Welcome to our practice. Our staff will make every effort to make your associations with the office a pleasant experience.

Payment is collected prior to your visit with the doctor. We are not participating with any insurance companies, with the exception of Medicare and Multiplan. **PAYMENT MAY BE MADE WITH CASH**, **CHECK OR CREDIT CARDS**. We will courtesy file a claim to your insurance company.

Please fill out the enclosed medical and demographic forms **completely** and bring them to the office on the day of your scheduled appointment. In addition, please make sure to bring in photo identification, insurance cards, and any other billing information.

Please remember to bring in your radiology studies, including MRIs, CT SCANS, X-RAYS, MYELOGRAMS, and the radiologist's reports to the office at the time of your visit. **IF FILMS ARE NOT PRESENT AT THE TIME OF YOUR VISIT, WE MAY HAVE TO RESCHEDULE YOUR APPOINTMENT.**

As neurosurgeons, we are called to the hospital for patients with emergency conditions on a frequent basis. These emergencies can result in our being late or having to cancel and reschedule office patients.

Please call the office when you are about to leave for your appointment to confirm that the doctor will be able to see you at or near the scheduled time.

Thank you for your cooperation.

Patient Information

Thank you for choosing our office. In order to serve you properly, we need the following information. Please print.
All information will be confidential.

Todays Date:_____Patient Name:_____(Male/Female)

***Ethnicity- Hispanic Not Hispanic**
***Race - White African American Asian Pacific Islander Amer Indian/Alaskan Other**

Address:_____
(Street) (City) (State) (Zip Code)
Phone#_____Date of Birth_____/_____/_____SSN#_____

Cell Phone#_____ **Preferred Communication**: Phone Mail Text E-mail_____

Employer:_____Phone#_____

Referring Physician:_____Phone#_____

Pharmacy Name:_____ Phone #_____

WE ARE ONLY PARTICIPATING WITH BASIC MEDICARE & MULTIPLAN

Primary Insurance

Insurance Co._____ID#_____

Policy Holder: (Self / Spouse / Other) Group#_____Phone#_____

Policy Holder's Name:_____ **DOB**:_____ **SS#**:_____

Secondary Insurance

Insurance Co._____ID#_____

Policy Holder: (Self / Spouse / Other) Group#_____Phone#_____

Policy Holder's Name:_____**DOB**:_____**SS#**:_____

If this appointment is related to an injury, please provider the information requested below in the appropriate category.

Worker's Compensation_____Insurance Company_____
Date of Injury Name Phone#
Claim#_____ **Employer Name**:_____ **Phone#**_____

Motor Vehicle Accident_____Insurance Company_____
Date of Injury Name Phone#
Claim #_____**Adjusters Name**:_____**Phone#**_____

Other Liability _____Adjuster/Claim Manager_____
Date of Injury Name Phone#
Claim #_____

Attorney_____
Name Address Phone#

Authorization and Release: I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to **Neurosurgical Consultants of South FL**

Signature:_____**Date:**_____

PATIENT HISTORY

Patient Name: _____ **Date of Birth**: _____

Primary Physician: _____ **Requested By**:_____

Chief Complaint:_____

Please list your single worst complaint that caused you to come to the doctor

	YES	NO	DATE
Is your condition related to a Motor Vehicle Accident?	__	__	_____
Work Related Injury?	__	__	_____

Medical History: Please check YES or NO for each disease

Yes	No		Yes	No	
__	__	AIDS or HIV+	__	__	Kidney disease
__	__	Arthritis	__	__	Migraine headaches
__	__	Asthma	__	__	Polio
__	__	Cancer (list condition below)	__	__	Rheumatic Fever
__	__	Diabetes	__	__	Stroke
__	__	Epilepsy	__	__	Thyroid disease
__	__	Heart disease (list condition below)	__	__	Tuberculosis
__	__	Hepatitis A B C (circle one)	__	__	Venereal disease
__	__	High blood pressure	__	__	Ulcers

Other: _____

Surgical History: List all surgeries and dates (or year) that surgery was performed.

_____ _____ _____

_____ _____ _____

Allergies: Please check YES or NO for each medication. If yes, please list the reaction you experienced.

Yes	No		Yes	No	
__	__	Antibiotics _____	__	__	Aspirin or Ibuprofen (circle one)
__	__	Morphine, Demerol or other	__	__	Tetanus antitoxin _____
		narcotics _____	__	__	Iodine or other antiseptics_____
__	__	Novocain or anesthetics _____	__	__	Shellfish

Medications: List all medications, the dose (mg/gram etc) and frequency (once a day, ect)

Drug Name	Dose	Frequency	Drug Name	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Social History: Please check: __ Married __ Single __ Divorced __ Widowed # of children _____

Do you, or have you ever smoked cigarettes? __yes __no; if yes, _____ packs/day for _____ years; If you quite, how long ago_____

Do you drink alcohol? __yes __no; if yes, how much-daily ____, weekly____, or monthly ____?

Do you now or have you ever used illicit drugs ? __yes __no; if yes, specify type and frequency. _____

What is your occupation?_____

Patient Name: _____ **Date of Birth**: _____

Family History: Please CIRCLE Current Age/Age at Death Health Conditions and/or cause of death

Father Alive/Dead _____ _____

Mother Alive/Dead _____ _____

Sister and or Bother Alive/Dead _____ _____

Review of systems: Have you had any of the following in the past 6 months**? Please check every line** Yes or No

Constitutional	Yes	No	**Respiratory**	Yes	No	**Neurologic**	Yes	No
Fever	__	__	Cough	__	__	Headaches	__	__
Weight loss	__	__	Short of breath	__	__	Numbness/tingling	__	__
Weakness	__	__	Wheezing	__	__	Memory loss/confusion	__	__
Eyes			**GI**			**Integumentary**		
Double vision	__	__	Nausea/vomiting	__	__	Easy bleeding/bruising	__	__
Blurred vision	__	__	Diarrhea	__	__	Skin rash	__	__
Visual loss / eye pain	__	__	Constipation	__	__	Varicose Veins	__	__
ENT			Blood in stool	__	__	**Endocrine**		
Sore throat	__	__	**GU**			Excessive thirst	__	__
Earache	__	__	Frequent urination	__	__	Cold/heat intolerance	__	__
Hearling loss	__	__	Incontinence	__	__	Decreased sex drive	__	__
Dizzy/vertigo	__	__	Nighttime urination	__	__	**Psychiatric**		
CV			**Musculoskeletal**			Depression	__	__
Chest pain	__	__	Joint pain	__	__	Anxiety	__	__
Palpitations	__	__	Neck pain	__	__	Insomnia	__	__
Swollen ankles	__	__	Back pain	__	__			

Radiologic Studies:

___MRI (date)_____ (performed at) _____

___CT (date) _____ (performed at) _____

To the best of my knowledge, all questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changed in my health status.

_____

** Patient (guardian) Signature ** Date Completed

Notes:_____

_____

_____

_____

_____

_____

_____

Dr.Signature:_____Date_____

David P. Sachs, M.D. Lloyd Zucker, M.D. Evan Packer, M.D. Martin Greenberg, M.D.

NEUROSURGICAL CONSULTANTS OF SOUTH FLORIDA
SPECIALIZING IN SURGERY OF THE BRAIN AND SPINE

David P. Sachs, M.D.F.A.C.S. Lloyd Zucker, M.D.
Evan Packer, M.D. Martin Greenberg, M.D.PhD

Patient Name:_____

Please provide the names of your physicians and the office phone numbers;

Primary care/ Family Medicine/ Internist:_____

Phone number:_____

Neurologist:_____

Phone Number:_____

Cardiologist:_____

Phone Number:_____

Oncologist:_____

Phone Number:_____

Physiatrist/ Pain Management_____

Phone Number:_____

Please handwrite any other physician or specialist and the office phone number treating you:

_____

_____

_____

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PATIENT FINANCIAL RESPONSIBILTY AGREEMENT

Financial Agreement

You agree to be responsible for and pay in full all charges by Neurosurgical Consultants of South Florida, L.L.C.'s ("NCSF") for treatment, services, and supplies provided to you. Payment is due upon receipt of our statement for services rendered. As a courtesy to you, NCSF will bill your insurance company, health maintenance organization or managed care company ("your health plan") for the medical services and supplies we provide to you. In billing your health plan, NCSF will rely upon the information you provide, including your current insurance identification card or other evidence of valid coverage. If your health plan changes in any way or your coverage terminates, please notify NCSF immediately so that we may update our records. It is particularly important to provide us with current and accurate billing information because the unpaid balance on your account will begin to incur an interest charge forty-five days after the date of the invoice. Interest will accrue at a rate of 1-1/2% per month.

If your health plan is a health maintenance organization, you are only responsible under Florida law for payment of deductibles, co-payments and charges for non-covered services as specified in your plan. As a patient enrolled in a health maintenance organization, you may be required to first contact your primary care physician before seeking any other medical care. Your health plan may require that your primary care physician or a contracted specialist physician refer you to us or obtain a prior authorization before you are referred to us for any medical services. If you do not comply with your health plan's policies and procedures, payment for the services we render could become your responsibility. If you are unsure of your obligations, please ask us. We will be pleased to help you clarify your obligations at any time. But, as the member of the health plan, it is your responsibility to ensure that you meet the obligations set forth in your plan documents.

NCSF's efforts to bill and collect on your behalf from your health plan and NCSF's acceptance of payment from your health plan will not relieve you of your obligation to make payment to NCSF in full. The amount your health plan pays NCSF may be less than the full charges or the amount you owe to NCSF. NCSF will credit all payments received from your health plan to your account and will bill you for the balance, unless otherwise provided under Florida law or if NCSF contracts with your health plan to accept the amount paid by them as payment in full.

All deductibles and co-payments required by your health plan are your responsibility. NCSF is prohibited by law from waiving deductibles and co-payments.

If payment is not made at any time and NCSF engages an attorney to assist in collection, you will be responsible for all fees and costs NCSF incurs in connection with its collection efforts. Your responsibility for the fees and costs NCSF incurs will be in addition to the charges and interest accrued on your account.

Advance Payment

You are required to make an advance payment of $_____.___ to NCSF prior to the provision of any further medical services. NCSF will apply this payment to your account and bill you for any balance due. If we bill a health plan on your behalf and receive payment, we will credit the payment to your account and send you a statement reflecting the balance due. If at the time of the conclusion of our services there is a credit balance on your account, we will refund the balance to you.

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Assignment of Insurance Benefits

You hereby authorize payment to be made directly to NCSF and assign to NCSF all Medicare and other insurance benefits that may be due and payable to you or on your behalf for any serviced and supplies rendered to you by NCSF. You hereby authorize NCSF and any other holder of medical or other information about you, including any Medigap insurer, to release to the Social Security Administration, the Centers for Medicare and Medicaid Services, and their agents, intermediaries and carriers, any information needed to determine the benefits or benefits payable to you for any claim with respect to NCSF's provision of health care services and supplies. Where Medicare and Medicaid benefits are applicable, you certify that the information given in applying for payment under Title XVIII or XIX of the Social Security Act is complete and correct. **You authorize NCSF to use this Agreement as evidence of your consent to bill and receive payment for health care services and supplies provided to you by NCSF. You further acknowledge that this assignment of benefits does not in any way relieve you of your liability to make payment to NCSF, and that you will remain financially responsible to NCSF until all charges for which you are legally responsible are paid in full. In the event the insurance carrier mistakenly sends payment for the claim directly to me, I agree that I will remit payment in its entirety to Neurosurgical Consultants of South Florida.**

Authorization for Appointment of Designated Appeal Representative of Designated Appeal Representative

I_____, authorize Neurosurgical Consultants of S. Fl, LLC to act as my representative in connection with the filing of an appeal on my behalf regarding a denial for the above referenced date(s) of service. I authorize (insurance carrier)_____to release any of my protected health information including benefits and policy information to Neurosurgical Consultants of S. Fl, LLC for the purpose of resolving this appeal. I understand that this information is privileged and confidential and will only be released as specified in this authorization or as required pr permitted by law.

I understand that I may revoke this authorization at any time by mailing a written notice to (insurance carrier)_____. I understand that revoking this authorization will not affect any action taken prior to my notice of revocation. My designated appeals representative also has the fight to rescind consent at any time.

I have read this consent or have had it read to me and it has been explained to my satisfaction. I understand that I am granting my consent for my representative to file an appeal on my behalf.

I have read and understand each of the above paragraphs and I acknowledge and accept these terms and conditions.

x_____ Date:_____
Signature of Patient or Guardian/Representative

_____ _____
Print Name Patient's Social Security Number

_____
Signature of Designated Representative of
Neurosurgical Consultants of S. FL, LLC

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Martin Greenberg, M.D.PhD

Authorization to Release Medical Record Information

NCSF will use and disclose your health information only for purposes of treatment, payment, and health care operations, unless you authorize us to use or disclose your health information for other purposes.

*You hereby authorize your physicians, hospitals, and health care facilities to disclose all or any part of your medical record to NCSF in connection with treatment, payment and health care operations for treatment and services provided to you by NCSF.

*This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may affect or limit the insurance coverage for treatment, services, or supplies provided by NCSF.

***Please list the names of family members or care givers we may speak with regarding your health information. We will not give any information out to anyone not listed on this form. ***

1 _____ **2** _____

3 _____ **4** _____

5 _____ **6** _____

OR

Do not leave me a message or release information to anyone. Speak directly with me before releasing medical information

_____ Date_____
Signature of Patient or Guardian/Representative

_____
Print Name

Notice of Privacy Practices

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services your receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Require Us to:

1. Keep your medical information private
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices we will change this notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality,

evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.
Additional Uses and Disclosures: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.
Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.
Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.
Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.
Fundraising: We may provide medical information to on of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.
Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.
Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.
Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.
Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration of purposes of reporting adverse events associated with product defects of

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EVAN PACKER, M.D.
MARTIN GREENBERG, M.D.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice
(Patient's Name)
of Privacy Practices.

Signature of Patient (Responsible Party): _____

Witness: _____

Date: _____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining the Acknowledgement

_____ Other _____

problems, to enable product recalls, repairs or replacements, to track products or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise by at rick of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health of safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services than may be of interest to you, and to describe or recommend treatment alternatives.

4. Your Individual Rights

You Have the Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional

restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).

4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Questions and Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer. If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complaint form. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

Notice of Privacy Practices

1. Our Pledge Regarding Medical Information

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2. Our Legal Duty

Law Require Us to:

1. Keep your medical information private
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices we will change this notice and make the new notice available upon request.

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The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality,

evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.
Additional Uses and Disclosures: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.
Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.
Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.
Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.
Fundraising: We may provide medical information to on of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.
Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.
Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.
Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.
Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration of purposes of reporting adverse events associated with product defects of