Sugarloaf Medical P.C.

General Internal Medicine – Primary Care

Registration Form

Patient Information

Name _____ Gender □ Male □ Female
Last First Middle

Date of Birth _____ / _____ / _____ Social Security # _____

Address _____
Street City State Zip

Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail _____

Marital Status: □ Married □ Single □ Widow □ Divorced □ Other _____

Employment □ Full Time □ Part Time □ Student □ Retired □ Other_____ Employer _____

Emergency Contact _____ Relation _____

Phone: Home _____ Work _____ Cell Phone _____

Pharmacy Information

Name _____ Phone _____ Fax _____

Address _____
Street City State Zip

Primary Insurance Information

Insurance Company _____ Policy # _____ Group # _____

Policy Holder _____ Relation to Patient _____ Date of Birth _____
Last First MI

Social Security #_____ Phone _____

Secondary Insurance Information

Insurance Company _____ Policy # _____ Group # _____

Responsible Party: If other than Patient, Please Complete

Person to bill _____ Relation to Patient _____ Social Security #_____
Last First MI

Address _____
Street City State Zip

Phone: Home _____ Work _____ Cell Phone _____

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Name _____ Date of Birth _____ / _____ / _____
Last First

Current Medications
(Include all Prescriptions, Supplements, Over the Counter and Herbal Medications)

	Name	Dose	Frequency	Diagnosis (asthma, depression…etc)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Allergies / Intolerances

Do You Have Allergies / Intolerances to Medication or Other Substance □ No □ Yes, Please List:	1	3	
	2	4	

Past Medical Problems
(Diabetes, Hypertension, Thyroid….etc)

	Problem	Date / Age Diagnosed		Problem	Date / Age Diagnosed
1			5		
2			6		
3			7		
4			8		

Past Surgeries

	Surgery	Date		Surgery	Date
1			3		
2			4		

Family History

(Please indicate if they have or ever had any of the following medical conditions)

Father □ Alive Age or DOB _____ □ Deceased Cause and age of death. _____	□ High Blood Pressure □ Elevated Cholesterol Levels □ Diabetes, □ Type 2 □ Type 1 □ Coronary Heart Disease, Age Diagnosed_____ □ Stroke, Age Diagnosed_____ □ Prostate Cancer, Age Diagnosed _____ □ Colon Cancer, Age Diagnosed _____ □ Other, _____
Mother □ Alive Age or DOB _____ □ Deceased Cause and age of death. _____	□ High Blood Pressure □ Elevated Cholesterol Levels □ Diabetes, □ Type 2 □ Type 1 □ Coronary Heart Disease, Age Diagnosed _____ □ Stroke, Age Diagnosed_____ □ Colon Cancer, Age Diagnosed _____ □ Breast Cancer, Age Diagnosed _____ □ Ovarian Cancer, Age Diagnosed _____ □ Other, _____
Siblings Number of Brothers _____ Sisters _____	□ High Blood Pressure □ Elevated Cholesterol Levels □ Diabetes, □ Type 2 □ Type 1 □ Coronary Heart Disease, Age Diagnosed _____ □ Stroke, Age Diagnosed_____ □ Colon Cancer, Age Diagnosed _____ □ Breast Cancer, Age Diagnosed _____ □ Ovarian Cancer, Age Diagnosed _____ □ Prostate Cancer, Age Diagnosed _____ □ Other, _____
Children Number of Sons _____ Daughters _____	□ _____ □ _____ □ _____

Social History

Smoking: Current Smoker □ No □ Yes Packs per Day _____ For How Many Years _____ Previous smoker □ No □ Yes Packs per Day _____ For How Many Years _____ Quite Date_____
Alcohol: □ No □ Social □ Yes How much and how often, Type _____
Marital Status: □Single Married Divorced Widowed Engaged
Occupation:

Review of Systems

Are you currently or regularly experience any of the following signs and symptoms (please check all that apply*)*

Constitutional
- □ Weight loss or gain
- □ Difficulty falling asleep
- □ Unrefreshed feeling after sleep
- □ Chronic fatigue

Skin
- □ New skin rashes or moles
- □ Changes to existing skin lesions

Eyes
- □ Diminished or blurred vision
- □ Wear glasses or contact lenses
- □ Last Eye Exam_____

Ears, Nose, Mouth and Throat
- □ Difficulty hearing
- □ Feeling of food stuck in throat or chest
- □ Last Dental Exam _____

Allergic / Immunologic
- □ Frequently suffer from allergic symptoms such as (Itchy eyes, runny nose or sneezing)
- □ Animal or food allergies

Hematologic / Lymphatic
- □ Swollen glands or lymph nodes
- □ Easy bruising

Endocrine
- □ Excessive thirst
- □ Excessive urination
- □ Heat or cold intolerance
- □ Diminished sexual drive

Cardiovascular
- □ Chest pain or tightness (angina)
- □ Skipping heart beat (palpitation)
- □ Trouble breathing when lying flat
- □ Leg pain / cramps with walking
- □ Swelling in legs

Respiratory
- □ Shortness of breath
- □ Persistent cough
- □ Coughing up blood
- □ Wheezing

Gastrointestinal
- □ Heartburn or sour taste in mouth
- □ Constipation
- □ Chronic diarrhea
- □ Changes in bowel habits
- □ Blood in stool

Genitourinary
- □ Blood in urine
- □ Urinary incontinence (leakage)

Men only
- □ Difficulty with erection
- □ Pain or mass in testicles
- □ Weak urine stream

Female only
- □ Heavy / irregular menstrual bleeding
- □ Pain during or following intercourse
- □ Lumps in breast or nipple discharge
- □ Hot flashes
- □ Menopause, Age _____
- □ Post menopausal vaginal bleeding

Musculoskeletal
- □ Joint pain
- □ Joint swelling or redness
- □ Joint stiffness

Neurological
- □ Tingling
- □ Tremors

Psychiatric
- □ Depression / sadness
- □ Feel like hurting someone or self
- □ Anxiety

Preventive Medicine

Colonoscopy: Date _____ Result _____

Women: Last: Pap smear: _____ / _____ Breast Exam: _____ / _____ Mammogram: _____ / _____

Men: Last: Rectal/Prostate exam: _____ / _____ Testicular exam: _____ / _____ PSA: _____ / _____

Immunization History

Flu: □ No □ Yes Date _____ / _____

Pneumonia: □ No □ Yes Date _____ / _____

Tetanus: □ No □ Yes Date _____ / _____

Hepatitis B vaccine: □ No □ Yes Date _____ / _____

Gardasil: □ No □ Yes Date _____ / _____

Zoster/Shingles: □ No □ Yes Date _____ / _____

Sugarloaf Medical P.C.

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Treatment and Payment Agreement

1. Treatment Consent and Authorization: I consent and authorize Sugarloaf Medical P.C. ("SMP") to examine me and perform all treatments for this and all following visits, including, without limitation, prescribed medications, performance of diagnostic procedures and laboratory tests as deemed necessary or advisable by the attending physician. This consent and authorization is given in advance of any specific diagnosis or treatment and is continuing until revoked in writing.

2. Insurance Plan Benefits: SMP participates with multiple insurance plans. Each insurance plan has different benefit packages and regulations. I understand, acknowledge, and agree that it is my responsibility to be familiar with my insurance benefits and to advise SMP's staff regarding my insurance coverage. **I understand, acknowledge, and agree that I am fully responsible for all charges, including, without limitation, laboratory tests, that are not covered by my insurance policy.**

3. Payment Agreement and Financial Patient Policies: SMP will file the insurance claim(s) with my insurance carrier for services provided to me. I understand, acknowledge, and agree that SMP must collect my co-payments and deductibles at the time the service is rendered. The patient is required to present his or her insurance card at the time of the visit. Without a current insurance card, SMP will not be able to file the patient's claims appropriately and the patient will be responsible for the payment of all charges. If my insurance coverage changes, I agree to notify SMP at the time of my visit. SMP may not be able to re-file claims, and I would be responsible for full payment.

4. Returned Checks: SMP accepts personal checks, cash, MasterCard, and Visa. I understand, acknowledge, and agree that if my check is returned for any reason, a $30 service charge will be charged to my account. SMP will require me to pay for all future visits by cash or credit card.

5. Laboratory Tests: Laboratory tests are normally drawn at SMP's offices. Some insurance companies require the patient to go to a particular laboratory. LabCorp performs the majority of SMP's tests. There may be some tests performed for which LabCorp will bill the patient directly, but the bulk of testing is billed by SMP.

6. No Show Policy: I understand, acknowledge, and agree that any time that I miss an appointment without giving 24-hour advance notification, SMP will assess me a $25.00 no-show fee for office visits and $50.00 for physical appointments. This will be my responsibility to pay prior to the next visit.

_____

Signature of Patient or Legal Guardian Date of Birth

_____

Print Name of Patient or Legal Guardian Date

Sugarloaf Medical P.C.

General Internal Medicine – Primary Care

ACKNOWLEDGMENT OF RECEIPT OF *NOTICE OF PRIVACY PRACTICES* AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge my receipt of Sugarloaf Medical P.C.'s *Notice of Privacy Practices* and give my consent for Sugarloaf Medical P.C. ("SMP" or "practice") to use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. I understand and acknowledge that the SMP's *Notice of Privacy Practices* provides a more complete description of such uses and disclosures than the examples provided in this consent form and that I have the right to review the *Notice of Privacy Practices* prior to signing this consent.

I understand and acknowledge that SMP reserves the right to revise its *Notice of Privacy Practices* at anytime and that a revised *Notice of Privacy Practices* may be obtained by sending a written request to SMP at the following address: Attn: Yasmine, Privacy Officer, Sugarloaf Medical P.C., 1300 Peachtree Industrial Blvd., Suite 4203, Suwanee, GA 30024.

SMP may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, patient statements, and any calls pertaining to my clinical care, including, without limitation, laboratory results among others.

SMP may mail or email to my home or other alternative location any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements.

I understand and acknowledge that I have the right to request that SMP restrict how it uses or discloses my protected health information to carry out treatment, payment, and healthcare operations. I understand and acknowledge that SMP is not required to agree to my requested restrictions, but if it does, it is bound by this request.

I understand and acknowledge that this consent does not expire on its own. I may revoke my consent in writing, except to the extent that the SMP has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, SMP may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian Date of Birth

_____

Print Name of Patient or Legal Guardian Date

Effective Date of this Notice: March 1, 2008

Sugarloaf Medical P. C.

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this Notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Attn: Yasmine, Privacy Officer
Sugarloaf Medical P.C.
1300 Peachtree Industrial Blvd., Suite 4203
Suwanee GA 30024
Telephone: (770) 831-3666; Facsimile: (770) 831-3669

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take a child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for purposes such as:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain a court or administrative order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices

- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Attn: Yasmine, Privacy Officer, Sugarloaf Medical, P.C., 1300 Peachtree Industrial Blvd., Suite 4203, Suwanee GA 30024; telephone: (770) 831-3666; facsimile: (770) 831-3669, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Attn: Yasmine, Privacy Officer, Sugarloaf Medical P.C., 1300 Peachtree Industrial Blvd., Suite 4203, Suwanee GA 30024; telephone: (770) 831-3666; facsimile: (770) 831-3669. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Attn: Yasmine, Privacy Officer, Sugarloaf Medical, P.C., 1300 Peachtree Industrial Blvd., Suite 4203, Suwanee GA 30024; telephone: (770) 831-3666; facsimile: (770) 831-3669, in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Attn: Yasmine, Privacy Officer, Sugarloaf Medical, P.C., 1300 Peachtree Industrial Blvd., Suite 4203, Suwanee GA 30024; telephone: (770) 831-3666; facsimile: (770) 831-3669. You must provide us with a reason that supports your request for amendment. Our practice will deny

your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Attn: Yasmine, Privacy Officer, Sugarloaf Medical, P.C., 1300 Peachtree Industrial Blvd., Suite 4203, Suwanee GA 30024; telephone: (770) 831-3666; facsimile: (770) 831-3669. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Attn: Yasmine, Privacy Officer, Sugarloaf Medical P.C., 1300 Peachtree Industrial Blvd., Suite 4203, Suwanee GA 30024; telephone: (770) 831-3666; facsimile: (770) 831-3669.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Attn: Yasmine, Privacy Officer, Sugarloaf Medical, P.C., 1300 Peachtree Industrial Blvd., Suite 4203, Suwanee GA 30024; telephone: (770) 831-3666; facsimile: (770) 831-3669. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the purposes described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Attn: Yasmine, Privacy Officer, Sugarloaf Medical, P.C., 1300 Peachtree Industrial Blvd., Suite 4203, Suwanee GA 30024; telephone: (770) 831-3666; facsimile: (770) 831-3669.