Rocklin Family Practice & Sports Medicine

Roy Harris, M.D. • Kuo Ooi, M.D. • Biljinder Chima, M.D.

Patient Name: _____ **Sex:** ☐M ☐F **Date of Birth:** _____
First Middle Last

Social Security: _____ **Email Address:** _____

Race:_____ **Ethnicity:** ☐Hispanic ☐Non-Hispanic ☐Decline to State **Preferred Language:**_____

Mailing Address: _____ **City** _____ **State** _____ **Zip** _____

Home Address: _____ **City** _____ **State** _____ **Zip** _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Employer: _____ **Occupation:** _____

Employer Address: _____ **City** _____ **State** _____ **Zip** _____

Spouse's Name:_____ Phone: ( )_____ DOB: _____

Immediate family members living with you: _____

EMERGENCY CONTACT

Nearest relative:_____ Relationship: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( )_____

RESPONSIBLE PARTY – If patient is a minor please name parent or guardian

Name: _____Social Security: _____ DOB: _____
(Use name of legally responsible person)

Mailing Address: _____ City _____ Zip _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( )_____

MEDICAL INSURANCE

WE BILL INSURANCE COMPANIES WITH WHICH ROCKLIN FAMILY PRACTICE AND SPORTS MEDICINE IS CONTRACTED, OTHERWISE PAYMENT IS DUE AT THE TIMEOF SERVICE.

Insurance Company: _____ Subscriber's Name:_____

I.D. # : _____ Group #: _____ Subscriber's DOB:_____

PATIENT OR AUTHORIZED PERSON SIGNATURE – Read and initial each statement

I authorize all medical treatment as deemed necessary by Rocklin Family Practice and Sports Medicine and affiliated providers.
I authorize release of any medical or other information necessary to process claims.
I authorize my insurance carrier to make payment directly to Rocklin Family Practice and Sports Medicine for any medical services rendered.
I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.
I understand I may be charged **$25.00** if I do not show for an appointment or give less than a 24-hour notice to cancel or reschedule.
I have received and read the "Advance Directives" and "HIPPA" Notice of Privacy Practices.
I give permission for the staff to leave a message when calling to confirm appointments.

Signature X _____ **Date:** _____

Personal Health History

A. Name:_____ **Date:**_____ **DOB:**_____

B. History

Condition:	Self		Family Member		Please list any family members with the conditions listed (**Family members may include:** mother's mother, mother's father, father's mother, father's father, father, mother, siblings, children)
	Yes	No	Yes	No	List relation if yes
Allergies / Asthma					
Alcohol abuse					
Arthritis / Gout					
Blood disorders					
Cancer (type)					
Elevated cholesterol					
Diabetes					
Epilepsy					
Glaucoma					
Heart Disease					
High blood pressure					
Psychiatric problems					
Stroke					
Tuberculosis					
Other conditions not listed					

Name of spouse:	
Your employer:	**Occupation:**
Who do we contact in case of emergency? Name:	**Phone: ( )**
Immediate family members living with you:	

C. HOSPITALIZATIONS, OPERATIONS, AND INJURIES

List Cause or Type, Include psychiatric, but omit pregnancies	Year
1	
2	
3	
4	
5	

D. MEDICINES: List all currently used medicines. Include doses and non-prescription drugs

E. ALLERGIES: Please list all known Allergies, especially to medicines, and describe reaction

F. TESTS: Please give the year of the most recent test or immunization

G. HABITS	Yes	No	**If Yes, then Describe**
Smoking			
Coffee or Tea			
Alcohol/Drugs			
Exercise			
List any special interests or hobbies:			

Roy Harris, M.D.

Kuo Ooi, M.D.

Biljinder Chima, M.D.

Rocklin Family Practice and Sports Medicine

Consent for Photography (For Patient Identification Purposes)

Patient's Name: _____

Patient Chart Number: _____

(Office Use Only)

I hereby give my consent to have a facial photograph of myself or family member to be used for patient chart identification purposes only.

Signature of Patient Date

*3104 Sunset Blvd., Suite 2B * Rocklin, CA 95677 Tel (916) 624-0300 Fax (916) 624-0631*

www.familymedicalpractice.info

Rocklin Family Practice and Sports Medicine
3104 Sunset Blvd #2 B
Rocklin, CA 95677
916-624-0300
916-624-0631

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Rocklin Family Practice and Sports Medicine may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Rocklin Family Practice and Sports Medicine has a detailed document called the *'**Notice of Privacy Practices**'*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Rocklin Family Practice and Sports Medicine will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Rocklin Family Practice and Sports Medicine to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Rocklin Family Practice and Sports Medicine has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Rocklin Family Practice and Sports Medicine 3104 Sunset Blvd #2 B, Rocklin, CA 95677, 916-624-0300, 916-624-0631 .

FORM Us

Roy Harris, M.D.

Rocklin Family Practice and Sports Medicine

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routing Physical Exams and Other Recommended Health Screenings

I understand that I am responsible for scheduling my annual routine physical exams. At that exam my doctor will explain to me which health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide Not to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels in best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatments plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____ _____ _____

Patient Signature Date Roy Harris MD, Kuo Ooi MD, Biljinder Chima MD

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PATIENT COPY

Roy Harris, M.D.

Rocklin Family Practice and Sports Medicine

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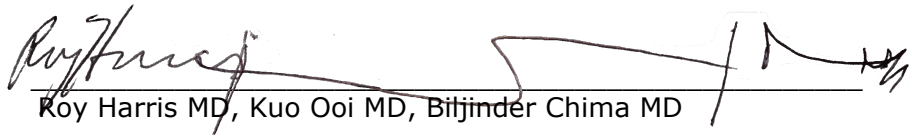

_____ _____ _____

Patient Signature Date Roy Harris MD, Kuo Ooi MD, Biljinder Chima MD

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Rocklin Family Practice and Sports Medicine

To Our New Patients,

Welcome to ROCKLIN FAMILY PRACTICE AND SPORTS MEDICINE. We look forward to providing you and your family with quality health care. We are a Family Practice office established in Rocklin in 1988. We look forward to getting to know you. The following information may help familiarize you with our office.

1. We offer same-day appointments, but these are booked quickly, so we advise calling the office in the morning when we open at 8:30am, if you would like to schedule a same-day visit.
2. As a convenience to our patients we offer on site blood draws (for most insurances). You do not need to schedule an appointment for this procedure. Blood draws are performed on a walk-in basis from 8:30am to 11:45 am and 1:30pm to 4pm, Monday through Friday. You will need to have an order from a medical provider in our office. We do not draw blood ordered by physicians outside our office.
3. We offer on-site x-ray capability (for most insurances).
4. We encourage yearly physical exams for both men and women and provide complete well woman visits, including pap smears.
5. We offer aesthetic services next door at Physician's Laser in Suite 3-C Procedures include; Time Machine, C02 laser resurfacing, skin tightening, acne treatment, brown spot removal, laser vein removal, Botox and Xeomin treatments, hair removal, fillers (Radiesse, Voluma, Juvederm), Kybella, Liposonix and more.
6. We ask for 48 hours turn around time for medication refills.

If you have additional problems to discuss that were not scheduled for todays' visit, please feel free to schedule another appointment; allowing us to provide adequate time for evaluation of each problem.

Thank you for your cooperation. We look forward to providing your health care.

Dr. Harris, Dr. Ooi, and Dr. Chima

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NOTICE OF PRIVACY PRACTICES
ROCKLIN FAMILY PRACTICE AND SPORTS MEDICINE

Effective Date: August 13, 2013

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. TO CONTACT OUR PRIVACY OFFICER, SUSAN BARBER, PLEASE CALL 916-624-0300.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]

4. **Appointment Reminders**. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.]
5. **Sign In Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Notification and Communication with Family**. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
8. **Sale of Health Information**. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. **Required by Law**. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. **Public Health.** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. **Health Oversight Activities**. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
12. **Judicial and Administrative Proceedings**. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. **Law Enforcement**. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. **Coroners**. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. **Organ or Tissue Donation**. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. **Public Safety**. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. **Proof of Immunization**. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.
18. **Specialized Government Functions**. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. **Worker's Compensation**. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. **Change of Ownership**. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. **Breach Notification**. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: We will only use email notification if we are certain it will not contain PHI and it will not disclose inappropriate information. For example if your email address is "digestivediseaseassociates.com" an email sent with this address could, if intercepted, identify the patient and their condition.]
22. **Psychotherapy Notes**. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if you sue us or bring some other legal proceeding, (4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
23. **Research**. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice.

After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX - Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD); (415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

ADVANCE DIRECTIVES

Advance Directives Are Written Instructions Which Communicate Your Wishes About The Care And Treatment You Want If You Reach A Point Where You Can No Longer Make Your Own Health Care Decisions

All health care facilities that receive Medicare and Medi-Cal payments must provide patients with written information concerning 1) their right to accept or refuse treatment and 2) their right to prepare advance directives. The law does not require that you actually have or make an advance directive.

Under California law adult persons with decision-making capabilities have the right to accept or refuse medical treatment or life sustaining procedures. Artificial nutrition and hydration are among the medical procedures you have the right to accept or refuse.

REASON WHY YOU MAY WANT TO PREPARE AN ADVANCE DIRECTIVE

- To ensure you receive the care and services you desire.
- To ensure the refusal of treatment at a determined stage if you have previously stated your desires to do so.
- To designate the person you would like to make decisions on your behalf.
- To ensure that family and friends understand your wishes regarding health care. If you do not make your wishes clear, your family members and friends may not agree about what type of care and treatment you would want. It is possible that your desires will not be carried out, since a conflict may lead to a lengthy court delay.

Being Prepared With An Advance Directive, You Can Say WHAT Types Of Treatment You Want, and WHO You Want To Speak For You.

THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This is a legally binding document that allows the person you choose (the "agent") to make health decisions for you if and when you are no longer able to make such decisions. You should select a person who knows you well, and whom you trust. Your agent may be a relative or a friend, but must not be your attending doctor. The Durable Power of Attorney for Health Care allows your agent to make any and all health care decisions for you once you are no longer able to decide. This includes routine medical decisions, as well as more complicated decisions. Your agent can even decide to withdraw or withhold life-sustaining procedures if you give your agent that authority.

To be valid, the document must be signed by you and witnessed by two qualified adult witnesses.

Those persons not eligible to be witnesses are your doctor, nurse, their employee or any other healthcare professional.

- You *DO NOT* need a lawyer to fill out a Durable Power of Attorney of Health Care.
- The Durable Power of Attorney for Health Care allows you, in writing, to declare your desire to receive or not receive life-sustaining treatment under certain conditions. You may list any instructions you want pertaining to health care.

THE NATURAL DEATH ACT

This is another type of advance directive most often called a "Declaration." This document *DOES NOT* require you to appoint an agent to make health care decisions for you.

The Declaration is for terminally ill patients. While you still have decision making capabilities, you may sign a Declaration which tells your doctors that you don't want any treatment that would prolong the dying process. The Declaration must be followed in these circumstances:

- If you fall into a permanent unconscious state or a terminal condition (certified by two doctors)
- At the time you cannot make your own health care decisions.

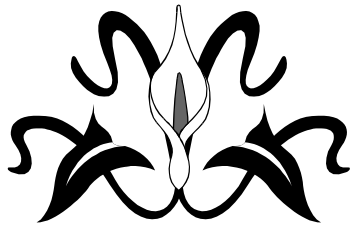
Those persons who are witnesses to the signing of the Declaration must meet the same requirements, as those needed for the Durable Power of Attorney for Health Care.

DO I NEED A SPECIAL FORM FOR THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE

YES. Use a ***Durable Power of Attorney for Health Care*** form, not a plain Durable Power of Attorney. You can ask your physician, nurse, or social worker about the form.

The California Medical Association has printed forms that meet the legal requirements. —
California Medical Association.
PO Box 7690
San Francisco, CA 94120-7690.
415-882-5175 or visit their website at:
www.cma.org

Many stationery stores carry the forms. There is a small charge for these forms from all sources.



OTHER DOCUMENTS

Other documents that help determine your health care desires IF and WHEN you are UNABLE to make such decisions for yourself:

"***DO NOT RESUSCITATE***." This form allows your doctor to withhold "resuscitative measures," should that be your desire. This should be signed by you, your doctor, and a surgeon. The law does not require witnesses and notarization. NO ONE CAN MAKE YOU SIGN A "DO NOT RESUSCITATE" ORDER.

"***PREFERRED INTENSITY OF CARE***." This is a document of your preferences for care under special circumstances. A discussion with your physician and/or legal representative occurs prior to creating this document.

"***LIVING WILL***." This lists your desires to receive or not receive life-sustaining medical treatment under certain circumstances. A living will is NOT a legally binding agreement, although it is often accepted as an accurate statement of one's wishes.

For more information about Advance Directives, contact the Ombudsman program.
State Ombudsman Program: 916-323-6681

Rocklin Family Practice & Sports Medicine

Roy Harris, MD | Kuo Ooi, MD | Biljinder Chima, MD

3104 Sunset Blvd Ste. 2B Rocklin, CA 95677 | Phone: (916) 624-0300 | Fax: (916) 624-0631

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

This authorization allows **Rocklin Family Practice & Sports Medicine and it's Physicians** to speak to and/or release confidential medical information and records on my behalf. Note: *information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

To release information regarding my: initial the following

_____ Appointment dates & times
_____ Reason for appointments
_____ Medical history
_____ Illness or injury
_____ Consultation
_____ Prescriptions
_____ Treatment (including coverage & benefits)
_____ Diagnosis or prognosis
_____ Test results (lab, pathology, radiology, etc)
_____ Correspondence
_____ All billing information
_____ Referrals and authorizations
_____ Durable Medical Equipment
_____ ALL THE ABOVE

TO: _____ Relation to patient: _____

TO: _____ Relation to patient: _____

TO: _____ Relation to patient: _____

TO: _____ Relation to patient: _____

I do consent to the specific release of the following records. I understand that the following information cannot be released without my specific consent.

Drug/alcohol/substance Abuse_____(initial)
Psychiatric/Mental Health_____(initial)
Test for antibodies to HIV_____(initial)
HIV Diagnosis/Treatment_____(initial)
Genetic Information_____(initial)

DURATION: This authorization shall be effective from the following dates:_____to _____
RESTRICTIONS:
Permission for further use or disclosure of the medical information is not granted unless another authorization is obtained from the undersigned or unless such disclosure is specifically required or permitted by law. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

_____ _____

Signature of patient *or legal guardian* Relationship *if other than patient*

_____ _____

Patient Name (**Print please**) Date

_____

Patient's Date of Birth