FAMILY tree CHIROPRACTIC

# Child Health Questionnaire

**Please fill out front and back**

## PATIENT INFORMATION

Name of Parent_____

Address_____

City_____

State_____ Zip_____

Cell (_____) _____

Home (_____) _____

How did you hear about our office?

_____

Name of Child_____

Address (if different from parent)_____

_____

Phone (_____) _____

Sex ( )M ( )F Age_____ Birthday _____

Who is responsible for your child's bill?

( )You ( )Spouse ( )Auto Insurance ( )Other_____

Email _____

## INSURANCE INFORMATION

Insurance Company _____ ID # _____ Date of Birth _____

Subscribers name _____ Sex of subscriber ( )**M** ( )**F**

Subscriber's address if different than above _____

Subscriber's phone if different than above _____

Is patient covered by additional insurance? ( )**Yes** ( )**No** Relationship to subscriber ( )**Son** ( )**Daughter** ( )**Other**

## CURRENT HEALTH

Is this injury related to an auto accident? ( )Yes ( )No (If yes, please fill out the Auto Questionnaire)

Is your child receiving care from other health professionals? ( )Yes ( )No

If yes, please list name and specialty: _____

Who is your families primary care physician: _____

Please list any drugs or medications your child is taking: _____

_____

Please list any vitamins/herbs/homeopathics/other your child is taking: _____

_____

Please list any allergies your child has:_____

_____

What health condition brings your child to our office? _____

_____

When did the symptoms first begin?_____

How did the problem start? ( )Suddenly ( )Gradually ( )Post-Injury

Is this condition? ( )Getting Worse ( )Improving ( )Intermittent ( )Constant ( )Not sure

What makes the problem better?_____

What makes the problem worse? _____

Has your child ever had a similar condition? ( )Yes ( )No

Please explain _____

Does your child eat well? ( )Yes ( )No Does your child have regular bowl movements? ( )Yes ( )No

Has your child ever been checked for vertebral subluxations? ( )Yes ( )No ( ) Don't Know

## BIRTH HISTORY

Child's birth was ( )At Home ( )At a birthing center ( )At a hospital

My obstetrician/midwife/family physician was _____

Child's birth was: ( )**Natural vaginal** (no medications/interventions)

( )**Vaginal with interventions**

( )Induction ( )Pain medication ( )Epidural ( )Episiotomy ( )Vacuum extraction

( )Forceps ( )Other:_____

( )**C-Section**

( )Scheduled ( )Emergency

Please list reasons for any interventions/complications :_____

_____

Child's birth weight: _____ Child's birth height:_____

Current weight: _____ Current height:_____

APGAR score at birth: _____ APGAR score after 5 minutes: _____

## GROWTH AND DEVELOPMENT

Was your child alert and responsive within 12 hours of delivery? ( )Yes ( )No

If no please explain:_____

At what age did the child:

Respond to sound _____ Follow an object _____ Hold head up _____ Vocalize _____

Sit alone _____ Teeth _____ Crawl _____ Walk _____

Patient/Hospitalization/Surgical History (please list below all surgeries and hospitalizations, including the year):

_____

_____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in has/her lifetime, including the year:_____

_____

_____

Is/was your child breastfed? ( )Yes ( )No If yes how long? _____

Formula introduced at what age? _____ What type? _____

Introduction of cows milk at age? _____ Began solid foods at:_____

Please list any food/juice intolerances:_____

_____

Did mother smoke during pregnancy? ( )Yes ( )No

Did mother drink alcohol during pregnancy? ( )Yes ( )No

Any illness of mother during pregnancy? ( ) Yes ( )No

If yes, please explain treatment/medications/supplements:_____

_____

List any drugs/medications (including over the counter) taken during pregnancy: _____

_____

List any supplements taken during pregnancy: _____

_____

Any exposure to ultrasound? ( ) Yes ( )No If so, how many and what was the medical reason? _____

_____

Any pets at home? ( )Yes ( ) No Any smokers at home? ( ) Yes ( ) No

Has your child received any vaccinations? ( ) Yes ( ) No If yes, which ones and list any reactions _____

_____

Has your child received any antibiotics? ( ) Yes ( )No If yes, how many times and list reason _____

_____

Any difficulty with breastfeeding? ( ) Yes ( )No If yes, please explain_____

_____

Any difficulty with bonding? ( ) Yes ( ) No If yes, please explain_____

_____

Any night terrors, sleepwalking, or difficulty sleeping? ( ) Yes ( ) No If yes, please explain_____

_____

Age child began day care? _____ Average number of hours of TV/video games per week? _____

Does your child seem normal for their age? ( )Yes ( ) No If no, please explain _____

_____

## FAMILY HISTORY

Please check those involving immediate family and circle : M=Mother, F=Father, S=Sibling, G=Grandparents

| | | | |
|---|---|---|---|
| ☐ Cancer, type _____ | ☐ Depression | ☐ Diabetes | ☐ Back Problems |
| M F S G | M F S G | M F S G | M F S G |
| ☐ Heart Disease | ☐ Liver Disease | ☐ High Blood Pressure | ☐ H igh Cholesterol |
| M F S G | M F S G | M F S G | M F S G |
| ☐ Lung Problems | ☐ Scoliosis | ☐ Neck Problems | ☐ Osteoporosis |
| M F S G | M F S G | M F S G | M F S G |
| ☐ Seizures | ☐ Osteoarthritis | ☐ Rheumatoid Arthritis | |
| M F S G | M F S G | M F S G | |

☐ Other _____

_____

## Do YOU KNOW ABOUT CHIROPRACTIC?

Do you know what a subluxation is? ( )Yes ( )No Do any of your relatives or friends see a chiropractor? ( )Yes ( )No

If yes, do they use a chiropractor for ( )Health maintenance/optimization ( ) Health Problems ( )Both

Are you seeking a chiropractor for ( )Health maintenance/optimization ( ) Health Problems ( )Both

What would you like to gain from chiropractic care? _____

_____

Are there other health concerns or anything else you would like us to know about your child? _____

_____

# DETAILED REVIEW OF SYSTEMS

**Patient Name:** _____ **Date:** _____

### Cardiovascular ☐ N/A

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Poor Circulation |
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Aortic Aneurysm |
| ☐ | ☐ | Heart Disease |
| ☐ | ☐ | Heart Attack |
| ☐ | ☐ | Chest Pain |
| ☐ | ☐ | High Cholesterol |
| ☐ | ☐ | Pacemaker |
| ☐ | ☐ | Jaw Pain |
| ☐ | ☐ | Irregular Heartbeat |
| ☐ | ☐ | Swelling of Legs |
| ☐ | ☐ | Stroke |

### Genitourinary ☐ N/A

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Kidney Disease |
| ☐ | ☐ | Lower Side Pain |
| ☐ | ☐ | Burning Urination |
| ☐ | ☐ | Frequent Urination |
| ☐ | ☐ | Blood in Urine |
| ☐ | ☐ | Kidney Stone |
| ☐ | ☐ | Bed Wetting/Enuresis |
| ☐ | ☐ | Prostate Problems |
| ☐ | ☐ | Rectal Prolapse |

### Hematological/Lymphatic ☐ N/A

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Poor Circulation |
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Aortic Aneurysm |
| ☐ | ☐ | Heart Disease |
| ☐ | ☐ | Heart Attack |
| ☐ | ☐ | Chest Pain |
| ☐ | ☐ | High Cholesterol |
| ☐ | ☐ | Pacemaker |
| ☐ | ☐ | Jaw Pain |
| ☐ | ☐ | Irregular Heartbeat |
| ☐ | ☐ | Swelling of Legs |
| ☐ | ☐ | Stroke |

### Respiratory ☐ N/A

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Asthma |
| ☐ | ☐ | Shortness of Breath |
| ☐ | ☐ | Upper Resp. Infection |
| ☐ | ☐ | Cold/Flu |
| ☐ | ☐ | Pnemonia |
| ☐ | ☐ | Cough/Wheezing |
| ☐ | ☐ | Emphysema |
| ☐ | ☐ | RSV |
| ☐ | ☐ | Tuberculosis |

### Ear/Nose/Throat ☐ N/A

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Sinus Congestion |
| ☐ | ☐ | Sinus Infection |
| ☐ | ☐ | Nosebleed |
| ☐ | ☐ | Sore Throat |
| ☐ | ☐ | Difficulty Swallowing |
| ☐ | ☐ | Ear Ache |
| ☐ | ☐ | Ear Infections |
| ☐ | ☐ | Dizziness |
| ☐ | ☐ | Hearing Loss |
| ☐ | ☐ | Bleeding Gums |

### Eyes ☐ N/A

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Glaucoma |
| ☐ | ☐ | Double Vision |
| ☐ | ☐ | Blurred Vision |
| ☐ | ☐ | Red, Itchy (Allergy) |

### Allergic/Immunological ☐ N/A

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Autoimmune Disorder |
| ☐ | ☐ | Chronic Allergies |
| ☐ | ☐ | Seasonal |
| ☐ | ☐ | Food Allergies |
| ☐ | ☐ | Environmental Allergies |
| ☐ | ☐ | Allergy Shots |
| ☐ | ☐ | Cortisone Use |
| ☐ | ☐ | HIV/AIDS |
| ☐ | ☐ | Hives |
| ☐ | ☐ | Weak Immune System |

### Gastrointestinal ☐ N/A

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Pancreatitis |
| ☐ | ☐ | Acid Reflux |
| ☐ | ☐ | Bowel Problems |
| ☐ | ☐ | Constipation |
| ☐ | ☐ | Upset Stomach |
| ☐ | ☐ | Gas Pains |
| ☐ | ☐ | Ulcers |
| ☐ | ☐ | Gallbladder Problems |
| ☐ | ☐ | Liver Problems |
| ☐ | ☐ | Diarrhea |
| ☐ | ☐ | Nausea/Vomiting |
| ☐ | ☐ | Poor Appitite |
| ☐ | ☐ | Bloody Stools |
| ☐ | ☐ | Chrohn's Disease |
| ☐ | ☐ | Hiatal Hernia |

### Musculoskeletal ☐ N/A

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Chronic Hip Dislocations |
| ☐ | ☐ | Torticollis |
| ☐ | ☐ | Poor Posture |
| ☐ | ☐ | Neck Pain |
| ☐ | ☐ | Back Pain |
| ☐ | ☐ | Arthritis |
| ☐ | ☐ | Rheumatoid Arthritis |
| ☐ | ☐ | Joint Stiffness |
| ☐ | ☐ | Muscle Weakness |
| ☐ | ☐ | Osteoporosis |
| ☐ | ☐ | Broken Bones |
| ☐ | ☐ | Joint Replacement |
| ☐ | ☐ | Gout |

### Neurological ☐ N/A

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Tic Disorder |
| ☐ | ☐ | Seizures |
| ☐ | ☐ | Head Injury |
| ☐ | ☐ | Brain Aneurysm |
| ☐ | ☐ | Numbness/Tingling |
| ☐ | ☐ | Pinch Nerve |
| ☐ | ☐ | Sciatica |
| ☐ | ☐ | Radiating Pain |
| ☐ | ☐ | Parkinsons Disease |
| ☐ | ☐ | Carpal Tunnel |

### Neurological Cont.

| | | |
|---|---|---|
| ☐ | ☐ | Balance/Coordination |
| ☐ | ☐ | ADHD/ADD/Sen. Proc. Dis. |
| ☐ | ☐ | Autism/Spectrum Disorder |
| ☐ | ☐ | Migraine Headaches |
| ☐ | ☐ | Bell's Palsy |
| ☐ | ☐ | Poor Fine/Gross Motor Skills |
| ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Inflamation |
| ☐ | ☐ | Trigeminal Neuralgia |
| ☐ | ☐ | Ear Ringing/Tinnitus |
| ☐ | ☐ | Auditory Processing |
| ☐ | ☐ | Toe Walking |
| ☐ | ☐ | Sinus Headache |
| ☐ | ☐ | Tension Headache |
| ☐ | ☐ | Vertigo/Dizziness |
| ☐ | ☐ | Sensory Integration |

### Endocrine ☐ N/A

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Hyperthyroid Issues |
| ☐ | ☐ | Hypothyroid Issues |
| ☐ | ☐ | Type 1 Diabetes |
| ☐ | ☐ | Type 2 Diabetes |
| ☐ | ☐ | Hair Loss |
| ☐ | ☐ | Menopause |
| ☐ | ☐ | Hot Flashes |
| ☐ | ☐ | Endometriosis |
| ☐ | ☐ | Polycysitic Ovarian Cancer |
| ☐ | ☐ | Hashimoto |
| ☐ | ☐ | Graves |

### Psychiatric ☐ N/A

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Depression |
| ☐ | ☐ | Anxiety Disorder |
| ☐ | ☐ | Unusual Stress |
| ☐ | ☐ | OCD |
| ☐ | ☐ | Bipolar Disorder |
| ☐ | ☐ | Seasonal Affective Disorder |
| ☐ | ☐ | Mood Swings |
| ☐ | ☐ | Social Anxiety |
| ☐ | ☐ | Memory Loss |
| ☐ | ☐ | Night Tremors |

### Constitutional ☐ N/A

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Weight Gain/Loss |
| ☐ | ☐ | Energy Level Low |
| ☐ | ☐ | Energy Level High |
| ☐ | ☐ | Difficulty Sleeping |
| ☐ | ☐ | Chronic Fatigue |
| ☐ | ☐ | General Malaise |
| ☐ | ☐ | Compulsive Behavior |
| ☐ | ☐ | Behavior Issues |
| ☐ | ☐ | Learning Diabilities |
| ☐ | ☐ | Speech Delays |
| ☐ | ☐ | RLS |
| ☐ | ☐ | Pregnancy/Fertility |
| ☐ | ☐ | Obesity |

FAMILY tree CHIROPRACTIC

# Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As part of that process you have the right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. The information is intended to make you a better informed in order that you can knowledgably with hold your consent.

**Chiropractic** is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

**Adjustments** are made by chiropractors and in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods and techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

**I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.**

**I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THE INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I AUTHORIZE FAMILY TREE CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.**

Patient Signature: _____ Date: _____

Please Print Name: _____

Parental Consent to Treat a Minor Patient:

Patient Name: _____ Patient Age: _____ DOB: _____

Printed Name of Legal Guardian: _____ Relationship to Patient: _____

Signature of Legal Guardian: _____

**In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.**

Patient: _____ Signature: _____

Relationship to Patient: _____

information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected information to treat you.

**Patient Rights**

- Right to Request Restrictions: You may request that we restrict the uses and disclosures of your health record information for treatment, payment, and operations, or restrictions involving your care or payment related to that care. We are not required to agree to that restriction; however, if we agree, and comply with it, except with regard to emergencies, disclosure of the information to you, or if are otherwise required by law to make a full disclosure without restriction. Your request must be made in writing to our Privacy Official. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your insurer. We will say "yes" unless law requires us to share that information.
- Right to Receive Confidential Communications: You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled. Your request to receive confidential communications must be made in writing to our Privacy Official.
- Right to Inspect and/or Copy: You have the right to inspect copy and request amendments to your health records including electronic health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.
- Right to Amend: You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested information.
- Right to Receive and Accounting: You have the right to inspect copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information complied in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.
- Right to Receive Notice: You have the right to receive a paper Notice, upon request. We are obligated to notify you if there is a breach of your Private Health Information unless there is a low probability of PHI compromise.

**Complaints**

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addresses to the Privacy Officer (in case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint.
All questions concerning this notice or request made pursuant to it should addresses to: Privacy Officer, Family Tree Chiropractic 8158 Hwy 59, Suite 106, Foley, AL 36535

I do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures.

Patient Name: _____

Patient Signature: _____ Date: _____

Name of Personal Representative: _____

Signature of Personal Representative: _____ Date: _____

Legal Authority of Personal Representative: _____

Effective Date of Notice: _____

# NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

**Our Legal Duty**

We are required by law to maintain the privacy of protected health information and to provide you with our notice of our legal duties and privacy practices with respect to your protected health information. We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make new provisions effective for all of the protected health information that we maintain. If we make changes in the terms of the Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

**Uses and Disclosures**

There are a number of situations in which we may use or disclose to other persons or entities your confidential information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment, or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstances, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgment that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

- Treatment Example: We may use your health information with in our office to provide health care services to you or we may disclose your health information to refer you to them for services.
- Payment Example: We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.
- Health Care Operations Example: We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.
- Appointment Reminders Example: Your name, address and phone number and health care records may be used to contact you regarding appointment reminders (such as voicemail messages, postcards, or letters), information about alternatives to you present care, or other health related information that may be of interest to you.

In the following cases we never share your information unless you give us written permission: Marketing purposes, sale of your information, most sharing of psychotherapy notes. In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization:**

Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We contact you from time to time to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

**Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protect health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public entity to assist in disaster relief efforts and to coordinate uses and disclosure to family or other individuals involved in your healthcare.

**Communication Barriers and Emergencies:** We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using our professional judgment, that you intended to consent to use our disclosure under the circumstances. We may use or disclose your protected health