Ramin Altaha, MD
24 N. Church Street Suite 308 • Wailuku • Hawaii • 96793 P|808-242-1110 F|855-839-9759 W| www.mauicancerclinic.com

Office Use Only:	
☐ Complete	☐ Partial
☐ Scanned ID/CARDS	

Patient Information

Name:		
Social Security Number:	Birth Date:	
Sex: ☐ Male ☐ Female ☐ Other	Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced	
Physical Address:		
Mailing Address:	☐ Mark if same as physical address	
Home Phone:	Mobile:	Work:
May we leave a basic message at the numbers above?	☐ Yes	☐ No
Email Address:		
Preferred Pharmacy:		
May we access your pharmacy history?	☐ Yes	☐ No
Race: ☐ Alaskan Native ☐ Asian ☐ African American ☐ Native American ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Hispanic ☐ Other Race ☐ I do not want to disclose		
Ethnicity:	☐ Hispanic	☐ Not Hispanic ☐ Other
Preferred Language:		
Primary Care Physician:	Referring Physician:	
Do you authorize the release of your medical information to anyone other than your insurance carrier? ☐ Yes ☐ No If yes,		

Employer Information

Employer:	
Occupation:	

Emergency Contact Information

Name:	
Relationship:	Phone:

Insurance Information

Company Name:	Policy Number:
Subscriber:	DOB:

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New Patient History Form

		Date:
Name:	Date of Birth: ______/______/______	☐ Male ☐ Female ☐ Other
Occupation:		Retired: ☐ Yes ☐ No
Primary Care Physician:	Referring Physician:	
Additional Physicians/Specialists:		
Reason for This Visit:		
Living Will: ☐ Yes ☐ No	Power of Attorney: ☐ Yes ☐ No (If Applicable Name:)	

Medical History (Check the items which apply to you, currently, or in the past)

GENERAL:
☐ Weight Loss ___________
☐ Fever(s) ___________ºF
☐ Chills
☐ Night Sweats
☐Fatigue

EYES:
☐ Wears Glasses/Contacts
☐ Blurred Vision
☐ Double Vision

EARS, NOSE, THROAT:
☐ Hard of Hearing/Deaf
☐ Ringing in Ears
☐ Enlarged Lymph Nodes
☐ Chronic Sinus Problems
☐ Sore Throat
☐ Mouth pain/sores

CHANGES/DIFFICULTY IN
☐ Taste
☐ Smell
☐ Voice

CARDIOVASCULAR:
☐ Chest pain/ Angina
☐ Palpations/Murmur
☐ Irregular Heart Beat
☐ High Blood Pressure

RESPITORY:
☐ Chronic/Frequent Cough
☐ Bloody Sputum
☐ Shortness of Breath

GASTROINTESTINAL:
☐ Painful/Difficult Swallowing
☐Abdominal Pain
☐ Nausea
☐Vomiting
☐ Heart Burn
☐ Indigestion
☐ Lump or sensation in throat
☐ Food sticking
☐ Bloating
☐ Belching
☐ Diarrhea
☐ Constipation
☐ Rectal Bleeding
☐ Black or tarry stools
☐ Blood in stool
☐ Excessive rectal gas/flatus
☐ Poor appetite
☐ Jaundice

GENITOURINARY:
☐ Kidney Stones
☐ Pelvic Pain
☐ Incontinence
☐ Pain/Burning on Urination
☐ Blood in Urine
☐ Difficult Urination

MUSCULEOSKETAL:
☐ Joint Pain/Arthritis
☐ Muscle or joint weakness
☐ Back Pain
☐ Bone Pain
☐ Muscle aches

NEUROLOGICAL:
☐ Numbness
☐ Tingling Arms/Legs
☐ Light-Headed
☐ Dizziness
☐ Fainting spells
☐ Headache
☐ Tremors

SKIN:
☐ Rashes or Itching
☐ Changes in color or moles
☐ Varicose Veins
☐ Skin Cancer

PSYCHIATRIC:
☐ Anxiety/Agitation
☐ Depression
☐ Crying for no reason
☐ Insomnia
☐ Alcoholism
☐ Drug Problem (Now/Past)

HEMATOLOGIC:
☐ Easy Bruising
☐ Gum/Nose Bleeding
☐ Blood Transfusion (Past)

ALLERGY/IMMUNOLOGY:
☐ Chronic Infections
☐ Allergies

MEN:
☐ Prostate Problems

ENDOCRINE:
☐ Heat or Cold Intolerance
☐ Excessive Skin Dryness
☐ Excessive Thirst or Urination
☐ Weight Problem
☐ Hot Flashes

BREAST:
☐ Rashes/Itches
☐ Change in Skin Color
☐ Lump(s)
☐ Cancer
☐ Pain
☐ Discharge

GYNECOLOGY:
☐ Age at Start of Menses
____
☐ Last Menses Period
____
☐ Vaginal Discharge
☐ Menstrual Irregularity
☐ Abnormal Bleeding

OTHER:
☐ _________________
☐ _________________
☐ _________________
☐ _________________
☐ _________________

Past Surgical History: (List All / Location)	
	Date:
	Date:
	Date:
Drug Allergies: (List All Medication Allergies)	
	Reaction:
	Reaction:
	Reaction:
☐ Iodine ☐ Latex ☐ Shellfish ☐ Iodine ☐ CT Scan Dye/ IV Contrast ☐ Eggs ☐ Peanuts	
Medications: (List All or Provide List to Staff)	
	Dose:
	Dose:
	Dose:
	Dose:
	Dose:
	Dose:
	Dose:
Family History: (Indicate Family Member with Cancer of Blood Disease	**Relationship to Patient:**

Social History:
Tobacco Use: (Present/Past): ☐ Never Smoked ☐ Current Smoker ☐ Quit smoking When_______ Years Smoked________
How many packs/day:___________ ☐ Cigarettes ☐ Pipe Cigars ☐ Chewing Tobacco
Alcohol Use: (Present/Past): ☐ Non-drinker ☐ Drinker Alcohol of Choice:
Illicit Drug Use: (Present/Past): ☐ No ☐ Yes If yes, what type(s):

I certify that the information I have given here today is to the best of my abilities, and is as complete and accurate as possible. I will notify the physician/staff to any changes, additions, or deletions at subsequent visits.

Signature:	Date:

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Consent to and Conditions of Treatment & Payment Agreement

Consent to the Maui Cancer Clinic, Inc., Ramin Altaha, MD

1. I wish to receive medical care and treatment at the Maui Cancer Clinic, Inc., Ramin Altaha, MD. Accordingly, I authorize and give consent to any x-ray; imaging; examination; laboratory procedure; diagnostic procedures; or any other medical services rendered to me under the general and specific instructions of my attending physician as may be determined by his professional judgment.

I am aware that I should ask my physician any questions that I may have about my diagnosis; treatment; risks; complications; alternative forms of treatment; and or anticipated results of my treatment.

2. I recognize that the Maui Cancer Clinic, Inc., Ramin Altaha MD, participates with the medical professional schools. Therefore, I give my consent for nursing students to participate in my care under appropriate supervision. This participation will include reviewing my Protected Health Information.

General Nursing Duties

I understand that Maui Cancer Clinic, Ramin Altaha, MD, provides only general nursing care in accordance with standard practices of Maui Cancer Clinic, Ramin Altaha, MD. If I need or desire more nursing services, such as continuous or special nursing care, it is agreed that I or my legal representative, or my physician, will be responsible for making arrangements for those extra services.

Non-Discrimination

Maui Cancer Clinic, Inc., Ramin Altaha MD, treats patients without regard to race, color, religion, ancestry, creed, national origins, handicap, or sexual orientation.

Disclosure of Protected Health Information

I understand that Maui Cancer Clinic, Inc., Ramin Altaha MD, may disclose my protected health information for the purposes of treatment; payment; quality assurance; outcomes assessment; competence; or qualifications review of healthcare professionals, including but not limited to, accreditation; licensing; or credentialing activities; health plan claims or health record data analysis; provider clinical performance evaluations; utilization management; research; required audits, or other qualified healthcare operations. I understand further that my records contain entries or information relating to sexually transmitted diseases, including the Human Immunodeficiency Virus (HIV) or the Acquired Immune Deficiency Syndrome (AIDS), psychiatric impairment, drug and alcohol abuse, and other personal information.

Maui Cancer Clinic, Inc., Ramin Altaha MD, may disclose healthcare information to physician(s) or referring physician(s), or others in order to coordinate my current care, to arrange transfers of the provision of other continuing care following the treatment from Maui Cancer Clinic, Inc., Ramin Altaha MD.

Assignment of Insurance Benefits

In the event the undersigned is entitled to insurance benefits at any time whatsoever arising out of any policy of insurance as the patient or any other party liable to patient(s), said benefits are hereby assigned to Maui Cancer Clinic, Ramin Altaha, MD, for application to the patients bill, and it is agreed that Maui Cancer Clinic, Inc., Ramin Altaha MD, shall discharge the said insurance company of any and all obligation under that policy to the extent of such payment. The assignment of benefits will in no way obligate Maui Cancer Clinic, Inc., Ramin Altaha MD, to delay or relinquish its demand for direct payment from the patient or any portion of the outstanding balance.

Financial Agreement

The undersigned agrees, whether signing as an authorized representative or a patient, that in consideration of the services to be rendered to the patient, the patient is hereby individually obligated to pay the account of Maui Cancer Clinic, Ramin Altaha MD, or any portion that is not covered by one's insurance plan.

Missed appointment(s) or cancellation of appointments not received within 24 hours of your scheduled appointment will result in an assessed fee of $50.00 billed to your patient account. This amount will not be covered under any insurance policy (ies) and is due without hesitation to Maui Cancer Clinic upon notice.

The Use of My Name

I understand that it is sometimes necessary to visually post or say my name for healthcare and efficiency, allowing the healthcare team to locate me. I do hereby give my permission to have my name visually posted or said for these reasons.

Specific Designation of Authority/Limited POA

It is agreed and acknowledge by my signature in subsequence, that I allow Maui Cancer Clinic, and its agents to perform specific duties as a signatory regarding my healthcare. Specifically, Maui Cancer Clinic and its staff have full power and authority to sign documentation on my behalf, providing me with access to all healthcare considerations arising from my care within the clinic. This authority is effective upon my signature below, and is perpetual in duration, unless specifically revoked upon written notification. There is no encumbrances in this granted designation, and shall stand wholly in my stead.

The undersigned certifies that I/he/she understands the foregoing, and is the patient, or the patient's parent, next of kin, or authorized representative and is duly authorized to execute and accept its terms.

Patient Name:	Date of Birth:
Signature:	Date:

Signature of Witness:

If the patient is a minor or physically or mentally unable to sign, then his or her representative does hereby give the above consent on the patient's behalf.

Representative's Name:

Signature of Representative:	Date:

Relationship to the Patient:

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Authorization to Release Personal Health Information

To:	
Phone:	Fax:

Patient Name:	DOB:
Address:	SS#:

Please send (via fax) the following pertinent information:

☐ Progress Notes
☐ Lab Results
☐ Imaging Reports
☐ Pathology Reports
☐ All Other Applicable Documentation

You are hereby authorized to release the requested PHI contained in all of my medical records for the continuation of my medical care to Dr. Ramin Altaha, Maui Cancer Clinic, Inc.

Please Fax Records (if less than 20 pages) to: 855-839-9459.

If more than 20 pages, please call 808-242-1110 for further options or fax sections separately with this cover. If using E-Clinical Works (ECW EMR), you may submit electronically to Maui Cancer Clinic, Ramin Altaha, MD via P2P. Referring provider must confirm receipt with Maui Cancer Clinic. It is the referring provider's responsibility to be assured that patient notes are received.

Patient Please Complete Below:

Patient Name:	Date of Birth:
Signature:	Date:

Signature of Witness (if applicable or mark used):

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Consent to Release to the Public | Your Name, Location, and General Health Status

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the patient must be informed about how their "Protected Health Information" (PHI) will be used and given the opportunity to object to, or restrict the use or release of their information. **This consent form is for the release of the following information:**

Patient's Name

Patient's Location in the health-care provider's facility (unit and room number if in-patient)

Patient's General Health Status (e.g., critical, poor, fair, stable, or satisfactory)

This consent may be amended or revoked at any anytime, upon written notice from the person who has signed it below. I understand that this authorization is effective only during my course of treatment and my follow-up visits.

________________ **I AGREE** to have my name, location, and health status released to the public

________________ **I DO NOT AGREE** to have my name, location, and health status released to the public.

Otherwise, ALL inquiries about me will be answered with the following response or a variation

"I am sorry, but I have no information about that individual".

Patient Name:	Date of Birth:
Signature:	Date:
Signature of Witness:	

If the patient is a minor or physically or mentally unable to sign, then his or her representative does hereby give the above consent on the patient's behalf.

Representative's Name:	
Signature of Representative:	Date:
Relationship to the Patient:	

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Acknowledgement of Receipt of Notice of Privacy Practices

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used for treatment, payment, and normal health care operations. I understand the Notice of Privacy Practices containing a complete description of the uses and disclosure of my protected health care information. I understand that Maui Cancer Clinic, Ramin Altaha MD, may change this form at anytime and that I may contact the practice at the above address to request a copy of the current Notice of Privacy Practices.

Furthermore, I am aware that I may request in writing that this office restricts how my protected healthcare information is used. I understand that this office is not required to comply with my request, but if Maui Cancer Clinic, Ramin Altaha MD agrees it must abide by these conditions.

Patient Name:	Date of Birth:
Signature:	Date:
Signature of Witness:	

If the patient is a minor or physically or mentally unable to sign, then his or her representative does hereby give the above consent on the patient's behalf.

Representative's Name:	
Signature of Representative:	Date:
Relationship to the Patient:	

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NOTICE OF PRIVACY PRACTICES

Effective Date: **01/01/2015**

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.

About Us

In this Notice, we use terms like “we,” “us,” “our” or "Practice" to refer to Maui Cancer Clinic, Ramin Altaha MD, its physicians, employees, staff and other personnel. All of the sites and locations of Maui Cancer Clinic, Ramin Altaha MD follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes and for other purposes as described in this Notice.

Purpose of this Notice

This Notice describes how we may use and disclose your health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities

We are required by law to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information. We are also required to notify you of a breach of your unsecured health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information

The following categories describe examples of the way we use and disclose health information without your written authorization:

For Treatment:
We may use and disclose your health information to provide you with medical treatment or services. For example, your health information will be shared with your oncology doctor and other health care providers who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your primary care physician or another healthcare provider to be sure they have all the information necessary to diagnose and treat you.

For Payment:
We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information that

identifies you, your diagnosis, and treatment or supplies used in the course of treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

For Health Care Operations:
We may use and disclose your health information in order to support our business activities. These uses and disclosures are necessary to run the Practice and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities. We may also disclose your health information to third party "business associates" that perform various services on our behalf, such as transcription, billing and collection services. In these cases, we will enter into a written agreement with the business associate to ensure they protect the privacy of your health information.

Individuals Involved in Your Care or Payment for Your Care and Notification:
If you verbally agree to the use or disclosure and in certain other situations, we will make the following uses and Disclosures of your health information. We may disclose to your family, friends, and anyone else whom you identify who is involved in your medical care or who helps pay for your care, health information relevant to that person's involvement in your care or paying for your care. We may also make these disclosures after your death. We may use or disclose your information to notify or assist in notifying a family member, personal representative or any other person responsible for your care regarding your physical location within the Practice, general condition or death. We may also use or disclose your health information to disaster-relief organizations so that your family or other persons responsible for your care can be notified about your condition, status and location.

We are also allowed to the extent permitted by applicable law to use and disclose your Health information without your authorization for the following purposes:

As Required by Law:
We may use and disclose your health information when required to do so by federal, state or local law.

Judicial and Administrative Proceedings:
If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information 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 or to obtain an order protecting the information requested.

Health Oversight Activities:
We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement:
We may disclose your health information, within limitations, to law enforcement officials for several different purposes:

- To comply with a court order, warrant, subpoena, summons, or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime, if the victim agrees or we are unable to obtain the victim’s agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime not occurring on our premises, the nature of a crime, the location of a crime, and the identity, description and location of the individual who committed the crime, in an emergency situation.

Public Health Activities:
We may use and disclose your health information for public health activities, including the following:

- To prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- Activities related to the quality, safety or effectiveness of FDA-regulated products;
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition as authorized by law; and
- To notify an employer of findings concerning work-related illness or injury or general medical surveillance that the employer needs to comply with the law if you are provided notice of such disclosure.

Serious Threat to Health or Safety:
If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat or as necessary for law enforcement Authorities to identify or apprehend an individual.

Organ/Tissue Donation:
If you are an organ donor, we may use and disclose your health information to organizations that handle procurement, transplantation or banking of organs, eyes, or tissues.

Coroners, Medical Examiners, and Funeral Directors:
We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Workers' Compensation:
We may disclose your health information as authorized by and to the extent necessary to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Victims of Abuse, Neglect, or Domestic Violence:
We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Military and Veterans Activities:
If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities:
We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others:
We may disclose your health information to authorized federal officials so they may provide protective services for the President and others, including foreign heads of state.

Inmates:
If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing your health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research:
We may use and disclose your health information for certain research activities without your written authorization. For example, we might use some of your health information to decide if we have enough patients to conduct a cancer research study. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your health information without your authorization.

Other Uses and Disclosures of Your Health Information that Require Written Authorization:

Other uses and disclosures of your health information not covered by this Notice will be made only with your written authorization. Some examples include:

- Psychotherapy Notes: We usually do not maintain psychotherapy notes about you. If we do, we will only use and disclose them with your written authorization except in limited situations.

- Marketing: We may only use and disclose your health information for marketing purposes with your written authorization. This would include making treatment communications to you when we receive a financial benefit for doing so.

If you authorize us to use or disclose your health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by your revocation, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

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

Right to Request Restrictions:
You have the right to request restrictions on how we use and disclose your health information for treatment, payment or health care operations. **In most circumstances, 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 make your request in writing and submit it to Privacy Officer, 24 North Church Street, Suite 308, Wailuku, HI 96793. We are required to agree to a request that we restrict a disclosure made to a health plan for payment or health care operations purposes that is not otherwise required by law, if you, or someone other than the health plan on your behalf, paid for the service or item in question out-of-pocket in full.

Right to Request Confidential Communications:
You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to Privacy Officer, 24 North Church Street, Suite 308, Wailuku, HI 96793**.** We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

Right to Inspect and Copy:
You have the right to inspect and copy health information that may be used to make decisions about your care. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to Privacy Officer, 227 24 North Church Street, Suite 308 Street, Wailuku, HI 96793. You may request access to your medical information in a certain electronic form and format if readily producible or, if not readily producible, in a mutually agreeable electronic form and format. Further, you may request in writing that we transmit a copy of your health information to any person or entity you designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy. If you request a copy of your health information, we may charge a cost-based fee for the labor, supplies, and postage required to meet your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. 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 Amend:
If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to Privacy Officer, 227 24 North Church Street, Suite 308 Street, Wailuku, HI 96793. We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us that will become part of your medical record.

Right to an Accounting of Disclosures:
You have the right to request an accounting of disclosures we make of your health information. Please note that certain disclosures need not be included in the accounting we provide to you.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to Privacy Officer, 227 24 North Church Street, Suite 308 Street, Wailuku, HI 96793. Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to a Paper Copy of This Notice:
You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact Privacy Officer, 227 24 North Church Street, Suite 308 Street, Wailuku, HI 96793. You may also obtain a paper copy of this Notice at our website, www.mauicancerclinic.com.

Changes to this Notice

We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in our office and on our website. Each version of the Notice will have an effective date Listed on the first page. Updates to this Notice are also available at our website, www.mauicancerclinic.com

Complaints
If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to: Privacy Officer, 227 24 North Church Street, Suite 308 Street, Wailuku, HI 96793. You may also file a complaint with the Secretary of the Department of Health and Human Services. **You will not be retaliated against or penalized for filing a complaint.**

Questions
If you have questions about this Notice, please contact Privacy Officer, at 808-242-1110.