Community Health Center CHC

107 Commercial Street
Mashpee, MA 02649
508-477-7090
508-539-6063 (fax)
CHCofCapeCod.org

Welcome to your new medical home! We are excited to offer you high quality, integrated health care services including medical, dental, behavioral health, optometry, pharmacy, and so much more!

Please follow these easy admission steps to become a patient:

1. **Apply for health insurance if you don't already have it**. We require that you apply for insurance **before** we can schedule you for an appointment. If you need help applying, assistance is available at our Mashpee office Monday - Friday, 9 a.m. - 4 p.m. For general questions about applying for insurance, please contact our Outreach Coordinator, at 508-477-7090, ext. 1155
2. **Complete and return the following registration forms** via drop off (at any CHC location), fax or mail:
    - New Patient Registration
    - New Patient Intake
    - Social Needs Screen
    - Forms to Request and Share Information
3. **Read our New Patient Information Guide and Notice of Privacy Practices** by visiting our website, www.chcofcapecod.org, request a copy from any of our offices.
4. **Sign up for our patient portal, MyChart**. MyChart will allow you to communicate with your care team, view your medical records, and request referrals and medication refills. You will receive a text message or email inviting you to join the OCHIN MyChart portal when we set up your chart. Please visit our website or call us for more information.

Once we have completed your registration, usually within 5 business days of receiving your forms, you will receive a text message or recorded call inviting you to schedule your first appointment. Please respond to the text or call us at 508-477-7090 and press 0 for an operator during business hours to schedule the appointment, or if you need additional assistance. If we do not hear back from you within 15 days, we will mark your chart inactive and may not be able to hold a spot for you with a primary care provider.

Sincerely,

Karen Gardner
Chief Executive Officer

Community Health Center ~ New Patient Registration Form –- please complete in black ink Nov-22

Preferred primary location: □*Mashpee* □*Falmouth* □*Bourne* □*Sandwich* □*Centerville*

I am registering for the following Services: □Primary Care ☐Walk-in only ☐Dental ☐Gynecology ☐ Substance Use Disorder Treatment

☐Vision ☐Behavioral Health* (*You must be a Primary Care patient at CHC to access Behavioral Health services)

If you receive Primary Care elsewhere, please provide name & phone for your PCP:_____

Patient Last Name:	Patient First Name:	SSN:	Date of Birth:	Sex (legal): □M □F

Title:	Middle Name:	Preferred Name/Nickname:	Maiden Name:	Other names or aliases:

Mailing Address:	City:	State:	Zip Code:
Home Address (if different from Mailing):	City:	State:	Zip Code:

PHONE & EMAIL Please provide number where you prefer to receive calls or text messages & where we may leave a message for you.

Phone (_____) _____ Patient E-mail: _____

This is my: □Mobile □Home □Work □Other _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Domestic Partner ☐Separated ☐Widowed

Ethnicity – check one □Mexican/Mexican American/Chicano □Puerto Rican □Cuban □Puerto Rican □Other Hispanic, Latino/a, or Spanish Origin □Not Hispanic, Latino/a, or Spanish Origin □Choose not to disclose

Race - Check as many as apply: □White □Asian Indian □Chinese □Filipino □Japanese □ Korean □Vietnamese □Other Asian □Native Hawaiian □Samoan □Other Pacific Islander □Guamanian or Chamorro □Black/African American □American Indian/Alaska Native □Choose not to disclose

Sex assigned at birth: ☐M ☐F

Sexual Orientation: □Straight or Heterosexual □Bisexual □Something else □Don't' know □Choose not to disclose □Gay □Lesbian □Pansexual □Queer

Gender Identity: □Male □Female □Transgender Female/Male to Female □Transgender Male/Female to Male □Other □Choose not to disclose □Nonbinary/genderqueer □Questioning

Pronoun: □she/her/hers □he/him/his □they/them/theirs □ze/hir/hirs □ey/em/eirs □xe/xem/xyrs □ve/vir/vis □other □my name □decline to answer

Is patient a US VETERAN? ☐Yes ☐No

Country of Birth - ☐US ☐Brazil ☐Cape Verde ☐Jamaica ☐_____

EMERGENCY CONTACT Name:_____ Phone Number: (_____)_____

Relationship to patient:

PARENT/GUARDIANSHIP: please complete for Patients under age 18 and patients with Legal Guardian

Does the patient have a Legal Guardian, other than a parent? ☐Yes ☐No **If Yes, Please attach Guardianship paperwork.**

Name of Parent/Guardian:_____ Relationship to Patient _____

Parent/Guardian Phone Number: (_____)_____ Parent/Guardian SSN:_____

PATIENT EMPLOYER: PATIENT OCCUPATION:

PATIENT EMPLOYMENT STATUS: Are you a seasonal or migrant worker? □ Yes □ No

□Full-time □Not employed □Part-time □Retired □Active Military □Self-employed □Student FT □Student PT

Is Patient visually impaired? □Yes □ No Is Patient hearing impaired? □Yes □ No

Primary Language if not English:_____ Interpreter needed? □Yes □ No

How did you hear about us?: ☐ Friend ☐Employer ☐ Social Service Agency ☐Hospital ☐Doctor ☐Newspaper

☐TV ☐Radio ☐Online search ☐Online ad ☐CHC postcard ☐CHC brochure ☐Other _____

For grant reporting purposes only. No personally identifiable information is ever reported. This section helps us to receive funding

How many people are in your household: _____ What is the annual income for your household:_____

MEDICAL INS ID# _____
Primary

MEDICAL INS ID# _____
Secondary if applicable

Insurance (check all that apply): □ No Insurance □Applied □Mass Health (C3) □HSN □Medicare □Harvard Pilgrim □BC/BS □ Tufts □Tricare □United Health □Veterans □Other:_____

Are you a member of Indian Health Services? ☐Yes ☐No

Subscriber info (if insurance subscriber is not the patient):

Name_____ Date of Birth_____

Dental Insurance _____ ID #_____

Dental Insurance _____ ID #_____

Vision Insurance_____ ID #_____

Vision Insurance_____ ID #_____

SIGNATURE (Patient or Parent/Guardian): Date:

Date received by CHC:	*Office/PCP assigned:*	*CHC Staff initials accepting packet/date:*

Community Health Center CHC

NEW PATIENT INTAKE FORM MAR 2022

Name *(Last, First, M.I.):*	Date of Birth:	Date Completed:

MEDICATIONS

Please list any medications that you are currently taking and reason for that medication. *Place a checkmark next to any that needs refills.*

Refill needed? Medication	Reason for medication	Refill needed? Medication	Reason for medication
☐		☐	
☐		☐	
☐		☐	
☐		☐	

Please list any allergies to medications or any other allergies:

Please check here if you do not have any medication allergies ☐ Please check here if you are not on any medications ☐

RECENT HISTORY

Name of Previous Physician:	Phone:

Have you been seen in the ER in the last 10 days?	☐ Yes	☐ No
Have you been an inpatient at a hospital, rehab, detox or nursing facility in the last 21 days?	☐ Yes	☐ No
Do you have any URGENT medical needs that require you to be seen immediately?	☐ Yes	☐ No
Please explain briefly:		
Who is your health care proxy? (Please provide us with a copy of the document):		
Do you have an advance directive document? (Please provide us with a copy)	☐ Yes	☐ No
Have you seen a specialist recently? (i.e. Neurologist, Orthopedist, Cardiologist, Behavioral Health, etc.)	☐ Yes	☐ No
Do you have thoughts of hurting yourself or others?	☐ Yes	☐ No
Would you like to see a counselor?	☐ Yes	☐ No
For pediatric patients: is the patient in need of immunizations or a time-sensitive physical?	☐ Yes	☐ No
Do you need an antibiotic prior to dental treatment? (eg joint replacement, artificial heart valve)	☐ Yes	☐ No
Have you ever had any complications following dental treatment?	☐ Yes	☐ No
If yes, please explain:		

HEALTH ISSUES

☐ AIDS/HIV	☐ Excessive Bleeding	☐ Rheumatic Fever	☐ Pregnancy, Due Date:
☐ Anxiety	☐ Fainting	☐ Radiation Treatment	☐ Rheumatic Fever
☐ Ability to sleep	☐ Growths	☐ Liver Disease	☐ Sexually Transmitted Infection
☐ Arthritis	☐ Hay Fever	☐ Pacemaker	☐ Sinus Problems
☐ Asthma/Emphysema	☐ Heart Disease/ Heart Attack	☐ Ulcers	☐ Stroke
☐ Artificial Joints	☐ Heart Murmur	☐ Glaucoma	☐ Thyroid disease
☐ Blood disease	☐ Hepatitis	☐ Throat	☐ Tuberculosis
☐ Cancer	☐ High Blood Pressure	☐ Rheumatism	☐ Tumors
☐ Depression	☐ Jaundice	☐ Lungs	☐ Vision problems
☐ Diabetes	☐ Kidney Disease	☐ Stomach Problems	☐ Other
☐ Dizziness	☐ Respiratory Problems	☐ Head injuries	
☐ Epilepsy	☐ Alcohol / Drug Dependency (past or present)	☐ Mental Disorders	

Signature:_____ Date:_____

Community Health Center CHC

Name		Date of Birth		Today's Date	

Social Needs Screen

Directions: Please fill out all the questions, whether you are answering for yourself or for a child, so that your care team has the most complete information to care for you.

1. What is your housing situation today?

- ❑ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
- ❑ I have housing today, but I am worried about losing housing in the future
- ❑ I have housing
- ❑ I am not sure

2. Think about the place you live. Do you have problems with any of the following?
(Check all that apply)

- ❑ Pests such as bugs, ants, or mice
- ❑ Mold
- ❑ Lead paint or pipes
- ❑ Inadequate heat
- ❑ Oven or stove not working
- ❑ No or not working smoke detectors
- ❑ Water leaks
- ❑ None of the above
- ❑ I am not sure

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- ❑ Often true
- ❑ Sometimes true
- ❑ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have enough money to get more.

- ❑ Often true
- ❑ Sometimes true
- ❑ Never true

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?
(Check all that apply)

- ❑ Yes, it has kept me from medical appointments or getting medications
- ❑ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
- ❑ No
- ❑ I am not sure

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

- ❑ Yes
- ❑ No
- ❑ Already shut off
- ❑ I am not sure

7. Think about the place you live. Do you have access to internet/wifi when you need it?

- ❑ Yes
- ❑ No…If no, why not? (Check all that apply)
  - o I cannot afford it
  - o Internet/wi-fi access is not available where I live
  - o My internet/wi-fi access is not consistent or reliable
  - o I do not want or need it
- ❑ I am not sure

8. Would you like help with any of the needs that you have identified?

- ❑ Yes
- ❑ No

Dear Patient, Please complete separate Authorization for Release of Protected Health Information forms for each provider who has medical records for you from the past 7 years if you are over 25 years old and for the past 10 years if you are 24 or younger. Additional forms can be downloaded from chcofcapecod.org or picked up any of our office locations. Please initial all of the items in the RELEASE OF SENSITIVE INFORMATION section to ensure we get your complete medical records.

Community Health Center CHC

REQUEST MY RECORDS: AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

107 Commercial Street, Mashpee MA 02649
Phone (508) 477-7090 Fax (508) 539-6063

Patient Last Name:	Patient First Name:	Middle Initial:	Date of Birth:

Patient Mailing Address:	Patient Phone:

I authorize Community Health Center to request my medical records from

Name/Facility:	Phone:	Fax:

Street:	City:	State:	Zip

Medical records include information pertaining to my identity, prognosis, diagnosis, or treatment
Information to be released:

☒ My Entire Record

RELEASE OF SENSITIVE INFORMATION – Please initial to ensure your complete records are released

Under Massachusetts state law we cannot release certain information unless you give us special permission to release it.
By initialing each item I agree to its release:

___HIV/AIDS information (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST WITH SPECIFIC DATES)
___Details of Domestic Violence Victims' Counseling
___Details of Sexual Assault Counseling
___Details of Mental Health Diagnosis and/or treatment provided by a Mental Health Provider (I understand that my permission may not be required to release my mental health records for payment purposes)
___Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon written request

This authorization is valid for release of Protected Health Information for 180 days from date below OR (please indicate):
❑ a one-time disclosure ❑ upon termination from services ❑until revoked ❑other_____

I understand that by law, I do not need to consent to the release of/request for this information to receive care or payment for care or to be eligible for enrollment or any benefits. However, I choose to do so willingly and voluntarily for the purpose specified above. My signature acknowledges my receipt and understanding of CHC of Cape Cod Notice of Privacy Practices. I understand that I have the right to request a copy of my records as provided by CFR 164.524. I understand that I have a right to receive a copy of this form after I have signed it. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Manager.

I understand that I may revoke this authorization in writing. Upon revocation, information will not be released except to the extent that we have already taken action in response to this authorization.
I also release Community Health Center of Cape Cod from all legal responsibilities and liabilities that may arise from the release of the information.

Signature of Patient/personal representative:_____ Date:_____

If signed by anyone other than patient, print name and select relationship and/or reason and legal authority to do so

Name:_____
Patient is: ❑minor ❑incompetent ❑deceased ❑Parent/legal guardian ❑Legal authority (proof attached)

Signature of witness:_____ Date:_____

Dear Patient (Parent or Guardian), If there is an individual (eg family member, advocate, etc) you would like to grant CHC permission to discuss your care, make appointments, share your medical information with, and in the case of minor patients accompany your child to visits, please complete and sign this Authorization to Release Protected Health Information form with their information. Thank you!

Community Health Center CHC

SHARE MY RECORD: AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

107 Commercial Street, Mashpee MA 02649
Phone (508) 477-7090 Fax (508) 539-6063

Patient Last Name:	Patient First Name:	Middle Initial:	Date of Birth:

Patient Mailing Address:	Patient Phone:

I authorize Community Health Center to SHARE my medical records with

Name/Facility:	Phone:	Fax:

Street:	City:	State:	Zip

Medical records include information pertaining to my identity, prognosis, diagnosis, or treatment
Information to be released:

☒ My Entire Record

RELEASE OF SENSITIVE INFORMATION – Please initial to ensure your complete records are released

Under Massachusetts state law we cannot release certain information unless you give us special permission to release it.
By initialing each item I agree to its release:

___HIV/AIDS information (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST WITH SPECIFIC DATES)
___Details of Domestic Violence Victims' Counseling
___Details of Sexual Assault Counseling
___Details of Mental Health Diagnosis and/or treatment provided by a Mental Health Provider (I understand that my permission may not be required to release my mental health records for payment purposes)
___Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon written request

This authorization is valid for release of Protected Health Information for 180 days from date below OR (please indicate):
❑ a one-time disclosure ❑ upon termination from services ❑until revoked ❑other_____

I understand that by law, I do not need to consent to the release of/request for this information to receive care or payment for care or to be eligible for enrollment or any benefits. However, I choose to do so willingly and voluntarily for the purpose specified above. My signature acknowledges my receipt and understanding of CHC of Cape Cod Notice of Privacy Practices. I understand that I have the right to request a copy of my records as provided by CFR 164.524. I understand that I have a right to receive a copy of this form after I have signed it. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Manager.

I understand that I may revoke this authorization in writing. Upon revocation, information will not be released except to the extent that we have already taken action in response to this authorization.
I also release Community Health Center of Cape Cod from all legal responsibilities and liabilities that may arise from the release of the information.

Signature of Patient/personal representative:_____ Date:_____

If signed by anyone other than patient, print name and select relationship and/or reason and legal authority to do so

Name:_____
Patient is: ❑minor ❑incompetent ❑deceased ❑Parent/legal guardian ❑Legal authority (proof attached)

Signature of witness:_____ Date:_____

Notice of Privacy Practices for Patients

Please read and keep

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.

At Community Health Center (CHC) we are committed to safeguarding your privacy and ensuring that your personal information is handled with care and respect.

Additionally, we are required by law to maintain the privacy of your protected health information (PHI) and to provide you with notice of our legal duties and privacy practices with respect to your PHI. This Notice of Privacy Practices describes how we may collect, use and disclose your PHI, and your rights concerning your PHI.

Understanding Your Personal Health Information

PHI is information which:

- Identifies you (or can reasonably be used to identify you) and
- Relates to your physical or mental health condition, the provision of health care to you or the payment for that care.

Every time you visit CHC and are seen by a provider or receive other services a record is made of that visit. This medical record usually contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. The medical records for CHC are stored on paper or on computer.

Medical information may also be used and stored by other departments in CHC in the regular course of business. This information may be stored on paper or on computer. CHC also may receive information about your health from providers or facilities not part of CHC and store such information with your CHC medical record. All of this information is considered confidential and is subject to the protections mentioned in this privacy notice.

Your medical information is used for many purposes, including:

- Planning your care and treatment
- Communication among the health care providers who take care of you
- Proving that services billed to your insurance company were actually provided
- Helping to improve the quality of care provided to Health Center patients
- Assisting public health officials in improving the health of the public
- Providing a legal record of the care and treatment you received

Understanding what is in your PHI and how it is used helps you to:

- Ensure its accuracy and completeness
- Understand who, what, where, why, and how others may access your PHI
- Make informed decisions about authorizing disclosures to others
- Better understand the PHI rights detailed below

Your Individual rights

Your PHI is the property of CHC, but you or your legally recognized representative have the right to:

- Obtain a paper copy of this notice upon request
- Request a restriction on some uses and disclosures of the information contained in your medical record
- Obtain a copy of your medical record

- Request to make an amendment to your medical record
- Receive an accounting or list of disclosures of your medical record
- Request that we provide your health information to you in an alternative way or at an alternative location in a confidential manner
- Revoke your authorization to use or disclose medical information except in cases where information has already been used or disclosed upon your previous authorization

CHC is required to:

- Protect the privacy of your medical information
- Provide you with a notice about our legal duties and privacy practices in regard to the information we collect and keep about you
- Follow the terms of this notice
- Let you know if we cannot agree to a requested restriction on the use or disclosure of your medical information
- Let you know if we cannot agree to a requested amendment to your medical information
- Agree to reasonable requests to communicate medical information by alternative means or at alternative locations than we usually use

CHC has the right to change the practices we follow. Should this happen we will let you know by having revised privacy notices posted and available at CHC.

We will not use or disclose your medical information except as described in this notice.

Examples of uses of medical information for treatment, payment, and health care operations
We will use your medical information for treatment
For example: Each time you visit CHC a record is made of the symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. All of the health care providers at CHC who take care of you are allowed to look at this information every time you return to the clinic for a visit or service.

We will use your medical information for payment
For example: When a bill is sent to an insurance company charging them for a visit it usually includes your name, other identifying information such as your date of birth and address, and information about the reason for your visit, the treatment given, and any supplies used.

We will use your medical information for regular health care operations
For example: CHC contracts with financial companies to audit the billing and payment processes. As part of auditing the billing and payment processes the contractor may need to review medical information related to the bill they are auditing. In all situations where a contractor or business associate receives access to protected health information, CHC requires the contracted person or company to protect the privacy of the medical information received. CHC may contact you to provide appointment reminders or information about health related benefits or services that may be of interest to you.

Health Information Exchange
CHC participates in Health Information Exchanges in order to share information securely and electronically with other providers and facilities involved in your care, including:

Massachusetts Immunization System (MIIS) – patients may opt out from MIIS sharing their immunization history with other practices

Massachusetts HIway – CHC uses Direct Messaging to communicate with some providers about your care. If the receiving provider's Direct Message address is a Mass HIway address the patient information

will be transmitted securely through the Mass HIway. No data is stored on the Mass HIway. Direct Messaging is a secure, electronic means of communication that replaces methods like mail or fax.

Epic Care Everywhere – Providers involved in a patient's care who use the Epic Electronic Health Record system can share information securely. Information shared via Care Everywhere may include sensitive health information such as drug and alcohol abuse treatment or referral, mental health diagnosis and treatment, genetic testing, sexually transmitted illness diagnosis and treatment, and HIV/AIDS diagnosis and treatment. Patients may opt out from their information being shared via Epic Care Everywhere.

Use or disclosure of medical information without authorization
CHC is allowed by federal or state law or regulation to disclose medical information without authorization from the patient or legally recognized representative in the following circumstances:

- In medical emergency situations medical information about a patient may be disclosed to another medical professional or facility taking care of the patient, and as necessary, to a patient's family member
- When a patient is being referred to another provider or facility for medical care, information that the receiving provider or facility needs to take care of the patient may be disclosed to the receiving facility
- Insurance companies paying for services delivered to a patient are able to receive information about the services they are paying for
- Licensing or accrediting agencies receive information about patients in order for them to decide if CHC is providing good medical care
- CHC is required by state law to report suspected cases of abuse, neglect and domestic violence to state agencies; in such cases patient medical information may be disclosed to the state agency
- When a person dies who has been a patient at CHC and the medical examiner is investigating the death CHC is required by state law to provide patient medical information to the medical examiner if he or she requests it
- When a person has filed a claim with the Industrial Accident Board CHC may disclose patient medical information to the board if they request it
- When information has been requested by a valid court order, CHC is required by law to disclose the information requested
- CHC is required to report certain illnesses and conditions to state agencies overseeing the public health
- If a health care provider thinks that a patient may harm another person or if a patient has made a threat to harm another person the health care provider may contact law enforcement authorities and disclose information about the patient and the threat(s)
- CHC is required by law to provide information to the Food and Drug Administration (FDA) if requested to do so in regard to the quality, safety or effectiveness of products or activities regulated by the FDA
- Employers are entitled by law to receive information related to medical surveillance of the workplace or to evaluate whether or not a person has a work related illness or injury
- The law requires that CHC provide information to health oversight agencies if requested to do so
- Certain requests from law enforcement agencies may be responded to
- When there has been a disaster, CHC is allowed to share information as necessary to public or private agencies providing disaster relief

Business Associates
We provide some services through contracts with business associates. Examples include but are not limited to, paper shredding copy service to make copies of medical records, and the like. When we use these services, we may disclose your health information to the business associate so that they can

perform the function(s) we have contracted with them to do. To protect your health information however, we require our business associates to appropriately safeguard your information.

CHC is a member of organized health care arrangements including participants in Massachusetts League of Community Health Centers (MLCHC) and OCHIN. A current list of OCHIN participants is available at **www.ochin.org**. As business associates of CHC, MLCHC and OCHIN are engaged in quality assessment and improvement activities on behalf of CHC and other network participants to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems.

OCHIN also supplies information technology and related services to CHC and other OCHIN participants. OCHIN helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by CHC with other OCHIN participants or a health information exchange only when necessary for medical treatment or for the health care operations purposes of the organized health care arrangement. Health care operations can include among other things geocoding your residence location to improve clinical benefits you receive.

The personal health information may include past, present and future medical information as well as information outlined in the Privacy Rules. The information to the extent disclosed will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.

Use or disclosure with authorization
Disclosures of information from your medical record other than those included in this privacy notice will be made upon your written authorization or the written authorization of the person legally able to act on your behalf.

Collection of Demographic Information
As part of our efforts to provide comprehensive and inclusive care, we collect demographic information, including race, ethnicity, preferred language, gender identity, sexual orientation, and disability status. This information helps us better understand and meet the diverse needs of our community. Access to demographic data is restricted to authorized personnel only. Physical safeguards, such as secure filing systems and restricted access areas, are in place to prevent unauthorized access. Our electronic health record (EHR) systems are equipped with robust security measures to protect against unauthorized access, including encryption, user authentication, and audit trails. Demographic information is used to tailor our services and programs to better meet your individual needs and preferences. Demographic information will never be used to discriminate against or stigmatize any individual or group. We will not disclose your demographic information to any third parties without your explicit consent, except as required by law. Your privacy is important to us, and we are committed to maintaining the confidentiality and security of your information.

For more information or to report a problem
If you have any questions or concerns about this notice or want more information you may contact the Compliance Officer at 508-477-7090. Thank you for entrusting us with your care

If you think your privacy rights have been violated you can file a complaint with the Compliance Office by mail at Community Health Center, 107 Commercial Street, Mashpee, MA 02649, or by calling the Compliance Officer at 508-477-4090. These calls will be confidential and will not adversely affect your relationship with CHC.

Community Health Center CHC

Pharmacy Services

Scan to Learn More

Three On-Site CHC Pharmacies

- **One-Stop Convenience**: Get your prescriptions filled right after your visit, with minimal wait times
- **Integrated, Personalized Care**: Our outstanding pharmacy team works closely with your provider
- **Easy Prescription Management**: Seamless transfers and use of mobileRx app for refills and text alerts

Mashpee	107 Commercial Street	(508) 477-0004
Falmouth	200 Jones Road, Homeport	(508) 681-7399
Bourne	123 Waterhouse Road	(508) 539-6090

Fill your prescriptions at a CHC pharmacy today - we accept most insurances!

CHCofCapeCod.org | @CHCofCapeCod