



Harbor-UCLA
MEDICAL CENTER

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Miguel Ortiz-Marroquin
Chief Executive Officer

Gail V. Anderson, Jr., MD
Chief Medical Officer

Peggy Nazarey, RN
Chief Nursing Officer

1000 West Carson Street
Torrance, CA 90509

Tel: (310) 222-2901
Fax: (310) 782-8599

*To improve health
through leadership,
service and education*



Health Services
www.dhs.lacounty.gov

January, 2009

Dear Medical Graduate,

Welcome to Harbor-UCLA Medical Center. As a newly hired employee you are required to be cleared by Employee Health Services (EHS). Attached are items that can be completed prior to orientation. This will assist your visit at Employee Health Services.

Items you MUST do and bring to orientation:

1. History and Physical completed by a licensed physician or midlevel provider. The Medical Examination Data form is provided. If you need any accommodations or work restrictions please bring in orders written by your physician.
2. Other forms to be filled out:
 - a. Medical History Questionnaire- 7 pages
 - b. Civil Service Evaluation
 - c. PPD Testing Assessment
 - d. Hepatitis B Consent/Declination Form
 - e. Notice of Privacy Practices
 - f. Latex Allergy- Are you at Risk?

Items you can do before you arrive to make the orientation process easier:

1. Provide copy of PPD test documented in millimeters done within the last 12 months.
2. Present to EHS for application of an intermediate strength (5 TU PPD) tuberculosis skin test (TST).
3. A "2 Step" method will be used for those who cannot provide documentation of a negative TST within the previous 12 months.
4. Those with documentation of a positive TST in the past will be screened with a single view (PA) chest x-ray unless a printed report of a negative chest x-ray interpreted by a radiologist and obtained within the previous 6 months is provided.
5. Bring copies of past immunizations to orientation. These are not required, but are helpful if you need a booster for Td or Hepatitis B.

Test that will be done during your orientation are as followed:

1. Serology; including Mumps, Rubeola, Rubella, Varicella, HBsAB, HBsAG, HBcAB.
2. Chest x-ray may be required
3. Documentation and/or completion of a 2 Step PPD procedure.
4. Respiratory Fit Test.

Thank you for your cooperation.

For questions or further information please contact Employee Health Services at 310-222-2360.

Harbor-UCLA Medical Center

Employee Health Services

(310) 222-2360, Fax (310) 222-5326

Pre-Employment PPD (Mantoux) Testing Assessment

- 1. Do you have a history of a previous POSITIVE PPD (Mantoux)? YES__NO__
Do you have documentation of your + PPD? YES__NO__
2. Do you have documentation of your NEGATIVE PPD, placed within the last 12 month?
YES__NO__

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDLES OF PPD STATUS.

T.B. Risk Assessment:

- 1. Are you immunocompromised? (i.e. on steroids, an insulin dependent (diabetic or a poorly controlled diabetic, on antineoplastic medication, HIV infected, have leukemia, lymphoma or any other illness that may affect your ability to fight infection.) Yes__ No__
2. Have you ever had a blood transfusion? Yes__ No__
If yes, when and where__
3. Have you ever used street I.V. drugs? Yes__ No__
4. Have you ever engaged in high risk sex? (i.e. multiple sex partner, sex with prostitutes, or people who use IV drugs, or if male, do you have sex with other men) Yes__ No__
5. Have you ever had clinical TB (Pneumonia)? Yes__ No__. If yes when__
6. What medications are you taking?__

IF YOU ANSWER YES TO ANY OF THE ABOVE QUESTIONS YOU MAY BE AT HIGHER RISK OF ACQUIRING CLINICAL TUBERCULOSIS.

In the past 3 months have you

- 1. Been exposed to anyone with TB? [] Yes [] No []Unknown (not sure)
If yes, where did exposure occur and when__
2. Experienced chronic cough (lasting more than 3 weeks)? []Yes []No
3. Coughed up blood? []Yes []No If yes, how many times__ dates__
4. Experienced night sweats? []Yes []No If yes, when?__ how long?__
5. Noted weight loss? []Yes []No If yes, how much?__
6. Noticed unexplained fever? []Yes []No If yes, when?__
7. Been coughing up excessive sputum? []Yes []No If yes, since when?__
8. Noticed excessive fatigue? []Yes []No If yes, since when?__

Would you be interested in an anonymous HIV blood test? []Yes []No []Maybe

Name (print)____
Signature____ Date____

LATEX ALLERGY- ARE YOU AT RISK?

What is Latex? Latex is the milky sap from the rubber tree. Common latex products used in the medical center include:

- ✓ Rubber gloves
- ✓ Adhesive tape
- ✓ Urinary catheters
- ✓ Rubber based items (rubber band, balloons)

Other common latex products include:

- ✓ Condoms
- ✓ Baby bottle nipples and pacifiers
- ✓ Dental dams

Who is at high risk for developing latex reactions?

- ✓ Workers with ongoing latex exposure
- ✓ Physicians, Nurses, Dentists, Technicians
- ✓ Persons with a tendency to have multiple allergic conditions
- ✓ Allergies to certain foods- avocado, potato, banana, tomato, chestnuts, kiwi, papaya

What are the symptoms of latex allergy?

- ✓ Skin rash
- ✓ Hives or welts
- ✓ Watery or itchy eyes
- ✓ Sneezing
- ✓ Fainting or unconsciousness
- ✓ Body swelling or itching
- ✓ Difficulty breathing or chest tightness

What do you do in the event of an allergic reaction?

- Remove the offending latex object causing the problems.
- Rinse the area of contact with large amounts of water.
- If there are breathing problems, call for emergency help.
- Wear a medic-alert bracelet stating "Allergic to Latex".
- Carry an Epi-Pen if prone to severe reactions.

If you are sensitive to latex-Ask for latex free gloves.

- Your supervisor or the Nursing Supervisor of the area you are working in, is able to order and supply you with latex free, sterile and non-sterile gloves.

Please contact Employee Health Services for further information.

**For additional information about latex allergy call 1-800-CDC-INFO
(1-800-232-4636).**

Applicant's Signature

Date



HARBOR-UCLA MEDICAL CENTER
Employee Health Services
1000 West Carson Street, BOX 451
Torrance, CA 90509
(310) 222-2360 FAX(310) 222-5326

Los Angeles County
Board of Supervisors

Gloria Molina
 First District

Yvonne B. Burke
 Second District

Zev Yaroslavsky
 Third District

Don Knabe
 Fourth District

Michael D. Antonovich
 Fifth District

Miguel Ortiz-Marroquin
 Chief Executive Officer

Gail V. Anderson, Jr., MD
 Chief Medical Officer

Peggy Nazarey, RN
 Chief Nursing Officer

1000 West Carson Street
 Torrance, CA 90509

Tel: (310) 222-2101
 Fax: (310) 328-9624

*To improve health
 through leadership,
 service and education*

Date of Medical Evaluation _____ / _____ / _____
 Mo. Day Year

Dear Civil Service Applicant,

The Employee Health Services (EHS) of Harbor-UCLA Medical Center welcomes you.

You are now undergoing a required Civil Service Medical Evaluation, to determine whether you are medically capable of performing the job you are being considered for. This examination consists of history and physical information, blood tests, screening for infectious/communicable diseases, verification of PPD status in millimeters of induration, chest x-ray if indicated, respiratory fit test (if applicable), color and vision testing, and other medical evaluations that are deemed necessary to determine your fitness for duty.

The results of these tests must be reviewed before final clearance is issued. Therefore, EHS will not clear you for hire until all your pre employment requirements have been completed. This includes any additional documentation requested of you to complete your pre employment medical fitness assessment.

Failure to comply with all Civil Services Medical Examination requirements within 10 working days may result in your medical disqualification.

I have read the above and fully understand its contents. I have been provided the opportunity to ask questions relating to the above, and have a clear understanding. I will adhere to these requirements.

 Applicant's Signature

 Date

 Witness's Signature

 Date



Health Services
www.ladhs.org

**NOT TO BE PRESENTED
TO THE
PERSONNEL OFFICER
NOR TO BECOME
A PART OF A
PERSONNEL FILE**

CONFIDENTIAL

MEDICAL HISTORY QUESTIONNAIRE

**OCCUPATIONAL HEALTH SERVICE
DEPARTMENT OF PERSONNEL
COUNTY OF LOS ANGELES**

TO THE APPLICANT/EMPLOYEE

Answers to the questions contained in this booklet, together with the results of your evaluation by a Health Professional, are important.

This evaluation is designed to help place you in an appropriate position for as long as you wish to remain; it is not designed to exclude or remove you from employment.

This will become a part of your medical record which will remain in the Occupational Health Service. It will help us understand you now and serve your future health needs. Information is not available to anyone outside of this Health Service except on your written approval, or by court order.

This questionnaire is confidential. Please answer the questions carefully and completely, after reading all the instructions. Your answers will become part of your medical record.

When answering YES-NO questions place an (x) in the appropriate space. If you are unable to answer a question for any reason place a (?) in the YES space.

Give a date where a line is provided for that purpose.

AT THE TIME OF YOUR APPOINTMENT FOR MEDICAL EVALUATION, YOU MUST PRESENT THIS QUESTIONNAIRE, COMPLETED, TO THE MEDICAL / NURSING SERVICE. IT IS NOT TO BE GIVEN OR SHOWN TO ANYONE ELSE, IN ORDER TO PROTECT ITS CONFIDENTIALITY. EXAMINEES SHOULD BRING A VALID DRIVER'S LICENSE, OR OTHER FORM OF IDENTIFICATION, WHICH CARRIES BOTH THEIR PHOTOGRAPH AND SIGNATURE.

Date of Examination Appointment MONTH DAY YEAR

Mr. Ms. LAST NAME FIRST NAME MIDDLE NAME OR INITIAL

Social Security Number / / Birth Date MONTH DAY YEAR

Present Address NUMBER AND STREET CITY ZIP CODE

Home Telephone () AREA CODE Business () AREA CODE EXT.

Name SPOUSE OR NEXT OF KIN RELATIONSHIP

Address NUMBER AND STREET CITY ZIP CODE

STATE ZIP CODE Telephone () AREA CODE

Do you have a personal physician? Yes No If "Yes," give:

Name Telephone Number () AREA CODE

Address NUMBER AND STREET CITY ZIP CODE

I, the undersigned, do hereby consent to undergo a medical examination, including blood specimens, X-rays, photographs, skin tests, immunization and other examinations which the examiner may consider necessary to complete my medical evaluation.

Signature Date

I, the undersigned, declare that my answers to the questions contained in this medical history/questionnaire, are true to the best of my knowledge and belief. I am aware that any inaccuracy on this record may be seriously harmful to me, inasmuch as it may prevent my receiving health care I need and, if willful, may be regarded as cause for dismissal or disqualification for employment.

Signature Date

1. Have you ever been medically examined for employment in any position in the County including a staff position of a County Hospital?

No Yes When For Position of

Your name at that time? Dept.

2. Please list any medicines you have taken in the last 2 months:

(a) (b)

(c) (d)

3. Name those medications you regularly use, including vitamins, hormones, laxatives, aspirins, tranquilizers, anti-depressants, etc.

(a) (b)
 (c) (d)

4a. Name any drugs to which you may have ever had an allergic reaction.

(a) (b)
 (c) (d)

4b. Other Allergies: Please list other substances to which you are allergic, including food, animal bites or stings, etc

(a) (b)
 (c) (d)

5. Hospitalization: Please list the reasons that you have been hospitalized in the last 5 years, starting with the most recent, excluding pregnancies, but including psychiatric hospitalization or detoxification.

(a) MONTH YEAR
 (b) MONTH YEAR
 (c) MONTH YEAR

6. If members of your immediate family have had any of the following diseases, please indicate the relative.

Disease	Relative	Disease	Relative
Diabetes	Tuberculosis
Stroke	Heart Disease
Cancer or tumor	Glaucoma
High Blood Pressure	Hereditary or Familial Disease

7. Yes..... No..... Have you ever had trouble with your thyroid gland?

8. Yes..... No..... Have you lost or gained more than 10 pounds in the past 5 years without trying to?

9. Yes..... No..... Have you had a change in the size or color of a mole (a dark growth) or wart in the past year or recurrent skin eruptions?

10. Yes..... No..... Do you have a skin rash which reappears from time to time, burning, itching or any other skin sensitivity?

11. Yes..... No..... Have you had any skin cancers removed?

12. Yes..... No..... Have you ever had a skull fracture?

13. Yes..... No..... Have you ever had a head injury which made you unconscious?

14. Yes..... No..... Do you suffer from severe headaches or migraine attacks?

15. Yes..... No..... Does aspirin relieve your headaches?

16. Yes..... No Do you have ringing or buzzing noises in your ears for no apparent reason?
17. Yes..... No..... Do you often have difficulty hearing what is said to you?
18. Yes..... No..... Does your eyesight ever blur?
19. Yes..... No..... Have you ever had a serious eye injury or eye infection?
20. Yes..... No..... Do you wear corrective glasses or lenses?
-
21. Yes..... No..... Have you had bleeding gums in the past year?
22. Yes..... No..... Does your nose ever bleed for no apparent reason?
23. Yes..... No..... Do you have sinus trouble more than once a month?
24. Yes..... No..... Do you have colds more than twice a month?
-
25. Yes..... No..... Have you ever coughed up blood?
26. Yes..... No..... Do you cough up large amounts of mucus?
27. Yes..... No..... Have you had a chest X-ray in the past year? If so, please bring film or physician's report.
28. Yes..... No..... Do your ankles or feet often swell?
29. Yes..... No..... Do you get pains in the backs of your legs when walking?
30. Yes..... No..... Have you had a feeling of pressure or tightness in your chest in the past year?
31. Yes..... No..... Have you had pain in your chest in the past year?
32. Yes..... No..... Does very little effort leave you short of breath?
33. Yes..... No..... Do you often wake up at night short of breath?
34. Yes..... No..... Do you smoke cigarettes?
 How many per day?
35. Yes..... No..... Do you use tobacco in any other form?
36. Yes..... No..... Do you sometimes have severe soaking sweats at night?
37. Yes..... No..... Have you had an electrocardiogram (EKG or ECG) within the past year?
38. Yes..... No..... Have you ever had a heart attack?
 If "Yes," when? Month: Year:
-
39. Yes..... No..... Do you suffer from indigestion or heartburn?
40. Yes..... No..... Is it painful or difficult for you to swallow?
41. Yes..... No..... Do you frequently have pain in your stomach?
42. Yes..... No..... Do you frequently take medicine for "stomach acid," such as Tums or Alka Seltzer?
43. Yes..... No..... Have you ever vomited blood?
44. Yes..... No..... Are your bowel movements ever black or bloody?
-
45. Yes..... No..... Do you get up more than twice at night to urinate (pass water)?
46. Yes..... No..... Do you ever have difficulty starting or stopping urination?
47. Yes..... No..... Has your urine ever been black, brown, or bloody?
48. Yes..... No..... Has a physician ever told you that you had sugar or pus in your urine?

(GO ON TO THE NEXT PAGE)

49. Yes..... No..... Have you ever had a hernia (rupture)?
Yes..... No..... If "Yes," have you ever had it surgically repaired?

Have you ever been exposed to any of the following?

50. Yes..... No..... Prolonged loud noises while at work, at home, with your hobbies, or while in the Armed Services?
51. Yes..... No..... Any substances which irritated your skin or eyes while at work or at home?
52. Yes..... No..... Sprays and powders for bugs or plants?
53. Yes..... No..... Prolonged X-rays or radiation of any kind?
54. Yes..... No..... Dusty conditions such as sandblasting, grinding, or drilling of rock, coal, silica and asbestos or asbestos products?
55. Yes..... No..... Has your job included long periods of extreme heat, such as in a boiler room, or extreme cold such as with the refrigeration in a packing plant?

If "Yes," please answer the following:

56. Yes..... No..... Did you have a bad reaction to the extreme heat?
57. Yes..... No..... Did you have a bad reaction to the extreme cold?

58. Yes..... No..... Have you ever had a minor back sprain?

If "Yes," please answer the following:

59. How many times did you have an attack of this condition?
60. How many days were you unable to work because of this condition?
61. Yes..... No..... Have you ever had a severe back injury?

If "Yes," please answer the following:

62. How many times did you have an attack of this condition?
63. How many days were you unable to work because of this condition?
64. Yes..... No..... Have you ever had a problem with your bones or joints such as swelling or pain?

If "Yes," please describe the problem:

.....
.....

65. Yes..... No..... Have you ever been rejected by the military for health reasons?

(Reason.....)

66. Yes..... No..... Were you ever in the Armed Services?

If "Yes," please answer the following:

67. Yes..... No..... Did you receive a medical discharge?

Have you ever had a claim for the following:

68. Yes..... No..... An occupational disease?
(Date: Type of Disease:)
69. Yes..... No..... An industrial injury?
(Date: Type of Injury:)
70. Yes..... No..... Have you any claim now pending for the above?
If "Yes," Date: Claim for:
Jurisdiction:

If you have ever had or now have any of the following, please check in the appropriate space.

71. Yes..... No..... Tuberculosis
72. Yes..... No..... Pneumonia
73. Yes..... No..... Bronchitis
74. Yes..... No..... High blood pressure
75. Yes..... No..... Typhoid fever
76. Yes..... No..... Epilepsy or a convulsive disorder
77. Yes..... No..... Rheumatism or arthritis
78. Yes..... No..... Sickle cell disease or trait
79. Yes..... No..... Valley fever (coccidioidomycosis)
80. Yes..... No..... Histoplasmosis
81. Yes..... No..... Heart murmur, heart disease
82. Yes..... No..... Jaundice (yellow eyes or skin)
83. Yes..... No..... Duodenal or stomach ulcer
84. Yes..... No..... Gallbladder trouble
85. Yes..... No..... Liver trouble or hepatitis
86. Yes..... No..... Hiatus or diaphragmatic hernia
87. Yes..... No..... Has a physician ever told you you have prostate trouble?
88. Yes..... No..... Venereal disease (V.D., syphilis, gonorrhea)
89. Yes..... No..... Anemia
90. Yes..... No..... Encephalitis
91. Yes..... No..... Are you now pregnant?
92. Yes..... No..... Asthma
93. Yes..... No..... Diabetes (sugar disease)
94. Yes..... No..... Emphysema
95. Yes..... No..... Kidney disease

(GO ON TO THE NEXT PAGE)

- 96. Yes..... No..... Varicose veins
- 97. Yes..... No..... Hay fever
- 98. Yes..... No..... Cancer
- 99. Yes..... No..... Glaucoma
- 100. Yes..... No..... Other, not mentioned above.

Describe anything else which you feel might be important in your medical history, including any condition(s) not specifically referred to in any of the preceding questions.

**OCCUPATIONAL HEALTH SERVICE
DEPARTMENT OF PERSONNEL – COUNTY OF LOS ANGELES
MEDICAL EXAMINATION DATA – PART II**

IDENTIFYING INFORMATION

TEMPERATURE	PULSE	RESPIRATION	ETHNIC CODE (Circle One) 1 - White 3 - Black 5 - Mexican 6 - American 7 - Asian 9 - Other
BLOOD PRESSURE			
_____ / _____			

CLINICAL EVALUATION		N O R M A L	A B N O R M A L	DETAILED DESCRIPTION OF ABNORMAL FINDINGS
Circle Appropriate number for each abnormal finding. Check normal box if evaluated. If not evaluated, write NE in "Normal" Box.				
SKIN, HAIR, NAILS, LYMPHATICS			01	
IDENTIFYING BODY MARKS, SCARS			02	
HEAD, FACE, NECK AND SCALP			03	
EARS – GENERAL			04	
EYES – GENERAL			05	
OPHTHALMOSCOPIC EXAMINATION			06	
NOSE			07	
MOUTH, TEETH AND THROAT			08	
BREASTS			09	
CHEST			10	
LUNGS			11	
HEART			12	
VASCULAR SYSTEM			13	
ABDOMEN AND VISCERA			14	
ENDOCRIN SYSTEM			15	
G-U SYSTEM			16	
UPPER EXTREMITIES			17	
LOWER EXTREMETIES			18	
FEET			19	
BACK			20	
SPINE			21	
NEUROLOGICAL EXAMINATION			22	1
PSYCHOLOGICAL IMPRESSION			23	2
RECTAL EXAMINATION			24	3
PROCTOSCOPIC EXAMINATION			25	4
				5
				6
Signature	M.D.			7
	R.N. Nurse Pract.			8
Signature				9
	M.D.			10
Signature of Reviewer				

SUMMARY OF POSITIVE FINDINGS
(Must be completed by Examiner)

**HARBOR-UCLA MEDICAL CENTER
HEPATITIS B VACCINATION INFORMATION FORM**

All LA County Employees and certain Harbor-UCLA associated organizations are offered the Hepatitis B Vaccine. Hepatitis B is an inflammation of the liver caused by the Hepatitis B virus. Hepatitis B Virus can be contracted through contact with infected blood and body fluids. Thus potential exposure could be from an infected sexual partner, intravenous drug use, a small risk through blood transfusions, and through needle sticks and body fluid exposures mostly experience by doctors and nurses due to their type of work. I may receive the Hepatitis B vaccine to protect me from acute type B Hepatitis and its complications. Harbor/UCLA Medical Center has offered me the opportunity to receive HBV vaccine free of charge.

Recombivax HB is a non-infectious viral vaccine containing hepatitis B surface antigen produced in yeast cells. The vaccine against hepatitis B prepared from recombinant yeast cultures is free of association with human blood products. Because of the way this vaccine is made, there is no risk of contracting other bloodborne diseases, such as HIV.

Adverse reactions to the vaccine seen in the trials were limited to mild effects. Soreness of the injection site of the arm and/or low grade fever. Severe reactions are exceedingly rare but the risk cannot be excluded. I understand that in accepting vaccination for the benefits it offers, I must also accept personal and financial responsibility for any health problems that may be attributed to the HBV vaccine.

I know that to have maximum protection from the vaccine, I must receive three doses. The second dose to be given in one month, and the third six months after the first. By accepting the first dose, however, I do not give up my right to refuse the later doses for any reason. Such refusal shall in no way jeopardize my rights to the benefits to which I would otherwise be entitled as an employee of Harbor/UCLA Medical Center. These include any sick benefits of workers' compensation if I subsequently develop type B hepatitis as a consequence of occupational exposure.

I further understand that any immunization procedure is associated with occasional failure in protection, even if all doses of vaccine have been received at the recommended times. I also know that booster doses of HBV vaccine may be necessary to maintain an effective level of protection.

My signature below indicates acknowledgement of the information given above.

Employee Signature

date

**HARBOR-UCLA MEDICAL CENTER
HEPATITIS B VACCINATION CONSENT/DECLINATION FORM**

PART I

Last Name (print) First Name Date

Employee Number Phone Extension Work Location

1. I wish to receive the vaccine. YES NO

- If YES, I authorize Employee Health to administer the Hepatitis B Vaccine, a series of 3 injections and if needed the 4th booster.

Employee Signature Date

Witness Date

- If NO, and you have not already received the Hepatitis B vaccine, you must complete and return Part II below.

2. I have already received the vaccine. YES NO

If YES, doses received to date: 1 2 3

Part II

Hepatitis B Vaccine Declination

I do not wish to receive the vaccine at this time. I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine at no charge to myself. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B (a serious disease). If in the future, I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Name (print) Signature Date
Page 2

**LOS ANGELES COUNTY
DEPARTMENT OF HEALTH SERVICES
NOTICE OF PRIVACY PRACTICES**

Effective Date: April 14, 2003

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

WHO WILL FOLLOW THIS NOTICE

This Notice describes the practices of Los Angeles County Department of Health Services (LACDHS), and that of:

- All employees, staff and other LACDHS personnel
- Any member of a volunteer group we allow to help you while you are in the facility.

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the facility. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care furnished to you at this facility. As required and when appropriate, we will ensure that the minimum necessary information is released in the course of our duties.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations regarding the use and disclosure of medical information.

We are required by law to:

- Keep your medical information, also known as “protected health information” or “PHI,” private;
- Give you this Notice of our legal duties and privacy practices with respect to your PHI; and
- Follow the terms of the Notice that is currently in effect. LACDHS agrees to abide by the terms of the Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION

The following categories describe different ways that we use and disclose protected health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment

We create a record of the treatment and services you receive at our facilities. We may use your PHI to provide you with medical treatment or services. We may disclose your PHI to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you at the facility. For example, a doctor treating you for diabetes may need to know if you have problems with your heart because some medications affect your blood pressure. We may share your PHI in order to coordinate the different things you need, such as prescriptions, blood pressure checks and lab tests, and to determine a correct diagnosis. We also may disclose your PHI to people outside the facility who may be involved in your treatment, such as your case manager, or other persons for coordination and management of your health care.

For Payment

We may use and disclose your PHI in order to get paid for the treatment and services we have provided you. For example, we may need to give your health plan information about a medication, visit, or treatment session you received at the facility so your health plan will pay us. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also disclose your PHI to other health care providers for their payment purposes.

For Health Care Operations

We may use and disclose your PHI to carry out activities that are necessary to run our operations and to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many facility patients to decide what additional services the facility should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other facility personnel for review and learning purposes. We may also share your PHI with other health care providers for certain health care operations such as quality assurance and compliance, and for health care operations of LACDHS.

Appointment Reminders

We may use and disclose your PHI to contact you as a reminder that you have an appointment for treatment or medical care at the facility.

Treatment Alternatives and Health-Related Products and Services

We may use and disclose your PHI to recommend possible treatment options or alternatives that may be of interest to you. Additionally, we may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you (for example, Medi-Cal eligibility or Social Security benefits).

Fundraising Activities

We may use your PHI to contact you in an effort to raise money for the hospital and its operations. We may disclose medical information to a foundation related to the hospital so that the foundation may contact you in raising money for the hospital. We only would release contact information, such as your name, address and telephone number and the dates you received treatment or services at the hospital. If you do not want the hospital to contact you for fundraising efforts, you must notify the facility in writing and state that you do not want this information released.

Hospital Directory

We may include your PHI to a limited extent in the hospital directory while you are an in-patient at the hospital, provided that you agree to this, or we give you an opportunity to object or restrict the inclusion of your PHI in the hospital directory. This information may include your name, location in the hospital, your general condition (e.g., fair, stable, critical, etc.) and your religious affiliation. Unless there is a specific written request from you asking us not to do this, this directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation (e.g., Catholic, Protestant, Buddhist, Jewish, etc.) 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 information is released so your family, friends and clergy can visit you in the hospital and generally know how you are doing.

Individuals Involved in Your Care or Payment for Your Care

We may disclose your PHI to a friend or family member who is involved in your medical care or payment related to your health care, provided that you agree to this disclosure, or we give you an opportunity to object to this disclosure. However, under appropriate circumstances, including emergencies, we will use our professional judgment to decide whether this disclosure is in your best interests or to infer that you do not object.

Disaster Relief Purposes

We may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. We will give you the opportunity to agree to this disclosure or object to this disclosure, unless we decide that we need to disclose your PHI in order to respond to the emergency circumstances.

Research

We may disclose your PHI without your authorization for certain purposes. For Example, in limited circumstances, we may disclose your information to researchers preparing a research protocol or if our Institutional Review Board committee (which is charged with ensuring the protection of human subjects in research) determines that an authorization is not necessary. We also may provide limited health information about you (not including your name, address, or other direct identifiers) for research, public health or health care operations, but only if the recipient of such information signs an agreement to protect the information and not use it to identify you.

As Required By Law

We will disclose your PHI when required to do so by federal, state or local law.

To Avert a Serious Threat to Health and Safety

We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would be to someone able to help prevent the threat.

Workers' Compensation

We may release your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose medical information about you for public health activities, such as those aimed at preventing or controlling disease, preventing injury or disability, and reporting the abuse or neglect of children, elders and dependent adults.

Organ and Tissue Donation

We may release your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Health Oversight Activities

We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a

subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the PHI requested.

Law Enforcement

We may disclose PHI to government law enforcement agencies in the following circumstances:

- In response to a court order, warrant, subpoena, summons or similar process issued by a court.
- To identify or locate a suspect, fugitive, material witness or missing person.
- If you are a victim of a crime, under certain limited circumstances, and we are unable to obtain your agreement.
- About a death that may be the result of criminal conduct.
- About criminal conduct at the facility.
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.
- If we believe you, while hospitalized, have committed or have been a victim of a crime. Such disclosures must be limited to information that constitutes evidence of criminal conduct that occurred on the premises, and must not include any information that relates to your health or the circumstances of your treatment.
- To report your discharge, if you were involuntarily detained after a peace officer initiated a 72-hour hold for evaluation and requested notification.
- In certain circumstances, if you have been admitted to a facility, and have disappeared or have been transferred.

Coroners, Medical Examiners and Funeral Directors

We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the facility to funeral directors as necessary to carry out their duties.

Specialized Government Functions

We may disclose your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

We may disclose your PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates

If you are an inmate or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Other Uses of Your Medical Information

Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by the authorization, except that, we are unable to take back any disclosures we have already made when the authorization was in effect, and we are required to retain our records of the care that we provided to you. For example, if we have already used or disclosed your PHI for a research study pursuant to your authorization, we are not required to destroy PHI that was collected, nor take back PHI that was disclosed in order to preserve the integrity of the research.

RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI in our records:

Right to Inspect and Copy

With certain exceptions, you have the right to inspect and copy your PHI from our records. Usually, this includes treatment and billing records. To inspect and copy PHI that may be used to make decisions about you, you must complete and submit your request in writing on the *Request for Access to Health Information* form. If you request a copy of your PHI, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances. If you are denied the right to inspect and copy your PHI in our records, you may request that the denial be reviewed. With the exception of a few circumstances that are not subject to review, another licensed health care professional within LACDHS, who was not involved in the denial, will review the decision. We will comply with the outcome of the review.

Right to Request Amendment

If you feel that your PHI in our records is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the PHI. To request an amendment, you must complete and submit a *Request to Amend Protected Health Information*. 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 PHI that:

- Was not created by us, unless you can provide us with a reasonable basis to believe that the person or entity that created the PHI is no longer available to make the amendment;
- Is not part of the PHI kept by or for the facility;
- Is not part of the PHI which you would be permitted to inspect and copy; or
- Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a *Request for Review of Denial of Access* form, with a description not to exceed 250

words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want this form to be made part of your medical record, we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures

You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of your PHI other than our own uses for treatment, payment and health care operations, (as those functions are described above) or pursuant to your authorization and with other exceptions pursuant to the law.

To request this list or accounting of disclosures, you must complete and submit a *Request for an Accounting of Disclosures* form. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request that we follow additional, special restrictions when using or disclosing your PHI for treatment, payment or health care operations. You also have the right to request that we follow additional, special restrictions when using or disclosing your PHI to someone who is involved in your care or the payment for your health care, like a family member or friend. For example, you could ask that we not use or disclose that you are receiving services at this facility. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must complete and submit a *Request for Additional Restrictions on Use or Disclosure of Protected Health Information* form. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about your appointments or other matters related to your treatment in a specific way or at a specific location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must complete and submit a *Request to Receive Confidential Communications by Alternative Means or at Alternative Locations* form. Your request must specify how or where you wish to be contacted. We will not ask you the reason for your request. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice at the DHS website: www.dhs.co.la.ca.us.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the facility. The Notice will contain on the first page, in the top right-hand corner, the effective date. If we change our Notice, you may obtain a copy of the revised Notice by requesting one from our staff or by visiting the www.dhs.co.la.ca.us website.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Los Angeles County or the Federal Government. All complaints must be submitted in writing. **You will not be penalized or retaliated against for filing a complaint.** To file a complaint, or if you have comments or questions regarding our privacy practices, contact facility administration or any of the following offices:

**Los Angeles County Department of Health Services (LACDHS)
Privacy Officer
313 N. Figueroa Street, Room 708
Los Angeles, CA 90012
(800) 711-5366**

**Los Angeles County Chief Information Office
Chief Information Privacy Officer
500 West Temple Street, Suite 493
Los Angeles, CA 90012
(213) 974-2164
Email: CIPO@cio.co.la.ca.us**

To file a complaint with the Federal Government, contact:

**Office of Civil Rights (Room 515 F)
US Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Attention: RobinSue Frohboese, Ph.D., J.D. Acting Director
(202) 619-0805 or (202) 619-0553**

