MARIPOSA COMMUNITY HEALTH CENTER

PATIENT RIGHTS

An administrator shall ensure that:

1. A patient is treated with dignity, respect, and consideration;
2. A patient as not subjected to:
   a. Abuse;
   b. Neglect;
   c. Exploitation;
   d. Coercion;
   e. Manipulation;
   f. Sexual abuse;
   g. Sexual assault;
   h. Except as allowed in R9-10-1012(B), restraint or seclusion;
   i. Retaliation for submitting a complaint to the Department or another entity; or
   j. Misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student; and
3. A patient or the patient's representative:
   a. Except in an emergency, either consents to or refuses treatment;
   b. May refuse or withdraw consent for treatment before treatment is initiated;
   c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic mediation or surgical procedure;
   d. Is informed of the following:
      i. The outpatient treatment center's policy on health care directives, and
      ii. The patient complaint process;

e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and

f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:

   i. Medical record, or

   ii. Financial records.

A patient has the following rights:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
6. To participate or have the patient's representative participate in the development of, or Decisions concerning, treatment;
7. To participate or refuse to participate in research or experimental treatment; and
8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

Welcome to Mariposa Community Health Center

Thank you for allowing us to care for you.

Name *First* *Last* *M.I.*	Today's Date

DOB	Preferred Language	Gender
	○English ○Español	Male Female

Street Address		
City	State	Zip Code

PO BOX *If applicable*		
City	State	Zip Code

PHONE NUMBERS ARE VERY IMPORTANT TO US!

Phone Number	Phone Number
( ) -	( ) -

INSURANCE INFORMATION

Insurance Name		Group Number
ID Number	Policy Holder	Insurance Phone Number

Insurance Address

No Insurance?

○Please contact me for more information about the *Sliding Fee Program* (Mariposa Plan)

This section is to ENROLL in our **PATIENT PORTAL**

Email: _____ ○I'm Registered

Preferred Pharmacy *(select up to two)*

○Mariposa Pharmacy ○Walmart Pharmacy ○Rio Rico Pharmacy

○Walgreens Pharmacy ○Food City Pharmacy ○Other _____

MARIPOSA Your COMMUNITY HEALTH CENTER

As a Community Health Center, we are required to request the following information from you. The data we receive is released in summary form, for collection purposes only. No Patient names are associated with any released data.

Today's date: _____

(Please print)
Patient Name: _____ Date of birth: _____

(If different)
Name of the Head of Household: _____ Date of birth: _____

Housing: Do any of the following apply to you?
- ☐ Living with friends
- ☐ Living in a shelter
- ☐ Living on the streets
- ☐ Living in Transitional Housing
- ☐ None

How many members live in your household?

_____

What is the approximate combined annual income of everyone living in your household?

_____

Are you a Veteran?
- ☐ Yes
- ☐ No

Check the box or boxes that describe your race:
- ☐ American Indian / Alaskan Native
- ☐ Asia
- ☐ Black / African American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ White

Are you Hispanic or Latino?
- ☐ Yes
- ☐ No
- ☐

What is the primary language spoken at home?
- ☐ English
- ☐ Spanish

Other: _____

MARIPOSA
Your
COMMUNITY
HEALTH CENTER

Notice of: Privacy Practices, Health Information Practices, & Patient Rights | Consent to Treat

Dear Patient,

The Health Insurance Portability and Accountability Act (HIPAA) requires us to provide you with notice of our privacy practices.

Please provide written acknowledgment that you have received and reviewed the attached Notice of Privacy Practices and Notice of Health Information Practices. These notices explain how our office may use protected health information about you, or disclose it, for treatment, payment, or healthcare purposes.

You may request that we restrict how we use or disclose your health information to carry out treatment, payment or healthcare operations. We are not required to agree to the requested restrictions; however, if we do agree to a requested restriction, we are bound by that restriction.

The privacy notice is subject to change because we continuously seek new ways to protect your health information. If we change this privacy notice, you may obtain a revised copy at the front desk or by writing to our Privacy Officer at Mariposa Community Health Center, 825 N. Grand Avenue, Suite 100, Nogales, AZ 85621.

Please provide written consent for treatment below. If you are a parent or guardian filling this out for someone this consent will allow a Mariposa provider to see and treat you or your child from a Mariposa location or a school either in-person or via telemedicine even if you are not present. You also authorize the school nurse or other representative to click the button on your behalf to start a telemedicine virtual visit expressing that they are the legal representative that agrees to the terms of use, privacy policy, and the use of telemedicine on your behalf. If you are filling this form out for yourself this provides your consent for us to treat you. Either way, this will enable us to process payments and proceed with our healthcare operations. You have the right to revoke this consent in writing, except where we have already processed or used the information for treatment, payment, and healthcare operations.

Also attached are your rights as a patient. Please acknowledge that you have received them below. In the event that there are any changes to patient rights, note that these will be posted in the lobbies of all Mariposa buildings and available upon request at the front desk.

Our goal is to protect your privacy and your rights. Your signature below indicates that you have received and reviewed the notices described above and consent to treatment.

Sincerely,
Mariposa Administration

_____

Signature Patient or Guardian Date

_____

Please Print Patient Name Here Please Print Guardian Name Here (as applicable)

MARIPOSA Your COMMUNITY HEALTH CENTER

healthcurrent

Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?

In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?

The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?

People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning, payment for your treatment, conducting quality assessment and improvement activities, developing clinical guidelines and protocols, conducting patient safety activities, and population health services. Medical examiners, public health authorities, organ procurement organizations, and others may also access health information for certain approved purposes, such as conducting death investigations, public health investigations and organ, eye or tissue donation and transplantation, as permitted by applicable law.

Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

You also may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.

Does Health Current receive behavioral health information and if so, who can access it?

Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from some substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share these protected substance abuse treatment records it receives from these programs in two cases. One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

MARIPOSA Your COMMUNITY HEALTH CENTER

PATIENT LABEL
MCHC USE ONLY

How is your health information protected?

Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing

You have the right to:

1. Ask for a copy of your health information that is available through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider.
2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.
3. Ask for a list of people who have viewed your information through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. Except as otherwise provided by state or federal law, you may "opt out" of having your information shared through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. Your information will not be available for sharing through Health Current within 30 days of Health Current receiving your Opt Out Form from your healthcare provider. Caution: If you opt out, your health information will NOT be available to your healthcare providers—even in an emergency.
2. If you opt out today, you can change your mind at any time by completing an Opt Back In Form and returning it to your healthcare provider.
3. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.

MARIPOSA Your COMMUNITY HEALTH CENTER

healthcurrent

Notice of Health Information Practices

"I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt-Out Form to my healthcare provider."

Effective Date: 01/29/2016

PRIVACY NOTICE
MARIPOSA COMMUNITY HEALTH CENTER
THIS NOTICE DESCRIBES HOW MEDICAL, DENTAL AND BEHAVIORAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

WHO WILL FOLLOW THIS NOTICE:

This notice describes the practice of Mariposa Community Health Center (d.b.a. Mariposa) regarding the use of your health information and that of:

- Any of our healthcare professionals authorized to enter information into your medical, dental, or behavioral health record;
- All departments and units of Mariposa;
- Any member of a volunteer/student group we allow to help you while you are in our facility;
- All employees, contracted staff and other Mariposa personnel;
- All affiliates, sites and locations of Mariposa will follow the terms of this notice. In addition, these affiliates, sites and locations may share health information with each other for the treatment, payment or healthcare purposes described in this notice.

OUR PLEDGE REGARDING HEALTHCARE INFORMATION

We understand that medical information about you and your health is personal. Protecting medical information about you is important. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records your care generated at Mariposa, whether made by healthcare professionals or other personnel.
This notice will tell you about the ways in which we may use and disclose healthcare information about you. Disclosure, as appropriate, may be verbal communication, electronic submission, paper record, or by fax. We also describe your rights and certain obligations we have regarding the use and disclosure of healthcare information.
We are required by law to:

- Keep personal healthcare information private;
- Give you this notice of our legal duties and privacy practice with respect to your healthcare information; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTHCARE INFORMATION ABOUT YOU

The following are examples of the types of permitted uses and disclosures of your protected healthcare information. These examples are not meant to be all inclusive, but rather to describe the types of uses and disclosures that may be made by our office once you have provided consent.

I. **Uses and Disclosures of Protected Health Information**

a. **For Treatment** – Information obtained by a nurse, provider or other member of your healthcare team will be recorded in your healthcare record and used to determine the course of treatment that should work best for you. We may disclose your health information to others that will need this information in order to treat you, such as another Mariposa provider, nurse practitioners, pharmacists, and others involved in your care. We may also disclose your protected health information to another healthcare provider (e.g., a specialist or laboratory) who, at the request of your Mariposa provider, becomes involved in your care by providing assistance with our healthcare diagnosis or treatment.

b. **For Payment** – We may use and disclose your protected health information for billing and collection purposes. For example, we may need to give your health plan information about your care so your health plan will pay us or reimburse you for this care. We may also provide information to your health plan or 3rd party payer about a treatment/service that has been ordered by your healthcare provider in order to obtain prior approval or to determine whether your plan will cover the treatment/service.

c. **For Healthcare Operations** – We may use or disclose, as needed, your personal health information in order to support our business activities. These activities include, but are not limited to, quality assessment, employee review, training for medical students, and the licensing, operation or development of other business situations. Other examples of healthcare operations might include:

- Use of a sign-in sheet at the front desk
- Calling you by name in the waiting room when your healthcare provider is ready to see you
- We may contact you (by telephone or mail) to remind you about your appointment

We will share your personal health information with 3rd party "business associates" that perform various activities for Mariposa. Whenever an arrangement between our office and a business associate involves the use or disclosure of your personal health information, we will have a written contact that contains terms that will protect the privacy of your health information. Some examples of our business associates would include X-ray interpretation services, contracted laboratory testing, record copy service and record storage facilities.

II. **Other Permitted and Required Uses and Disclosures that May be Made with Your Consent, Authorization or Opportunity to Object**

We may use and disclose your personal health information in the following instances—in which you have the opportunity to agree or object to the use or disclosure of all or part of your health information.

Individuals involved in your care or payment for your care - Unless you object in advance, we may release protected health information about you to a friend or family member who is involved in your medical care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine, based on our professional judgment that it is in your best interest. We may also give information to someone who helps pay for your care. In addition, we may disclose personal health information about you to an authorized entity assisting with disaster relief efforts.

We may allow family or friends to act on your behalf to pick up filled prescriptions, medical supplies, X-rays and similar forms of personal health information, when we determine, in our professional judgment that it is in your best interest to make such disclosures.

Emergencies - We may use or disclose your protected health information in an emergency treatment situation, should you be unable to consent prior to treatment. If this happens, we shall try to obtain your consent as soon as reasonably practicable after the treatment. If we are required by law to treat you and are unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Treatment Alternatives - We may use or disclose your personal health information, as necessary, to provide you with information about alternative treatments or other health-related benefits and services that may be of interest to you. We may also send you information about products or services that we believe may be beneficial to you; however, you may contact our Privacy Office to request that these materials not be sent to you.

Marketing/Fundraising Activities - We may use or disclose your demographic information in order to contact you for marketing or fundraising activities supported by our clinic. (For example, your name and address may be used to send you a newsletter about our organization and the services we offer.) If you do not want to receive these materials, please contact our Privacy Office and request that the fundraising materials not be sent to you.

III. Other Permitted and Required Uses and Disclosures That May be Made Without Your Consent, Authorization, or the Opportunity to Object

As Required By Law - We will disclose your personal health information when required to do so by federal, state or local law.

Research - We may disclose your personal health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your personal health information. For example, we may conduct a research project involving the review of healthcare records for all patients with specific types of medical conditions.

Public Health Risks - We may disclose your personal health information for public health reasons, including the following:

- To prevent or control disease, injury or disability
- To report deaths
- To report child abuse or neglect
- To report reactions to medications or problems with product
- To notify people about recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- To notify the appropriate authority if we believe a patient has been the victim of abuse, neglect or domestic violence

Workers Compensation - We may release your personal health information to Workers Compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Coroners, Funeral Directors and Organ Donation - We may release your personal health information to a coroner or medical examiner to assist with identifying the deceased or determining the cause of death. We may release personal health information to funeral directors, as needed, to help them carry out their duties. If you are an organ donor, we may release your personal health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Military and Veterans - If you are a member of the armed forces, we may release your personal health information as required by military authorities.

Health Oversight - We may disclose your personal health information to a health oversight agency for purposes authorized by law. Oversight may include: audits, investigations, inspections and licensure. These activities are required by the government to monitor the healthcare system, government programs, and compliance with civil rights laws.

Legal Proceedings - We may release your personal health information in response to a subpoena, discovery request, or other lawful orders from a court or administrative tribunal (to the extent such disclosure is expressly authorized).

Law Enforcement - We may release your health information if asked to do so by a law enforcement official as part of law enforcement activities; in investigations of criminal conduct or of victims of crime; in response to court orders; in emergency circumstances; or whenever required to do so by law.

Inmate. We may use or disclose your personal health information if you are an inmate of a correctional facility, and your healthcare provider created or received your personal health information in the course of providing care to you.

Protected Services for the President; and for National Security and Intelligence Reasons - We may release your personal health information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or conduct special investigations; or for intelligence, counterintelligence, and other national security activities by law.

IV. Uses and Disclosures of Personal Health Information Based Upon Your Written Authorization

Other uses and disclosures of your personal health information not covered by this notice, or the laws that apply to use, will be made only with your written authorization. If you provide us permission to use or disclose your personal health information, you may revoke this authorization at any time, in writing. After revoking your permission, we will no longer use or disclose your personal health information for the reasons stated in the written authorization. You understand that we are unable to take back any disclosures we have already made with your permission; and that we are required to retain records of the care that we provide to you.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Although your healthcare record is the physical property of Mariposa Community Health Center, the information belongs to you; and you have the following rights regarding the healthcare information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and obtain a copy of healthcare information that may be used to make decisions about your care. Usually, this includes medical, dental, prescription, and billing records; but does not include psychotherapy notes.
  To inspect and obtain a copy of healthcare information that may be used to make decisions about you, you must submit a written request to our Medical Information Department. If you request a copy of the information, we may charge a fee for copying or mailing, or for other supplies associated with your request.
  We may deny your request to inspect and obtain a copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by Mariposa 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 Amend.** If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment, as long as the information is kept.
  To request an amendment, your request must be submitted in writing to our Privacy Officer. In addition, you must provide a reason that supports your request.
  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us;
  - Is not part of the medical information kept by Mariposa;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures". This is a list of the disclosures that we made of health information about you.
  To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved; and you may choose to withdraw or modify your request at that time, before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the personal health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the personal health information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend.
  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 medical treatment.
  To request restrictions, you must make your request in writing to our Privacy Officer at the address below. In your request, you must tell us:
  - What information you want to limit;
  - Whether you want to limit our use of your information, disclosure to outside entities, or both; and
  - To whom you want the limits to apply.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. 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 a right to a paper copy of this notice at any time. You may request a copy of our most current privacy notice from the Registration Office or the Privacy Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. And we reserve the right to make the revised or changed notice effective for health information we already have about you, as well as for any information we receive in the future. We will post a copy of the current notice. The notice will contain the effective date in the upper right-hand corner of the first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Mariposa or with the Secretary of the Department of Health and Human Services toll free at 1-877-696-6775. To file a complaint with Mariposa, contact our Privacy Officer at the address and phone number below. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

CONTACT PERSON

If you have any questions about this notice, please contact:
Privacy Officer
Mariposa Community Health Center, Inc.
1852 N. Mastick Way
Nogales, Arizona 85621
520-281-1550

MARIPOSA
Your
COMMUNITY
HEALTH CENTER

Patient Financial Policy

Mariposa accepts most commercial insurance plans, AHCCCS and Medicare. In most cases, we are able to bill both your primary and secondary (if any) insurance plan for you. We ask that you present a valid insurance card for each visit and any other information that may be required by your insurance company, in order for us to submit your claim for you.

If you are being seen for an injury or illness covered by Workers Compensation, we will need your case number and the Workers Compensation Insurance Carrier name at the time service is provided.

You are responsible for payment of any co-payment or deductible under your plan at the time of service, unless other arrangements have been made in advance. If you have no insurance, Mariposa offers services on a sliding-fee-scale based on income and family size.

Payments can be made by cash, personal check, or Master Card, Visa, Discover, and American Express cards. Checks returned for insufficient funds are assessed a $25.00 charge. For patient balances outstanding more than 90 days, where no payment arrangements have been made, Mariposa uses an external collection agency. You are ultimately responsible for any fee charge by the collection agency.

Your signature below acknowledges that you have read, understood and agreed to this financial policy.

Signature: _____ Date: _____

MARIPOSA Your COMMUNITY HEALTH CENTER

Novel Coronavirus Screening Tool- 6.23.2020

Purpose: This tool is intended to assist with screening for novel coronavirus (COVID-19).
Risk Assessment: Initial Screening Questions

Date: _____

Assessment Completed By (Employee Name): _____

PATIENT NAME:		**CELL PHONE NUMBER:**	
DOB:		**INITIAL TEMPERATURE:** _____	
NEW PATIENT: YES / NO		**TEMPERATURE RE-CHECK:** _____	
1.	Inform all patients: **"For the protection of you and other members of the community it is important to answer the following questions open and honestly. We assure that regardless of you answer, if you need to be seen, you will be evaluated by a nurse or provider."** Have you been in contact in the last 14 days with someone that is confirmed to be a case of COVID-19? **(If YES – send to secondary screening immediately)**	**YES**	**NO**
2.	**Are you feeling well** or have you had any of the below symptoms within the last 3 days?		
	• Fever greater than 99.7°F (37.6°C) or subjective fever	**YES**	**NO**
	• Cough	**YES**	**NO**
	• Shortness of breath/breathing difficulties	**YES**	**NO**
	• Change in smell or taste	**YES**	**NO**
	• Sore Throat	**YES**	**NO**
	• Nausea/Vomiting/Diarrhea	**YES**	**NO**
3.	Have you tested positive for COVID 19 in the past 14 days?:	**YES**	**NO**
4.	Have you had close contact (face-to-face contact within 2 meters/6 feet) with someone who is ill with cough and/or fever?.	**YES**	**NO**

IF NO TO QUESTIONS

Give Level 1 mask to patient or guest who are NOT wearing face coverings. Iof patient/guests are already wearing face covering, do not give masks.
Inform patient that face coverings/masks are MANDATORY AT ALL times while on campus and are NOT to be removed. Instruct to always have mouth and nose covered with mask.

1-4: Medical Assistant will check Temperature of Patient/Family member using ear thermometer.
- If Temperature 99.7F or higher send to secondary screening for temperature recheck by licensed staff.
- If Temperature <99.7F and negative screening questions they will be permitted to enter buildings.
- Medical Assistant will send FUZE message to medical team indicating temperature of patient.

IF YES TO ANY QUESTION:
- Maintain at least 6 feet distance from patient.
- Contact the nursing station over the radio (if no secondary station is available).
  ******Do not provide patient information (i.e. name, DOB, etc.) over the radio.******
- Maintain 6 feet distance and have the patient get mask from metal tray (if the patient is already wearing a mask, instruct them how to properly wear it). After the patient leaves disinfect the metal tray thoroughly with Cavi wipes.
- Direct the patient to wait 6 feet (2 meters) away from screeners and other patients until the nurse arrives.
  - At sites with multiple stations, direct the patient to the secondary station.
  - **Do not give the patient a sticker, do not check temperature.**

MARIPOSA
·COMMUNITY·
HEALTH·CENTER

Authorization for Disclosure & Release of Protected Health Information

Patient's Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Social Security #: _____

Authorization to Disclose & Receive Information:
I, the undersigned, consent the release of medical information
From: Mariposa Community Health Center, 825 N Grand Avenue, Ste. 100, Nogales, AZ 85621
Medical Information Fax: (520) 281-4487
To:
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

Information to be released: **Dates:** _____

_____ List of Allergies
_____ Progress Notes
_____ Laboratory Results
_____ X-Ray Reports
_____ Other _____
_____ Medication List
_____ Immunization Records
_____ Problem List
_____ Most Recent History & Physical

Each of the following applicable items must be dated and initiated prior to their release.
In accordance with Federal Regulations 42 CFR Part 2, I hereby consent to the release of records pertaining to:
Initial & Date _____ CONDITIONS RELATED TO DRUG AND/ OR ALCOHOL ABUSE
Initial & Date _____ CONDITIONS RELATED TO PSYCHIATRIC/PSYCHOLOGICAL TREATMENT
Initial & Date _____ ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) (as defined in A.R.S. Section 36-661)

This information is needed for the following purpose(s): _____

Right to revoke & validity:
Unless revoked this authorization will be valid until the information is released. To revoke my authorization, I must submit in writing to:
Mariposa Community Health Center, 825 N. Grand Avenue, Ste. 100, Nogales, AZ 85621

Re-disclosure & Treatment:
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees and doctors are hereby released from any legal responsibility or liability for disclosure of the above information. I understand that Mariposa Community Health Center will not condition treatment on my signing this authorization and will not deny treatment if I do not wish to sign this authorization form.

By signing below I acknowledge that I have read and understand this authorization.

Signature of Patient _____ Date _____

Signature of Parent/ Legal Guardian/ Authorized Person _____

Relationship to Patient: _____ Date _____