University of California
San Francisco
UCSF
Fresno Medical Education Program

NEUROPSYCHOLOGICAL HISTORY QUESTIONNAIRE

UCSF Fresno Neuropsychological Assessment Clinic

Patient Name: _____ Date: _____

Who is completing this history form? _____

If not patient, indicate name and relationship of the individual completing history questionnaire:

_____

Patient DOB: _____ Patient Age: _____ Patient Sex: _____

Is the patient (circle one): Right Handed Left Handed Ambidextrous

If left-handed or ambidextrous, is anyone else in the patient's family left-handed or ambidextrous?

_____

Preferred phone number for best contact person: _____ Preferred email: _____

Who referred the patient for neuropsychological testing? _____

For what concerns?

_____

_____

_____

Date of onset of primary cognitive concerns: _____

Have these symptoms:

- ☐ Gotten worse over time (progressive)
- ☐ Stayed about the same (stable)
- ☐ Fluctuating (up and down)
- ☐ Unsure

Has the patient had any of the following tests? Check all that apply **and please bring to your appointment if available**:

- ☐ CT scan of the brain
- ☐ MRI of the brain
- ☐ EEG
- ☐ Lab workup for cognitive issues (e.g. TSH, folate, B vitamins)
- ☐ Other:
  If yes, please describe: _____
- ☐ Previous cognitive or personality testing:
  If yes, please describe: _____

Are you currently involved in any legal action or ongoing litigation? If yes, please describe:

_____

_____

COGNITIVE SYMPTOMS

Please check all the cognitive symptoms that apply to the patient:

- ☐ Difficulty recalling recent events or details
- ☐ Difficulty recalling remote events or details
- ☐ Trouble remembering to complete future events, tasks, or appointments
- ☐ Difficulty recalling names
- ☐ Searching for words
- ☐ Slurred speech
- ☐ Slowed speech
- ☐ Slowed thinking
- ☐ Getting lost while driving
- ☐ Getting lost in familiar places
- ☐ Confusion/Disorientation
- ☐ Trouble focusing or paying attention
- ☐ Poor organization
- ☐ Trouble judging distances, dropping items, or bumping into things
- ☐ Disorganized thinking
- ☐ Trouble solving complex problems
- ☐ Losing items

Did any or all cognitive symptoms come on gradually or suddenly? When did the patient or patient's family/friends first become aware of them?

_____

What caused these symptoms/makes them worse?

_____

NEUROBEHAVIORAL SYMPTOMS

Please check all the emotional/behavioral symptoms that apply to the patient:

- ☐ Changes in personality. Describe: _____
- ☐ More anxious than usual
- ☐ More withdrawn or depressed than usual
- ☐ Quick fluctuations in mood (for example, quick to laugh or cry)
- ☐ New obsessive thoughts
- ☐ Compulsive repetition of behaviors
- ☐ New onset of hoarding behaviors
- ☐ Seeing things that aren't there (visual hallucinations). Describe:_____
- ☐ Hearing things that aren't there (auditory hallucinations). Describe:_____
- ☐ Increasingly paranoid or suspicious of others
- ☐ Unusually elated or jubilant
- ☐ Unusual or risky behaviors such as spending too much money, risky business ventures, unusual sexual behaviors
- ☐ Having thoughts most people would consider strange or bizarre
- ☐ History of physical, sexual, or emotional trauma
- ☐ Stopping many of your interests or hobbies

PHYSICAL SYMPTOMS AND MEDICAL HISTORY

Please check all the physical symptoms that apply to the patient:

- ☐ Dizziness
- ☐ Headache
- ☐ Nausea/vomiting
- ☐ Changes in walking. Describe: _____
- ☐ Losing bladder
- ☐ Losing bowels
- ☐ Urinary hesitation
- ☐ Constipation
- ☐ Tremors or shaking
- ☐ Rigid limbs
- ☐ Changes in posture. Describe: _____
- ☐ Vision changes
- ☐ Decreased smell
- ☐ Decreased hearing
- ☐ Falls
- ☐ Seeing spots or dizziness upon standing
- ☐ Changes in sexual functions or libido
- ☐ Heart problems (e.g. chest pain, palpitations, changes in rhythm)
- ☐ Sleeping too much
- ☐ Sleeping too little
- ☐ Unusual movements (e.g. sleep walking, talking) during sleep
- ☐ Trouble moving eyes smoothly vertically or horizontally
- ☐ Seizures
- ☐ Stroke
- ☐ Head injuries (concussion or traumatic brain injury)
- ☐ Infections of the brain
- ☐ Urinary tract infection (UTI)
- ☐ Low thyroid
- ☐ Low B vitamins (B1, B12)
- ☐ Hydrocephalus (water on the brain, enlarged ventricles)
- ☐ Diabetes
- ☐ Period of time where the brain was deprived of oxygen
- ☐ Autoimmune conditions (lupus, rheumatoid arthritis, MS, thyroid, etc.) Describe: _____
- ☐ Exposed to toxic or harmful chemicals Describe: _____

Please list all the patient's medical conditions with approximate date of onset/diagnosis:

_____

_____

_____

Any major surgeries? If so, please list them with the approximate date:

_____

_____

MEDICATIONS

Please list all the patient's *current* medications and dosages below:

Medication	Dosage

Please list all family members and any diagnosed medical or psychiatric illnesses below:

Family member	Medical History

PSYCHIATRIC HISTORY

Has the patient ever been diagnosed with any of the following psychiatric or neurodevelopmental conditions?

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar disorder (I or II, also known as manic depressive)
- ☐ Schizophrenia
- ☐ Psychosis
- ☐ ADHD / ADD
- ☐ Learning disorder (e.g. dyslexia, writing or math disorder)
- ☐ Developmental delay
- ☐ Autism spectrum disorder
- ☐ Personality disorder
- ☐ Disordered eating behaviors. Describe: _____
- ☐ Trauma history
- ☐ Somatoform disorder
- ☐ Dissociative disorder
- ☐ Sleep disorder. Describe: _____
- ☐ Substance use
- ☐ Obsessive compulsive behaviors
- ☐ Delirium

Has the patient ever had any mental health interventions (for example seeing a psychiatrist or psychologist)?

_____

_____

Has the patient ever been psychiatrically hospitalized? If so, please describe:

_____

_____

_____

PSYCHOSOCIAL AND DEVELOPMENTAL HISTORY

Place of birth: _____ If not US, when did the patient come to the United States? _____

Native Language: _____

Does the patient speak any other languages fluently? _____

Any issues with the patient's mother's pregnancy or delivery?

If yes, describe: _____

How many siblings does the patient have? _____

Where do they fall in the birth order? _____

Describe any developmental delays in talking, walking, or toilet training, if applicable:

_____

_____

Did the patient have any childhood difficulties including diagnosed learning disorder, behavioral disorder such as ADHD, or medical illness? If yes, describe:

_____

_____

Did the patient ever have to repeat a grade or complete remedial classes? If yes, describe:

_____

_____

Did the patient ever receive additional tutoring or an individualized education plan (IEP)? If yes, describe:_____

_____

What was the patient's grade average? (Circle one) A's B's C's D's F's

High school GPA: _____ SAT or ACT scores: _____

What is the patient's highest level of education and where did the patient attend school(s)?

_____

_____

If the patient attended college, what was your major? _____

Employment status? (circle one): Employed full-time Employed part-time Unemployed Disabled Retired

If employed, what is the patient's occupation and job title?:

_____

_____

If retired, what was the patient's last job and why did the patient retire?:

_____

_____

Is the patient currently in a relationship? Y or N

Is the patient married or in a long-term committed relationship? Y or N

Is the patient widowed? Y or N If yes, for how many years? _____

If married, how many years? _____

Number of previous marriages? _____

Who does the patient live with? _____

Does the patient have children? Y or N If yes, how many? _____

Who does the patient count on for sources of social support in their life?

_____

_____

How does the patient spend their free time?

_____

_____

All done, thank you! Please be sure to bring any relevant medical records, neuroimaging findings, etc. to your appointment.

UCSF FRESNO ALZHEIMER & MEMORY CENTER

Date: _____

PATIENT: _____ Married/Div/Sep/Wid/ ____ Sex:____ DOB: _____

Address: _____ City/State/Zip:_____

Phone: _____ Primary Language: _____ Military: Y/N _____

CONTACT: _____ Relationship to patient: _____

Address: _____ City/State/Zip Code:_____

Phone: _____ (home) _____ (work) _____ (cell)

PRIMARY CAREGIVER: _____ Relationship to patient: _____

Secondary Caregiver: _____ Relationship to patient: _____

Who primarily referred the patient to the AMC? _____

What are your reasons for coming to the AMC? ☐Diagnosis/recommendations ☐Second Opinion

☐Other: _____

Has a formal diagnosis been made at any time?

If yes, what was the diagnosis? _____ By Whom: _____ Year: _____

Describe the changes/current symptoms you see in patient:

_____ Date of onset: _____

_____

Is patient combative?☐ **Incontinent?**☐ **Anticipated level of cooperation?** _____

Special Needs: ☐Cane ☐Wheelchair ☐Walker ☐Hearing aids ☐Other: _____

Still driving?☐ **Holds valid driver's license?**☐

Patient's primary care physician: _____

Is primary care physician also the referring party? _____ Physician's specialty: _____

Physician's Address: _____ Phone: _____

_____ Fax: _____

Imaging: CT/MRI Head: ◯Yes ◯No *If yes*, where: _____

Health care coverage:

- ⊙ Medicare - part A (hospital insurance)
- ⊙ Medicare - part B (medical ins.-doctor visits)
- ⊙ Medi-Cal (Medicaid)
- ⊙ SANTE: _____ (HMO)
- ⊙ Tri-Care
- ⊙ _____: Other health Insurance

PHARMACY:
Name:_____
Phone: _____
Address:_____
_____

Revised: 8.2016

University of California
San Francisco

UCSF

Fresno Medical Education Program

UCSF Alzheimer & Memory Center (AMC)

Personal Representative

In the space below, if so desired, please indicate any personal representative (an individual who is permitted to receive or know information concerning your healthcare for the period of 12 months from the date you sign this form). If your designated personal representative changes during the time, this form is in effect, you must contact the AMC in writing to request the changes.

Name(s) of personal representative:

1. _____ Relationship to you: _____

   Phone number: _____

A personal representative as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) is any family member, friend, or individual designated by the patient to whom the patient's health information may disclosed.

Patients Name: _____ DOB: _____

_____ _____

Patients Signature Date

University of California
San Francisco

UCSF

Fresno Medical Education Program

Alzheimer & Memory Center
Patient Information

(To be filled out by the patient or patient representative)

Patient Name: _____ (Last) _____ (First) _____ (Middle)

Address: _____ (Street) _____ (Apt.#) _____ (City) _____ (State) * _____ (Zip Code)

Telephone Number: Home ( ) _____ Cell/Work: ( ) _____

Date of Birth: _____ Social Security #: _____ Please circle: Male ○ Female ○

1. Primary Insurance Name: _____

   Address: _____ City: _____ State: _____ Zip Code: _____

   Name of Policy Holder: _____

   Policy Holder SS#: _____ Policy Holder DOB: _____

   Relationship to Patient: _____

   Insurance ID: _____ Group #: _____ Effective Date: _____

2. Secondary Insurance Name: _____

   Address: _____ City: _____ State: _____ Zip Code: _____

   Name of Policy Holder: _____

   Policy Holder SS#: _____ Policy Holder DOB: _____

   Relationship to Patient: _____

   Insurance ID: _____ Group #: _____ Effective Date: _____

Guarantor Name: _____ (Last) _____ (First) _____ (Middle) _____ (Relationship to Patient)

Address: _____

Telephone Number: Home ( ) _____ Cell/Work: ( ) _____

Please sign below to acknowledge the following statement:

I request that payment of authorized Medicare or medical benefits to which I am entitled be made either to me or on my behalf to the Alzheimer & Memory Center (AMC) for any services furnished me by the AMC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. If I am unable to sign this form, my representative may sign on my behalf. In Medi-care assigned cases, the AMC agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

********I understand that I am financially responsible for all charges whether or not paid by insurance********

Signature: _____ (Patient) by _____ (Representative signature) Date: _____

_____ Representative's relationship to patient

_____ Representative's address (street) (city) (state) (zip)

University of California
San Francisco

UCSF

Fresno Medical Education Program

Patient Name: _____ DOB: _____

- **No Show/ Appointment Cancellation Policy:** We would like to provide you with outstanding service. This, however, requires your cooperation. If you are unable to keep a scheduled appointment, please call us at least 24 hours in advance so we can give this appointment to another patient.
- If you fail to keep an appointment or do not call at least 24 hours in advance, you are considered a "NO SHOW". We charge a $35.00 fee for "NO SHOWS" which is not covered by any insurance plans.

I have read, understand and agree to the above NO SHOW/appointment cancellation policy and fully agree to each of the statements and agreements herein, by signing below as my free and voluntary act.

_____ _____

Patient Signature or POA Representative Date

University of California
San Francisco

UCSF

School of Medicine
Fresno Medical Education Program

University of California, San Francisco, Fresno
Photography & Audio/Video Recording Consent Form

UCSF Fresno Center for Medical Education and Research
155 North Fresno Street, Fresno, CA 93701

Authorization and Consent to Photograph, Publish and Release Information

I give permission and authorize The Regents of the University of California, University of California, San Francisco, including the UCSF Fresno Medical Education Program and affiliated programs, and its personnel, their officers, agents, employees and students, to take photographs of me, to interview me, to publish, print and broadcast my voice and image to be used for educational purposes in resident/physician training, for patient and resident education and for the promotion of UCSF Fresno and various UCSF Fresno affiliated programs through the use of brochures, publications, posters, printed materials, displays, signs, TV/Video broadcast and internet/web.

I understand that I have the right to request that photography/video session end at any time during the session.

I understand that I have the right to withdraw my consent at any time, until a reasonable time before the photograph or videotape is used. Please contact the UCSF Fresno Educational Media Services department at ems@fresno.ucsf.edu to withdraw your consent. A written request for withdrawal of consent can be mailed to UCSF Fresno.

The photographs or videos will be stored by the UCSF Fresno Educational Media Services Department and will be destroyed when no longer needed. Photographs and videos include any electronic or audio recording media. The term "photograph," as used in this agreement shall mean motion picture or still photography in any format, as well as videotape, videodisc, web and any other means of recording and reproducing visual images and sound.

I release the UC Regents and the UCSF Fresno Medical Education Program, its personnel and its affiliated programs from any and all liability which may or could arise from the taking, recording, publication, distribution or other use of photography and audio/video media.

IN ALL CASES
I waive any right to compensation. I hold the UC Regents and their designees harmless from and against any claim for injury and or compensation resulting from the activities authorized by this agreement.

Date: _____

Print Name: _____ Signature: _____

If subject/patient is under the age of 18, parent or legal guardian authorization is required below

Print Name: _____ Signature: _____

ADDRESS: _____

City/State/Zip _____ Telephone: (_____) _____

Witness (if unable to sign):

Print Name: _____ Signature: _____

University of California
San Francisco
UCSF
Fresno Medical Education Program

Alzheimer & Memory Center

AUTHORIZATION TO RELEASE/EXCHANGE PATIENT RECORDS

(A copy or facsimile of this form is as valid as the original)

TO:_____
(Doctor or Institution)

NAME OF PATIENT:_____

SSN:_____ DOB:_____

NOTICE: UCSF and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. **YOUR RIGHTS:** This authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) create health information to provide to a third party.

Authorization includes the release of **all** records with documentation of treatment and/or follow-up care pertaining to mental health and other information as specified below:

- ☐ Brief summary of medical history including medications
- ☐ Reports of EKG, CXR, EEG, and lab work done in the last year
- ☐ Neuropsychological Assessment
- ☐ Neurological Assessment
- ☐ Brief summary of psychiatric history including medications
- ☐ MRI or CT Scan (Please send films and report of BRAIN MRI/CT scan only)

EXPIRATION OF AUTHORIZATION: Unless otherwise revoked, **this Authorization will expire 5 Years** after the date of my signing this form.

This Authorization may be revoked at any time. The revocation must be in writing, signed by me or my representative, and delivered to: UCSF Fresno Alzheimer & Memory Center (AMC), 2335 E Kashian Ln, #301 Fresno, CA 93701 The revocation will take effect when UCSF Fresno AMC receives it, except to the extent UCSF AMC or others have already relied on it.

I hereby authorize the UCSF Fresno Alzheimer & Memory Center to exchange information with any agency, professional or person that is deemed necessary. **I am entitled to receive a copy of this Authorization.**

_____
Print Name

_____
Signature (Patient, or individual with assigned Power of Attorney or Conservatorship)

_____
Date

_____
Witness (if patient is unable to sign) or interpreter

Revised: 8.2016

HEALTH INFORMATION

Please list Health Care Providers (Medical Doctors, Psychiatrists, Psychologists, Therapists, Hospitals, and Facilities) utilized over the past 5 years.

1. Name:_____ Specialty: _____

   Address:_____City_____State_____Zip_____

   Phone: _____

   Reason for Care_____

2. Name:_____ Specialty: _____

   Address:_____City_____State_____Zip_____

   Phone: _____

   Reason for Care_____

3. Name:_____ Specialty: _____

   Address:_____City_____State_____Zip_____

   Phone: _____

   Reason for Care_____

4. Name:_____ Specialty: _____

   Address:_____City_____State_____Zip_____

   Phone: _____

   Reason for Care_____

5. Name:_____ Specialty: _____

   Address:_____City_____State_____Zip_____

   Phone: _____

   Reason for Care_____

6. Name:_____ Specialty: _____

   Address:_____City_____State_____Zip_____

   Phone: _____

   Reason for Care_____

University of California
San Francisco

UCSF

Fresno Medical Education Program

SUMMARY OF UCSF FRESNO ALZHEIMER & MEMORY CENTER NOTICE OF PRIVACY PRACTICES

Alzheimer & Memory Center
2335 E Kashian Ln, #301
Fresno, CA 93701
Tel: 559-227-4810
Fax: 559-227-4167

Loren I. Alving, M.D.
Director
Neurologist

Alex C. Sherriffs, M.D., ABFM
Co-Director
Family Practice

Dzung Trinh, M.D., FACP
Geriatrics

Beverly Chang, M.D.
Psychiatrist

Toni Onkka, LCSW
Social Worker

Andres Sviercovich, MSW
Social Worker

Benicia Goka, M.D.
Neuroscientist

Anna Salazar
Administrative Assistant
Patient Relations

Email:
alz@fresno.ucsf.edu

Website:
www.fresno.ucsf.edu/alzheimer

UCSF Fresno Alzheimer & Memory Center (AMC) has always had privacy and patient confidentiality standards in place to ensure appropriate access or disclosure of protected health information. A new federal law called the Health Insurance Portability and Accountability Act (HIPAA) provides additional safeguards for ensuring that your health information is adequately protected. HIPAA also requires UCSF Fresno AMC to provide you with a Notice of Privacy Practices (Notice), which explains how your health information may be used and disclosed and also explains your rights related to your health information.

The attached Notice explains how UCSF Fresno AMC may use and disclose your protected health information to carry out treatment, payment for services and health care operations. Other reasons to use and disclose your protected health information as permitted or required by law are also referred to in the Notice. The Notice also explains your rights to review and control your **protected health information** and explains the responsibility UCSF Fresno AMC has to protect your information.

_____ _____

Signature of Patient (or individual with assigned Power of Attorney or Conservatorship) Date

Serving the Central Valley Community Since 1989

For Your Records

Effective Date: February 1, 2018

NOTICE OF PRIVACY PRACTICE

UNIVERSITY OF CALIFORNIA SAN FRANCISCO UCSF
Fresno—Alzheimer & Memory Center

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

UCSF Fresno—Alzheimer & Memory Center
UCSF Fresno—Alzheimer & Memory Center is one of the health care components of the University of California. The University of California health care components consist of the UC medical centers, the UC medical groups, clinics and physician offices, the UC schools of medicine and other UC health professional schools, departments engaged in clinical care, the student health service areas on some campuses, employee health units on some campuses, and the administrative and operational units that are part of the health care components of the University of California.

Our Pledge Regarding Your Health Information
UCSF is committed to protecting medical, mental health and personal information about you ("Health Information"). We are required by law to maintain the privacy of your Health Information; provide you information about our legal duties and privacy practices; and inform you of your rights and the ways in which we may use Health Information and disclose it to other entities and persons.

How We May Use and Disclose Health Information About You
The following sections describe different ways that we may use and disclose your Health Information. Some information; such as certain drug and alcohol information, HIV information, genetic information and mental health information; is entitled to special restrictions related to its use and disclosure. Not every use or disclosure will be listed. All of the ways we are permitted to use and disclose information, however, will fall within one of the following categories. Other uses and disclosures not described in this Notice will be made only if we have your written authorization.

For Treatment. We may use Health Information about you to provide you with medical and mental health treatment or services. We may disclose Health Information about you to doctors, nurses, technicians, students, or other UCSF personnel who are involved in taking care of you at UCSF. For example, a doctor treating you for a broken leg may need to know if

you have diabetes because diabetes may slow the healing process. A doctor treating you for a mental condition may need to know what medications you are currently taking, because the medications may affect what other medications may be prescribed to you. We may also share Health Information about you with other non-UCSF providers. The disclosure of your Health Information to non-UCSF providers may be done electronically through a health information exchange that allows providers involved in your care to access some of your UCSF records to coordinate services for you.

For Payment. We may use and disclose Health Information about you so that the treatment and services you receive at UCSF or from other entities, such as an ambulance company, may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give information to your health plan about surgery or therapy you received at UCSF so your health plan will pay us or reimburse you for the surgery or therapy. We may also tell your health plan about a proposed treatment to determine whether your plan will pay for the treatment.

For Health Care Operations. We may use and disclose Health Information about you for our business operations. For example, your Health Information may be used to review the quality and safety of our services, or for business planning, management and administrative services. We may contact you about alternative treatment options for you or about other benefits or services we provide. We may also use and disclose your health information to an outside company that performs services for us such as accreditation, legal, computer or auditing services. These outside companies are called "business associates" and are required by law to keep your Health Information confidential. We may also disclose information to doctors, nurses, technicians, medical and other students, and other UCSF personnel for performance improvement and educational purposes.

Appointment Reminders. We may contact you to remind you that you have an appointment at UCSF.

Fundraising Activities. We may contact you, using the contact information you have provided to us, to provide information about UCSF sponsored activities, including fundraising programs and events. We may use contact information, such as your name, address and phone number, date of birth, physician name, the outcome of your care, department where you received services and the dates you received treatment or services at UCSF. You may opt-out of receiving fundraising information for UCSF by contacting UCSF at **HIPAAOptOut@ucsf.edu, or 1-888-804-4722, or Records Manager, UCSF, Box 0248, San Francisco, CA 94143-0248.**

Hospital Directory. If you are hospitalized, we may include certain limited information about you in the hospital directory. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing. This information may include your name,

location in the hospital, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to members of the clergy, such as ministers or rabbis, even if they don't ask for you by name. You have the opportunity to limit the release of directory information by telling UCSF Admissions Department at the time of your hospitalization.

Our disclosure of this information about you if you are hospitalized in a psychiatric hospital will be more limited.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information to anyone involved in your medical care, e.g., a friend, family member, personal representative, or any individual you identify. We may also give information to someone who helps pay for your care. We may also tell your family or friends about your general condition and that you are in the hospital.

Disaster Relief Efforts. We may disclose Health Information about you to an entity assisting in a disaster relief effort so that others can be notified about your condition, status and location.

Research. The University of California is a research institution. We may disclose Health Information about you for research purposes, subject to the confidentiality provisions of state and federal law. All research projects involving patients or the information about living patients conducted by the University of California must be approved through a special review process to protect patient safety, welfare and confidentiality.

In addition to disclosing Health Information for research, researchers may contact you, using the contact information you have provided to us, regarding your interest in participating in certain research studies. Researchers may only contact you if they have been given approval to do so by the special review process. You will only become a part of one of these research projects if you agree to do so and sign a specific permission form called an Authorization. When approved through a special review process, other studies may be performed using your Health Information without requiring your authorization. These studies will not affect your treatment or welfare, and your Health Information will continue to be protected.

As Required By Law. We will disclose Health Information about you when required to do so by federal or state law. This includes releases to the U.S. Department of Health and Human Services, which oversees HIPAA regulations.

To Prevent a Serious Threat to Health or Safety. We may use and disclose Health Information about you when necessary to prevent or lessen a serious and imminent threat to your health

and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.

Organ and Tissue Donation. If you are an organ donor, we may release your Health Information to organizations that obtain, bank or transplant organs, eyes or tissue, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are or were a member of the armed forces, we may release Health Information about you to military command authorities as authorized or required by law.

Workers' Compensation. We may use or disclose Health Information about you for Workers' Compensation or similar programs as authorized or required by law. These programs provide benefits for work-related injuries or illness.

Public Health Disclosures. We may disclose Health Information about you for public health activities such as:

- preventing or controlling disease (such as cancer and tuberculosis), injury or disability;
- reporting vital events such as births and deaths;
- reporting child abuse or neglect;
- reporting adverse events or surveillance related to food, medications or defects or problems with products;
- notifying persons of recalls, repairs or replacements of products they may be using;
- notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition;

Abuse and Neglect Reporting. We may disclose your Health Information to a government authority that is permitted by law to receive reports of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose Health Information to governmental, licensing, auditing, and accrediting agencies as authorized or required by law.

Lawsuits and Other Legal Proceedings. We may disclose Health Information to courts, attorneys and court employees in the course of conservatorship, writs and certain other judicial or administrative proceedings. We may also disclose Health Information about you in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, or other lawful process.

Law Enforcement. If asked to do so by law enforcement, and as authorized or required by law, we may release Health Information:

- To identify or locate a suspect, fugitive, material witness, certain escapees, or missing person;
- About a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death suspected to be the result of criminal conduct;
- About criminal conduct at UCSF; and
- In case of a medical emergency, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Inmates. If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release Health Information about you to the correctional institution as authorized or required by law.

Coroners, Medical Examiners and Funeral Directors. We may disclose medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine cause of death. We may also disclose medical information about patients of UCSF to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. As required by law, we may disclose Health Information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities.

Protective Services for the President and Others. As required by law, we may disclose Health Information about you to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons or foreign heads of state.

Psychotherapy Notes. *Psychotherapy notes* means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.

Psychotherapy notes have additional protections under federal law and most uses or disclosures of psychotherapy require your written authorization.

Marketing or Sale of Health Information. Uses and disclosures of your Health Information for marketing purposes or any sale of your Health Information are strictly limited and require your written authorization.

Other Uses and Disclosures of Health Information Other uses and disclosures of Health Information not covered by this Notice will be made only with your written authorization. If

you authorize us to use or disclose your Health Information, you may revoke that authorization, in writing, at any time. However, the revocation will not be effective for information that we have already used and disclosed in reliance on the authorization.

Your Rights Regarding Your Health Information
Your Health Information is the property of UCSF. You have the following rights regarding the Health Information we maintain about you:

Right to Inspect and Copy. With certain exceptions, you have the right to inspect and/or receive a copy of your Health Information. If we have the information in electronic format then you have the right to get your Health Information in electronic format if it is possible for us to do so. If not, we will work with you to agree on a way for you to get the information electronically or as a paper copy.

You may request that a copy of your Health Information be released to a third party that you designate.

To inspect and/or to receive a copy of your Health Information, you must submit your request in writing to **UCSF Fresno Alzheimer & Memory Center, 2335 E Kashian Ln, #301 Fresno, CA 93701 .** If you request a copy of the information, there is a fee for these services.

We may deny your request to inspect and/or to receive a copy in certain limited circumstances. If you are denied access to Health Information, in most cases, you may have the denial reviewed. Another licensed health care professional chosen by UCSF will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Request an Amendment or Addendum. If you feel that Health Information we have about you is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record). You have the right to request an amendment or addendum for as long as the information is kept by or for UCSF.

Amendment. To request an amendment, your request must be made in writing and submitted to Patient Relations, **UCSF Fresno Alzheimer & Memory Center, 2335 E Kashian Ln, #301 Fresno, CA 93701 phone 1-559-227-4810, fax 1-559-227-4167.** You must be specific about the information that you believe to be incorrect or incomplete and you must provide a reason that supports the request.

We may deny your request for an amendment if it is not in writing, we cannot determine from the request the information you are asking to be changed or corrected, or your request does

not include a reason to support the change or addition. In addition, we may deny your request if you ask us to amend information that:

- Was not created by UCSF;
- Is not part of the Health Information kept by or for UCSF;
- Is not part of the information which you would be permitted to inspect and copy; or
- UCSF believes to be accurate and complete.

Addendum. To submit an addendum, the addendum must be made in writing and submitted to Patient Relations, **UCSF Fresno Alzheimer & Memory Center, 2335 E Kashian Ln, #301 Fresno, CA 93701 , phone 1-559-227-4810, fax 1-559-227-4167**. An addendum must not be longer than 250 words per alleged incomplete or incorrect item in your record.

Right to an Accounting of Disclosures. You have the right to receive a list of certain disclosures we have made of your Health Information.

To request this accounting of disclosures, you must submit your request in writing to Patient Relations, **UCSF Fresno Alzheimer & Memory Center, 2335 E Kashian Ln, #301 Fresno, CA 93701 , phone 1-559-227-4810, fax 1-559-227-4167**. Your request must state a time period that may not be longer than the six previous years. You are entitled to one accounting within any 12- month period at no cost. If you request a second accounting within that 12-month period, there will be a charge for the cost of compiling the accounting. 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 a restriction or limitation on the Health Information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the Health Information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend.

To request a restriction, you must make your request in writing to Patient Relations, **UCSF Fresno Alzheimer & Memory Center, 2335 E Kashian Ln, #301 Fresno, CA 93701 , phone 1-559-227-4810, fax 1-559-227-4167**. 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, only to you and your spouse. We are not required to agree to your request except in the limited circumstance described below. If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide you emergency care.

We are required to agree to a request not to share your information with your health plan if the following conditions are met:

- We are not otherwise required by law to share the information
- The information would be shared with your insurance company for payment purposes
- You pay the entire amount due for the health care item or service out of your own pocket or someone else pays the entire amount for you

Right to Request Confidential Communications. You have the right to request that we communicate with you about your Health Information in a certain way or at a certain location. For example, you may ask that we contact you only at home or only by mail.

To request confidential medical communications, you must make your request in writing to Patient Relations, **UCSF Fresno Alzheimer & Memory Center, 2335 E Kashian Ln, #301 Fresno, CA 93701 , phone 1-559-227-4810, fax 1-559-227-4167**. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

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.

Copies of this Notice are available throughout UCSF, or you may obtain a copy at our website, http://www.fresno.ucsf.edu/alzheimer-memory-center/..

Right to be Notified of a Breach. You have the right to be notified if we or one of our Business Associates discovers a breach of unsecured Health Information about you.

Changes to UCSF Privacy Practice and This Notice

We reserve the right to change UCSF privacy practices and this Notice. We reserve the right to make the revised or changed Notice effective for Health 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 throughout UCSF. In addition, at any time you may request a copy of the current Notice in effect.

Questions or Complaints

If you have any questions about this Notice, please contact Patient Relations, **UCSF Fresno Alzheimer & Memory Center, 2335 E Kashian Ln, #301 Fresno, CA 93701 , phone 1-559-227-4810, fax 1-559-227-4167.** If you believe your privacy rights have been violated, you may file a complaint with UCSF or with the Secretary of the Department of Health and Human Services, Office for Civil Rights. To file a written complaint with UCSF, contact Patient Relations, **UCSF Fresno Alzheimer & Memory Center, 2335 E Kashian Ln, #301 Fresno, CA 93701 , phone 1-559-227-4810, fax 1-559-227-4167**. You will not be penalized for filing a complaint.