Doctor on Call

Member Enrollment Checklist

Newport Hospital
Lifespan. Delivering health with care.®

Newport Hospital is pleased to welcome you to this exclusive access on-call physician service covering you and your family during the summer months. Below are the steps to completing the enrollment process. For more information, or to speak to an enrollment liaison, please call 401-845-4339.

1. Sign and date the Doctor on Call Program Membership Agreement. ☐
2. Complete the Member Demographics and Emergency Contact Sections of the DOC Member Enrollment Form. ☐
3. Complete the additional paperwork listed below:
    a. Authorization to Release Medical Records (for purpose of coordination of care) ☐
    b. Patient Acknowledgement of Receipt of the Lifespan Privacy Notice ☐
    c. Permission to Disclose Protected Health Information ☐
    d. Payment Information ☐
4. Member provides a copy of insurance card and driver's license. ☐
5. Return the items mentioned above by mail to: ☐
    Newport Hospital
    Attn: Newport Hospital Foundation
    11 Friendship Street
    Newport, RI 02840

Upon receipt of the completed enrollment forms, please expect a confirmation email or phone call.

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DOCTOR ON CALL PROGRAM
MEMBERSHIP AGREEMENT

This Membership Agreement ("Agreement") is made as of the date on the signature page (page 2) of this Agreement ("Effective Date") between you and the Doctor on Call Program at Newport Hospital.

1. **Purpose.** The purpose of this Agreement is to provide you with a special, seasonal, personalized approach to your health care that affords you ready access to on call physicians ("Physicians") through Newport Hospital's Doctor on Call Program ("Physician Service"), as well as certain other services for the summer months. The Program is available to Members of all ages who live in Newport, Middletown, Portsmouth, Tiverton and Jamestown, Rhode Island during the term of this Agreement. The Program is designed to provide routine and urgent care type physician services and does not replace your primary care physician. Every Member is required to have a primary care physician, who the Program will coordinate with as necessary.

2. **Term.** The term of this agreement is from May 24, 2019 through September 30, 2019.

3. **Services.** In exchange for the Membership Fee, the Physician Service agrees to provide you with the Services listed on **Schedule 1.**

4. **Membership Fee.** By executing this Agreement, you agree to pay to the Membership Fee as specified on **Schedule 2**. By executing this Agreement, you agree to bear the full financial responsibility for the Membership Fee, and you agree not to submit to your health insurer or health plan any bill, invoice or claim for reimbursement or payment with respect to the Membership Fee. You also understand and agree that this Agreement is a service contract and not a contract of insurance.

   The Membership Fee only covers the Services listed on **Schedule 1**. All Members will be responsible for any costs related to any additional necessary services such as ancillary services (i.e.: X-Ray, Lab), specialty physicians, and hospitalizations.

5. **Household Coverage.** You may select additional household members for coverage at an additional cost. The term "you" in this Agreement refers to both you and your designated household member(s).

6. **Physician(s).** The Physician Service will provide a Physician 24/7 to attend to your routine and urgent care medical needs during the term of this Agreement. Covering Physicians may vary. The covering Physician will have access to your medical history and course of care.

7. **Termination.** The Physician Service may terminate this Agreement at any time. The Physician Services will use reasonable efforts to provide ten (10) days' notice of

termination. If the Physician Service terminates this Agreement, you will be refunded a pro-rated portion of your Membership Fee. Any pro-rated refund will be based on the number of days you have been a Member.

8. **Communications.** The Physicians will communicate with you via telephone. Additionally, you will have the ability to access your medical information and results via Lifespan's secure electronic medical record portal "MyLifespan".

9. **Authorization.** You agree to execute a Patient Consent and Acknowledgment Form. If necessary for treatment, you may also be requested to execute an Authorization to Use or Disclose Protected Health Information Form for the Physician Service to obtain information from your primary care physician or other treatment providers.

10. **Independent Medical Judgement.** The Physician retains full and free discretion to exercise professional medical judgment in your treatment decisions and nothing in this Agreement shall be deemed or construed to influence or affect their independent clinical judgment.

WITNESS WHEREOF, the Member intending to be legally bound has executed this Agreement as of the date below.

_____
Member Name

_____ _____
Member Signature Date

***As the representative of the above individual, I acknowledge this agreement on his/her behalf.**

_____
Representative/Guardian's Name

_____ _____
Representative/Guardian's Signature Date

SCHEDULE 1

SERVICES

The Physician Service will provide Members with the following Services:

1. **Membership.** The Physician Service will limit the size of membership panel to approximately 200 members, and will arrange to provide the services described here within.

2. **Communications.** The Physician Service will have telephone, cellular phone, facsimile, and e-mail, and will provide you with detailed instructions on how to contact the Doctor on Call.

3. **24/7 Availability**. The Physician Service will contract with the Physicians to be available to communicate with you (or your authorized representative) 24 hours a day, seven days a week through one or more of the Communications (as described above).

4. **Same Day /Next Day Appointments.** The Physician Service will arrange for you to be able to use the Communications to make same day appointments to see a Physician either in your in Newport, Middletown, Portsmouth, Tiverton and Jamestown home or in the office at 23 Powel Avenue, Newport, Rhode Island. Scheduled office appointments, if desired, can be arranged Monday through Friday during office hours.

5. **Home Visits.** The Physician Service will be available for Newport, Middletown, Portsmouth, Tiverton and Jamestown home visits 7 days a week primarily between 8:00 a.m. to 5 p.m. Visits outside these hours will be at the discretion of the Physician on call. The Physician on call may determine that Emergency Department (ED) evaluation is more appropriate depending on the type of concern and may therefore direct you to the ED or to call 911.

6. **Office Services.** For office visits, the Physician Service will provide you with access to a comfortable reception area, with healthy refreshments, internet access, and educational materials for the occasional, brief wait for your Physician.

7. **Dedicated Office Personnel.** The Physician Service's staff will be available at the Physician Service office (23 Powel Avenue) to provide you with personalized, outstanding service. The Physician Service will address and coordinate the administrative aspects of your health needs, including assisting with referrals, scheduling appointments and tests, and working with the Physician Service to expedite the communication of test results to you.

8. **Medical Staff Privileges.** The Physicians will maintain medical staff privileges at Newport Hospital, and coordinate any of your necessary medical care at Newport Hospital or such other institution you choose for your medical needs.

9. **Social Visits**. At the discretion and availability of the Physician, social inpatient visits and ER visits at Newport Hospital may be provided to Members.

10. **Additional Service Coverage**. Physician house calls may be included for non-members at the primary Member's residence during normal business hours (Sunday – Saturday, 8 a.m. – 5 p.m.) through the per visit rate (see Schedule 2).

    Service to non-member(s) will be given based on Physician availability as Members take priority.

SCHEDULE 2

MEMBERSHIP COSTS

Program

For the term of this Agreement, the Program will cost $1,000.00 per Member.

Additional household Members can be covered at the rate of $1,000.00 per Member during time of service.

Non-Member Per Visit Rate:

As a courtesy to our Members, visits to non-members (extended family and/or friends) may be arranged subject to the availability and discretion of the Physician. The Physician will treat such non-members at a Member's home for an additional $300 per visit per person for the first hour. If service extends for more than 1 hour, an additional $300 hour would apply. The primary member's credit card will be charged for this service.

Doctor on Call

Member Enrollment Form

Newport Hospital
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Member Information

Full Name:

Last | *First* | *M.I.* | *Date*

Preferred phone number | *Preferred email* | *Date of Birth* | ☐ Male ☐ Female *Sex*

Permanent Address:

Street Address | *Apt #* | *City* | *State* | *Zip Code*

Local Address: ☐ Same as above

Street Address | *Apt #* | *City* | *State* | *Zip Code*

Primary Care Provider (PCP) Information

PCP Last Name | *PCP First Name* | *PCP Phone Number*

PCP Street Address | *City* | *State* | *Zip*

Pharmacy Information

Pharmacy Name

Street Address | *City* | *State* | *Zip*

Emergency Contact Information

Last | *First* | *Phone Number*

Street Address | *Apt #* | *City* | *State* | *Zip*

Relationship to member

Newport Hospital
Doctor On Call (DOC) Program
23 Powel Ave.
Newport, RI 02840
Tel: 401-845-1117; Fax: 401-236-2593

Authorization to Use or Disclose Protected Health Information

(This form must be completed in full before signing)

Patient Name_____ DOB_____ Phone _____

Address _____
Street City State ZIP

1. I hereby authorize Newport Hospital to obtain from care provider:
2. _____
Person /Place/Institution

_____
Street City State ZIP Phone

3. Dates of treatment or time period: Last 2 years

4. Purpose for which disclosure is to be made: Coordination of Care
5. Record Format-please: Paper

6. Information to be disclosed (check all applicable): ☐Emergency Dept. Record ☐Operative/Path Report ☐Lab/X-ray Reports ☐Other Diagnostic Testing ☐Clinic/Office Visit ☐Consultation/Evaluation ☐After Visit Summary ☐Discharge Summary ☐Other_____

   For Behavioral Health Affiliates: ☐Assessment ☐Treatment Plan ☐Psychiatric Evaluation ☐ Medications

7. I do not want the following information disclosed: ☐ alcohol/drug use/test ☐ sexually transmitted infections ☐ AIDS/HIV test results ☐sexual abuse ☐ mental health

8. I understand that my records are protected under the federal privacy laws and regulations and under the General Laws of Rhode Island, and cannot be disclosed without my written consent except as otherwise specifically provided by law. I also understand that certain health records containing alcohol or drug abuse information may be subject to further protection under Federal Regulation 42 CFR Part 2. Confidentiality of Alcohol and Drug Abuse.
9. I understand that if the person(s) or entity (ies) that receive(s) this information is not a health care provider or health plan covered by federal regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Lifespan, its employees and my physicians from all liability arising from this disclosure of my health information.
10. It is my understanding that this authorization is for information we have at the time of your request, only for the information requested above and will expire 1 year from the date signed below. I understand that I may revoke this authorization by notifying Lifespan in writing. I understand that any previously disclosed information would not be subject to my revocation request.
11. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits, unless otherwise described in the space provided here:

_____ _____
Signature of Patient*, Legal Guardian, or Representative Date/Time

_____ _____
Print name of Patient, Legal Guardian or Representative Date/Time

*Note Concerning Minors: For disclosures to persons/entities other than medical providers, the signature of a patient under 18 years who gave legal consent for testing, examination or treatment for reportable communicable disease (including HIV & venereal disease) or for alcohol and/or drug abuse treatment is required. Rev. 4/2015

Lifespan's Summary Notice Of Privacy Practices

See the attached Privacy Notice for greater details

Lifespan and its partners are required by federal law to provide a Privacy Notice that describes how medical and healthcare information we maintain about you may be used or disclosed. Your protected health information is confidential. The Notice describes each use and disclosure we are permitted to make, your rights and our obligations under the law.

Use and Disclosures:

Under a variety of circumstances we may use your medical information without obtaining your prior authorization. For example we may use this information to:

- Provide you with treatment,
- Ensure the quality of your care,
- Bill and collect payment for the services you were provided, or
- Report a communicable disease, domestic violence or criminal activity.

In other scenarios we may use your medical information, but you have the opportunity to object. For example unless you object:

- The hospital directory will include limited information about you such as your hospital room number, or
- We may release information, as permitted under the law, about your condition to family and friends involved in or who help pay for your care.

These examples are merely illustrative. For full descriptions see the attached Notice.

Your Rights:

While the records we maintain belong to us, you have a variety of rights with respect to the information in those records. For instance, you have the right to:

- Correct, but not delete, the information
- Chose where and how the information is sent to you, and
- Obtain a list of non-routine disclosures made of this information.

All of these rights are subject to some exceptions that are described in the attached Notice.

Our Obligations:

We are required to provide you with our Privacy Notice and abide by its terms. We can amend the Notice from time to time. We reserve the right to make the amended or changed notice effective for medical information we already have about you as well as any information we receive in the future.

After reviewing the Notice if you have any questions or require additional information, please call the Affiliate Hospital designated Privacy Officer at the telephone number below or contact the Lifespan Privacy Officer.

Rhode Island Hospital	401-444-4560
The Miriam Hospital/LPG	401-793-2910
Newport Hospital	401-845-1545 or 845-1152
Bradley Hospital	401-432-1129
Gateway Healthcare	401-724-8400
Lifespan Privacy Officer	401-444-4728

Effective Date – April 2018

Lifespan
Joint Privacy Notice

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

This Notice describes the types of medical information we gather about you (or your child or ward), with whom that information may be shared and the safeguards we have in place to protect it. You have the right to the confidentiality of your medical and healthcare information. If you have any questions about this Notice, please contact the Lifespan Privacy Officer or one of the Lifespan Affiliate Privacy Officers at the telephone numbers and/or addresses listed at the end of this document.

1. Who We Are

This Notice describes the privacy practices of Lifespan Corporation ("Lifespan") and the Lifespan affiliates that make up the Lifespan healthcare system. We believe it is in the best interest of patient care to standardize privacy practices at all Lifespan entities. The entities that make up Lifespan are as follows:

Rhode Island Hospital

Hasbro Children's Hospital, A Division of Rhode Island Hospital

The Miriam Hospital

Newport Hospital

Emma Pendleton Bradley Hospital

NHCC Medical Associates, Inc.

Lifespan Physician Group, Inc.

Gateway Health Care, Inc.

Gateway Professional Group, Inc.

The Autism Project

RIH Ventures

Lifespan Pharmacy, LLC

Radiosurgery Center of Rhode Island

This Notice also describes the privacy practices that apply to health care professionals and other persons, such as doctors and nurses and their support personnel, when they are providing services together with the Lifespan entities.

2. Our Pledge Regarding Protected Health Information

We understand that protected health information, commonly referred to as medical and healthcare-related information, about you is personal and needs to be kept confidential. We are committed to protecting this information.

We create and maintain a record of the care and services you receive from us and from other organizations that participate in your care. This information includes medical information and personal identification information we use to bill for your care. Lifespan needs this record to provide you with quality care and to comply with certain legal requirements. We store and manage your protected health information primarily in our Electronic Health Record, although we may also store and manage some of your protected health information in paper format only.

This Notice will tell you about the ways Lifespan uses and discloses protected health information about you. It will also describe your rights and certain obligations we have regarding the use and disclosure of this information. In general, Lifespan will disclose your protected health information in accordance with state and federal laws. To the extent state laws are more restrictive than federal laws, we will comply with the more restrictive state laws.

We are required by law to:

- Keep protected health information about you private;
- Give you this Notice of our legal duties and privacy practices; and
- Abide by the terms of the Notice that is currently in effect.

3. How We May Use And Disclose Protected Health Information About You

The following categories describe and give examples of the different ways we are permitted or required to use and disclose your protected health information without first asking for your permission or offering you the opportunity to agree or object. In addition, if you participate in one of Lifespan's federally assisted drug or alcohol abuse programs, your patient identifying information may receive some further protections.

A. De-Identified Health Information – We can release your protected health information without your permission if we first "de-identify" it such that the person looking at it will not know it refers to you.

B. For Treatment – We use your protected health information to provide, coordinate and manage your healthcare. This will include disclosing protected health information about you to doctors, nurses, technicians, or other healthcare professionals who care for you, whether or not they are employed by Lifespan. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietician you have diabetes so that we can arrange for appropriate meals. Different healthcare professionals also may share your protected health information in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose your protected health information to people outside the hospital. For example, your protected health information may be provided to a physician to whom you have been referred so that the physician has the necessary information to treat you. Relatedly, if your physicians outside the hospital participate in our electronic Health Information Exchange, we may electronically share your protected health information with them via the Exchange.

C. For Payment – We use your protected health information in order to bill and collect payment from you, your insurance company, or a third party for the services you receive. For example, your insurance company may need to know about the type of surgery you received in order to pay us appropriately. We may also use your protected health information to obtain your insurer's prior approval to provide you with certain types of care, if your insurer requires us to do this. If you elect to take full financial responsibility for the services you receive and you request that we do not bill your insurer, we will honor that request. Finally, we can disclose your protected health information for the payment activities of another covered entity or health care provider.

D. For Healthcare Operations Purposes – We may use and disclose your protected health information to support the operations of our organization. This is necessary to make sure all of our patients receive quality care. For example, we may use your protected health information to evaluate the performance of our staff. We may also disclose information to doctors, nurses, technicians, medical students, and other hospital personnel for review and learning purposes. Also, we can disclose your protected health information for certain types of health care operations of another covered entity.

E. Business Associates – We may disclose your protected health information to business associates who provide services or activities on our behalf. For example, we may contract with accreditation agencies, management consultants, quality assurance reviewers, billing and collection services, and accountants. To protect your health information, we require our business associates to sign a written agreement regarding the safeguards they will implement to protect the privacy of our records in their possession.

F. **As Required by Law –** We disclose protected health information about you when required to do so by federal, state, or local law.

G. **Appointment Reminders –** We may use and disclose your protected health information to contact and remind you of your healthcare appointments with any of our Lifespan entities.

H. **Treatment Alternatives, Benefits and Services –** In the course of providing treatment for you, we may use your health information to contact you about health promotion activities, disease awareness or case management. We may also use your protected health information to tell you about or recommend possible treatment options, health related benefits, or services that may be of interest to you. However, if a third party provides financial remuneration to us in exchange for making these types of communications to you, we will ask you for your authorization in advance.

I. **Fundraising –** We may use or disclose your demographic information and the dates you receive treatment in order to contact you for our fundraising purposes. Each of our hospital affiliates has established an institutionally-related fundraising foundation that solicits gifts. You have a right to opt-out of these types of communications in the future by following the instructions on fundraising communications from us.

J. **To Avert a Serious Threat to Health or Safety –** We may disclose protected health information about you when necessary to prevent a serious and imminent threat to your health and safety or to the health and safety of the public or another person. We may also release protected health information to the police in certain cases.

K. **Public Health Activities –** We may release your protected health information to appropriate authorities for public health purposes including, but not limited to, preventing or controlling disease, injury or disability; to report child abuse or neglect; to the Food and Drug Administration (FDA) for activities relating to quality, safety or effectiveness of FDA regulated products or activity. We may also release your protected health information for the public health purpose of alerting a person who may be at risk of contracting or spreading a communicable disease.

L. **Disclosures About Victims of Abuse, Neglect, or Domestic Violence –** We may release your protected health information in a situation where we believe you have been a victim of abuse, neglect, or domestic violence. In some cases, we may be required by law to release such information. In other cases, we may not be required to release the information, but we may choose to release it to appropriate authorities or social service providers in order to prevent harm to you or another person. If possible, we will ask you for your permission before we make the disclosure, or tell you as soon as possible after we make it.

M. Organ and Tissue Donation – If you are an organ donor, we may release your protected health information to organizations that obtain organ, eye or tissue for donation and transplantation.

N. Limited Disclosures for Research Purposes or For Purposes Leading Up to Research – We may use and disclose your protected health information within Lifespan as necessary to prepare for research studies. For example, a researcher might review your protected health information while he or she is thinking about how to design a research study. Also, after a patient's death, it is possible that his or her protected health information would be used for research purposes if at least fifty years have passed since the patient's death. In most other cases, we will not use your protected health information for research purposes unless we first explain the research to you and you consent to participate in the research and you give us permission to use your protected health information for the research. In some cases, though, we may use your protected health information for research without your permission. In order for this to happen, your information would have to be partially de-identified, or a committee of people who know about research, privacy and medical ethics would have to decide that use of your information was necessary and that it would be of low risk to you and your privacy.

O. National Security and Military – We may disclose your protected health information to authorized federal officials for conducting national security and other intelligence activities, including providing protective services to the President and other officials. If you are a member of the armed forces, we may release information about you as required by military command authorities.

P. Workers' Compensation – We may release protected health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Q. Legal Proceedings – We may release protected health information about you during the course of legal proceedings if we are ordered to release the information by a court or judge, or in response to a valid subpoena or warrant issued by a court, administrative tribunal or an officer of a court.

R. Law Enforcement – We may release your protected health information to a law enforcement official for a law enforcement purpose under the following circumstances: (1) as permitted or required by law, or in response to certain types of court orders, warrants, subpoenas, demands, requests or other legal process; (2) if the law enforcement official needs limited information about you because of a reasonable belief that you pose a danger to yourself, a particular person or people, or if you are trying to obtain narcotics illegally; (3) if it is believed you have been the victim of a crime, although we will try to discuss with you before making the disclosure; (4) for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; (5) if you have

died and we think your death involved a criminal act; (6) if a crime occurs at Lifespan and we think your protected health information is evidence of the crime and (7) in an emergency health care situation if necessary to report a crime.

S. **Coroners, Medical Examiners and Funeral Directors –** We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person when determining the cause of death. Following the patient's death, we may also be required to furnish funeral directors with a standard death certificate that includes certain protected health information.

T. **Health Oversight –** We may disclose your protected health information to governmental agencies authorized by law to audit, inspect, or investigate the health care system, government benefit programs, other government programs and civil rights laws.

U. **Inmates –** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we will release your protected health information only as permitted by law.

V. **Questions of Capacity to Consent –** In situations where you lack capacity to consent, we may use and disclose your protected health information as permitted by applicable Lifespan policies and by law.

4. Other Uses or Disclosures of Your Protected Health Information

All other uses or disclosures of your protected health information will be made only with your written authorization, consent, or after you have been given the opportunity to object and you have decided not to object. If you authorize or agree to a use and disclosure now, you can change your mind later. If you do change your mind, you must let us know in writing. If and when you revoke your permission, we will stop using or disclosing your protected health information pursuant to your written authorization to the greatest extent practical. You understand that we are unable to revoke any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

Below, we have provided a few examples of situations where we need to ask you before we can use or share your medical information.

A. **Hospital Directory –** Except for patients receiving mental health services, unless you object we will include certain limited information about you in the hospital directory while you are in the hospital. This information may include your name, location in the hospital, your general condition (e.g., fair, stable,

etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing. However, for patients receiving mental health services, we will not disclose that the patient is receiving care at the hospital, unless an official at the hospital determines that the release of such information to any of the following persons is in the patient's best interest: (1) members of the patient's family; (2) the patient's lawyer; or (3) the patient's guardian or conservator.

B. Individuals Involved in Your Care or Payment for Your Care – Unless you object in writing, we may release the fact of your admission and a general description of your condition to another person, such as a relative or friend, who is involved in your care, or who helps pay for your care. Also, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate permitted uses and disclosures to family or other individuals involved in your healthcare. In cases where you are not present or able to agree or object, the healthcare providers will use their professional judgment to determine whether it is in your best interest for them to make disclosures permitted by law.

C. Research – Except for research described in Section 3 of this Notice, we may not use or disclose your protected health information for research purposes unless you authorize us to do so.

D. Psychotherapy Notes – In general, we will not use or disclose information recorded by a mental health professional to document or analyze conversations with you, unless you authorize us to do so. However, we can use or disclose such protected health information without your authorization for the following purposes: (1) the health professional who recorded the information can use it to treat you; (2) in limited situations, Lifespan can use or disclose the information in connection with mental health counseling training that occurs at Lifespan; and (3) Lifespan can use a patient's psychotherapy notes to defend against any legal proceeding brought by a patient.

E. Marketing – Marketing communications are communications about a product or service that encourage you to purchase or use the product or service. We must get your authorization before we use or disclose your protected health information for marketing, with two exceptions. First, we may inform you about products or services during face-to-face communications with you without your authorization, including providing related written materials to you. Second, we may also, without your authorization, provide to you promotional gifts of nominal value that encourage you to purchase or use a product or service.

F. **Sale of Protected Health Information –** We will not sell your protected health information to a third party without your prior authorization, and the authorization must state that we will receive remuneration in exchange for the disclosure of your protected health information.

5. Your Rights Regarding Your Medical Information

You have the following rights regarding the protected health information we maintain about you.

A. **The Right to Request Restrictions –** You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment and health care operations. We are not required to agree to your request unless you request restriction on disclosures to a health plan for purposes of payment or healthcare operations, and the protected health information relates to an item or service for which you, or another person on your behalf, have assumed full financial responsibility. If we do agree to your request for restrictions, we are bound by the restrictions, except in limited circumstances, such as if there is an emergency. In many cases, restricting a caregiver's access to protected health information is not in the best interest of the patient and could impede Lifespan operations. For this reason, in many cases, Lifespan will not agree to your request.

   You may also request that we not release any part of your protected health information to family members or friends who may be involved in your care, but we are not required to agree to your request.

   To request restrictions, you must make your request in writing to the **Lifespan Privacy Officer, 225 Carolina Ave, Suite 300, Providence, RI 02905, or one of the Affiliate Privacy Officers at the addresses listed at the end of this Notice.**

B. **The Right to Request to Receive Confidential Communication –** We will accommodate reasonable requests to communicate protected health information to you at a certain location or in a certain way. For example, you may ask us to contact you at work, or at a location other than your home address. If possible, please make alternative location requests at your first contact or at the time of registration. However, you may make such requests anytime thereafter. Requests for alternative means of communication made after the first contact or registration must be made in writing to our Privacy Officers at the address listed above.

C. **Right to Inspect and Copy –** You have the right to inspect and obtain, in a timely manner, a copy of your protected health information used to make decisions about your care, known as a "designated record set." Usually, this includes medical and billing records, but does not include psychotherapy notes,

information gathered for research purposes, information compiled in reasonable anticipation of or use in a legal proceeding, and protected health information subject to any law that prohibits your access.

To inspect and copy your protected health information in a designated record set, you must submit your request in writing to our Privacy Officer at the address above or Affiliated Privacy Officer at the addresses listed at the end of this Notice. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. If we maintain the protected health information you request in an electronic format, you have the right to request a copy of your information in electronic format, and we will provide the information to you in the format you request so long as it is readily producible in that format. If the information is not readily producible in the electronic format you request, we will reach an agreement with you as to an alternative readable electronic format. We will not charge you more than our labor costs of responding to your request for an electronic copy of your protected health information.

We may deny your request to inspect and copy your protected health information in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by another Lifespan healthcare professional. Under some circumstances, however, we are not required to offer you such review. If we do comply with your request for review of a denial, we will comply with the outcome of this review.

D. Right to Amend – If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept.

To request an amendment, your request must be made in writing and submitted to the Lifespan Privacy Officer or Lifespan Affiliated Privacy Officers at the address listed at the end of this Notice. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the protected health information kept by Lifespan;
- Is accurate and complete.

E. Accounting of Certain Disclosures – In general, you have the right to receive an accounting of disclosures we made of your protected health information in the six (6) years prior to the date the accounting is requested. However, many

exceptions apply to this general rule. For instance, you do not have a right to receive an accounting for disclosures made: (1) for treatment, payment or health care operations; (2) to you or your personal representative; (3) that you authorized in writing; (4) for the hospital's directory ; (5) to family and friends involved in your care or payment for your care or certain other notification purposes; (6) to federal officials for national security or intelligence activities; (7) to correctional institutions or law enforcement officers regarding inmates; (8) as part of a limited data set; or (9) to health oversight officials in certain situations. The scope of your right to request an accounting may be modified by changes in federal law from time to time.

You have the right to receive specific information about those disclosures for which you do have a right to an accounting. The right to receive this information is subject to certain exceptions, restrictions and limitations. Your request must be submitted in writing to either the Lifespan Privacy Officer or the appropriate Lifespan Affiliate Privacy Officer at the address listed at the end of this Notice. The first disclosure list you request within a 12-month period will be free. For additional lists, we may charge you the cost of providing such lists.

F. **Right to a Paper Copy of This Notice –** You have the right to request a paper copy of this Notice at any time, even if you have agreed to receive this Notice electronically. Requests for paper copies may be obtained when registering at a Lifespan affiliate or can be requested, in writing, from either the Lifespan Privacy Officer, or the appropriate Lifespan Affiliate Privacy Officer listed at the end of this Notice.

G. **Right to Notification –** If we determine that your medical records have been improperly used or accessed, we will notify you of the improper use or access as required by law.

6. Minors and Personal Representatives

In most situations, parents, guardians, and/or others with legal responsibilities for minors (children under 18 years of age) may exercise the rights described in this Notice on behalf of the minor. However, there are situations where minors may themselves exercise the rights described in the Notice.

7. Changing This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for protected health information we already have about you as well as any information we receive in the future. We will prominently post a copy of this Notice at each Lifespan affiliate and on the Web at

http://www.lifespan.org/lifespan-joint-privacy-notice.html

The effective date will be printed on the first page of the Notice in the top right hand corner.

It should also be noted that in the event Lifespan or any of its affiliates are sold or merge with another organization, your medical information/medical record would become the property of the new owner.

8. Complaints/Informational Inquiries

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201. You may also file a complaint with the Lifespan Privacy Officer at the address and phone number below.

You will not be penalized for filing a complaint, nor will you be asked to waive your rights as a condition of treatment.

Lifespan Privacy Officer
225 Carolina Ave, Suite 300
Providence, RI 02905

401-444-4728 or privacyofficer@lifespan.org

We recognize that our patients may have questions about, or may wish to make inquiries about, their protected health information, this Notice or our privacy practices. Lifespan has appointed Lifespan Affiliate Privacy Officers who work closely with the Lifespan Privacy Office. The Lifespan Affiliate Privacy Officers, who work primarily in the Health Information Services area, are ready to assist you with your questions and inquiries and can be reached at the addresses and telephone numbers listed on the following page.

Contact Information for Affiliate Privacy Officials

Rhode Island Hospital
Health Information Services
Affiliate Privacy Officer
593 Eddy Street
Providence, RI 02903
401-444-4560

The Miriam Hospital/Lifespan Physician Group
Health Information Services
Affiliate Privacy Officer
164 Summit Avenue
Providence, RI 02906
401-793-2910

Newport Hospital/ NHCC Medical Associates, Inc
Affiliate Privacy Officer
11 Friendship Street
Newport, RI 02840
401-845-1545
401-845-1152

Emma Pendleton Bradley Hospital
Affiliate Privacy Officer
1011 Veterans Memorial Parkway
East Providence, RI 02915
401-432-1129

Gateway Healthcare, Inc./ Gateway Professional Group, Inc./ The Autism Project
Affiliate Privacy Officer
249 Roosevelt Ave. Suite 250
Pawtucket, RI 02860
401-724-8400

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DOCTOR ON CALL (DOC) PROGRAM
23 Powel Avenue
Newport, RI 02840
Phone: 401-845-1117, Fax: 401-236-2593

Patient's Acknowledgement of Receipt of the Lifespan Privacy Notice

- I have received a copy of the privacy notice
- It describes how my health information may be used or disclosed
- I understand that I should read it carefully
- I am aware that the notice may be changed at any time
- I may obtain a revised copy by calling any Lifespan Partner, (401) 444-4560 or (401) 444-4728, or by logging on to www.Lifespan.org

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

*As the representative of the above individual, I acknowledge receipt of the Privacy Notice on his/her behalf.

Representative/Guardian's Name: _____

Representative/Guardian's Signature: _____

Newport Hospital
Lifespan. Delivering health with care.®

DOCTOR ON CALL (DOC) PROGRAM
23 Powel Avenue
Newport, RI 02840
Phone: 401-845-1117, Fax: 401-236-2593

Permission to Disclose Protected Health Information

Patient Name: _____ (Please Print Clearly)

Date of Birth: _____

Permission to leave message:

I authorize the DOC program to leave non-clinical messages, such as appointment reminders or return call messages on my:

Home Phone: _____
Cell Phone: _____
Work Phone: _____

_____ _____
(Signature of Patient/Parent or Guardian) (Date)

Permission to Discuss/Disclose Protected Health Information:

I authorize the DOC program staff. to discuss and/or disclose my PHI (personal health information) to the following individual(s):

1. _____ _____
(Name) (Contact Number) (Relationship)

2. _____ _____
(Name) (Contact Number) (Relationship)

I understand I may revoke this authorization at any time by informing my Provider in writing.

_____ _____
(Signature of Patient/Parent or Guardian) (Date)

Doctor on Call

Payment/Invoice Information

Newport Hospital
Lifespan. Delivering health with care.®

Member Information

Name:

Last	*First*

Payment Information

I hereby authorize the credit card below to be charged for the membership fee and any other fees due pursuant to the Membership Agreement (i.e., courtesy non-member visits). I agree to provide any updated credit card information to maintain an active credit card on file.

Select Payment Method

☐ Credit Card, please select one:
- ☐ Visa
- ☐ Mastercard
- ☐ American Express
- ☐ Discover

☐ Check made payable to Newport Hospital

☐ Invoice

Name on Credit Card:

Credit Card #:

Expiration Date: **CVV # (see sample picture):**