health information.

Treatment: JHCHC may use and disclose PHI about you to provide, coordinate or manage your health care and related services. JHCHC may consult with other health care providers regarding your treatment and coordinate and manage your health care with others. For example, JHCHC may use and disclose PHI when you need a prescription, lab work, an x-ray, or other health care services. In addition, JHCHC may use and disclose PHI about you when referring you to another health care provider so that the health care provider has the information necessary to treat you.

Payment: JHCHC may use and disclose PHI so that JHCHC can bill and collect payment for the treatment and services provided to you. Before providing treatment or services, JHCHC may share details with your health plan concerning the services you are scheduled to receive. For example, JHCHC may ask for payment approval from your health plan before JHCHC provides care or services. JHCHC may use and disclose PHI to find out if your health plan will cover the cost of care and services JHCHC provides. JHCHC may use and disclose PHI to confirm you are receiving the appropriate amount of care to obtain payment for services. JHCHC may use and disclose PHI for billing, claims management, and collection activities. JHCHC may disclose PHI to insurance companies providing you with additional coverage. JHCHC may disclose limited PHI to consumer reporting agencies relating to collection of payments owed to us. JHCHC may also disclose PHI to another health care provider or to a company or health plan required to comply with the HIPAA Privacy Rule for the payment activities of that health care provider, company, or health plan. For example, JHCHC may allow a health insurance company to review PHI for the insurance company's activities to determine the insurance benefits to be paid for your care.

Health Care Operations: JHCHC may use and disclose PHI in performing business activities that are called health care operations (i.e. an Accountable Care Organization). Health care operations include doing things that allow us to improve the quality-of-care JHCHC provides and to reduce health care costs. You may opt out.

Required by Law: JHCHC may use and disclose PHI as required by federal, state, or local law. Any disclosure complies with the law and is limited to the requirements of the law.

Public Health Activities: JHCHC may use or disclose PHI to public health authorities or other authorized persons to carry out certain activities related to public health. To prevent or control disease, injury, or disability. To report disease, injury, birth, or death. To report child abuse or neglect. To report reactions to medications or problems with products or devices regulated by the federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities. To locate and notify persons of recalls of products they may be using. To notify a person who may have been exposed to a communicable disease in order to control who may be at risk of contracting or spreading the disease. To report to your employer, under limited circumstances, information related primarily to workplace injuries or illness, or workplace medical surveillance.

Abuse, Neglect, or Domestic Violence: JHCHC may disclose PHI in certain cases to proper government authorities if JHCHC reasonably believes that a patient has been a victim of domestic violence, abuse, or neglect.

Health Oversight Activities: JHCHC may disclose PHI to a health oversight agency for oversight activities including, for example, audits, investigations, inspections, licensure and disciplinary activities conducted by health oversight agencies.

Lawsuits and Other Legal Proceedings: JHCHC may use or disclose PHI when required by a court or administrative tribunal order. JHCHC may also disclose PHI in response to subpoenas, discovery requests, or other required legal processes.

Law Enforcement: Under certain conditions, JHCHC may disclose PHI to law enforcement officials. These law enforcement purposes include: Limited requests for identification and location purposes; Legal processes required by law; Suspicion that death has occurred as a result of criminal conduct; In the event that a crime occurs on the premises of the practice; Pertaining to victims of a crime; and in response to a medical emergency not occurring at the office, where it is likely that a crime has occurred.

Coroners and Medical Examiners: JHCHC may disclose PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death.

Organ and Tissue Donation: If you are an organ donor, JHCHC may use or disclose PHI to organizations that help procure, locate, and transplant organs in order to facilitate an organ, eye, or tissue donation and transplantation.

Research: JHCHC may use and disclose PHI about you for research purposes under certain limited circumstances. JHCHC must obtain a written authorization to use and disclose PHI about you for research purposes except in situations where a research project meets specific, detailed criteria established by the HIPAA Privacy Rule.

To Avert a Serious Threat to Health or Safety: JHCHC may use or disclose PHI about you in limited circumstances when necessary to prevent a threat to the health or safety of a person or to the public. This disclosure can only be made to a person who is able to help prevent the threat.
Specialized Government Functions: Under certain circumstances JHCHC may disclose PHI. For certain military and veteran activities, including determination of eligibility for veteran's benefits and where deemed necessary by military command authorities. For national security and intelligence activities. To help provide protective services for the president and others. For the health or safety of inmates and others at correctional institutions

Disclosures required by HIPAA Privacy Rule: JHCHC is required to disclose PHI to the Secretary of the United States Department of Health and Human Services when requested by the

Secretary to review our compliance with the HIPAA Privacy Rule. JHCHC is also required in certain cases to disclose PHI to you upon your request to access PHI or for an accounting of certain disclosures of PHI about you.

Workers' Compensation: JHCHC may disclose PHI as authorized by workers' compensation laws or other similar programs that provide benefits for work-related injuries or illness.

Decedents: In case of patient death, JHCHC may make relevant disclosures to the deceased's family and friends under essentially the same circumstances such disclosures JHCHC is permitted when the patient was alive; that is, when these individuals were involved in providing care or payment for care unless the decedent had expressed a contrary preference.

Childhood Immunizations: JHCHC may disclose immunizations to schools required to obtain proof of immunization prior to admitting the student so long as the physicians have and document the patient or patient's legal representative's "informal agreement" to the disclosure.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRE YOUR AUTHORIZATION

All other uses and disclosures of PHI about you will only be made with your written authorization. If you have authorized us to use or disclose PHI about you, you may revoke your authorization at any time, except to the extent JHCHC has acted based on the authorization. You understand that JHCHC is unable to take back any disclosures JHCHC has already made with your permission, and that JHCHC is required to retain our records of the care that JHCHC provided you.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

Under federal law, you have the following rights regarding PHI about you:

Right to Request Restrictions: You have the right to request additional restrictions on the PHI that JHCHC may use for treatment, payment and health care operations. You may also request additional restrictions on our disclosure of PHI to certain individuals involved in your care that otherwise are permitted by the Privacy Rule. JHCHC is not required to agree to your request. If JHCHC does agree to your request, JHCHC is required to comply with our agreement except in certain cases, including where the information is needed to treat you in the case of an emergency. To request restrictions, you must make your request in writing to our Compliance Officer. In your request, please include (1) the information that you want to restrict (2) how you want to restrict the information and (3) to whom you want those restrictions to apply. You also have the right to request that any services performed that were paid for in full by you and not billed to your insurance company not be disclosed- this request must be made in writing. For example, for services you request no insurance claim be filed and for which you pay privately, you have the right to restrict disclosures for these services for which you paid for out of pocket.

Right to Receive Confidential Communications: You have the right to request that you receive communications regarding PHI in a certain manner or at a certain location. For example, you may request that JHCHC contacts you at home, rather than at work. You must make your request in writing to our Compliance Officer. You must specify how you would like to be contacted (for example, by regular mail to your post office box and not your home). JHCHC is required to accommodate agreed upon reasonable requests.

Right to Access, Inspect and Copy: You have the right to request the opportunity to access, inspect and receive a copy of PHI about you in certain records that JHCHC maintains. This includes your medical and billing records but does not include any psychotherapy notes or information gathered or prepared for a civil, criminal, or administrative proceeding. JHCHC may deny your request to access, inspect and copy PHI only in limited circumstances. If JHCHC denies your access, JHCHC will give you written reasons for the denial and explain any right to have the denial reviewed. Please contact our Compliance Officer if you have questions about access to your medical record. If you request a copy of PHI about you, JHCHC may charge you a reasonable fee for the copying, postage labor and supplies used in meeting your request.

Right to Amend: You have the right to request that JHCHC amends PHI about you as long as such information is kept by or for our office. To make this type of request you must submit your request in writing to our Compliance Officer. You must also give us a reason for your request. JHCHC may deny your request in certain cases.

Right to Receive an Accounting of Disclosures: You have the right to request an "accounting" of certain disclosures that JHCHC has made of PHI about you. This is a list of disclosures made by us other than disclosures made for treatment, payment, and health care operations. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The first list that you request in a 12-month period will be free, but JHCHC may charge you for our reasonable costs of providing additional lists in the same 12-month period. JHCHC will tell you about these costs, and you may choose to cancel your request at any time before costs are incurred. In some limited circumstances, you have the right to ask for a list of the disclosures of your health information JHCHC has made during the previous six years. The list will not include disclosures made to you; for purposes of treatment, payment or healthcare operations, for which you signed an authorization or for other reasons for which JHCHC is not required to keep a record of disclosures. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

Right to a Paper Copy of this Notice: You have a right to receive a paper copy of this notice at any time. You are entitled to a paper copy of this notice.

Right to supply an alternate address: You have the right to ask that JHCHC send you information at an alternative address or by alternative means. JHCHC will consider your request, but are not legally bound to agree to the restriction. JHCHC will agree to your request as long as it is reasonably easy for us to do so.

Right to Notification: In the event of an unauthorized disclosure or access to your PHI, JHCHC will contact you promptly as required by law.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with us and/or the United States Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. JHCHC will take no retaliatory action against you for filing a complaint. JHCHC supports your right to the privacy of your health information. If you have questions about this Notice or any complaints about our privacy practices, please contact our Compliance Officer either by phone or in writing as follows: Attention: Chief Compliance Officer; Jackson-Hinds Comprehensive Health Center; 3502 West Northside Drive; Jackson, Mississippi 39213; Tel: 601-362-5321

PATIENT CERTIFICATION

I HAVE READ, UNDERSTOOD AND FULLY AGREE TO the above Notice of Privacy Practices. This acknowledgement shall go into effect upon my signature/electronic signature date and remain in effect as long as the above-named patient utilizes JHCHC services, unless revoked in writing and submitted to JHCHC. I hereby sign my signature/electronic signature below as my free and voluntary act.

Signature of Patient or Legal Guardian	Relationship to the Patient	Date