Gilbert Center
For Family Medicine

652 E. Warner Rd, Suite 107 · Gilbert, AZ 85296
Ph: 480-539-8680 **Fx:** 480-539-1763 www.gilbertcenter.net

Dear New Patient,

Welcome to Gilbert Center for Family Medicine! We are so glad you have chosen us as your healthcare home and look forward to getting to know you. To help make your first visit as smooth as possible, please review the steps below before your appointment.

YOUR NEW PATIENT PAPERWORK

We ask that all paperwork be completed **before your visit**. There are **five sections** that must each be filled out in full:

1	Registration and Health History
2	Notice of Privacy Policy- *For your Review*
3	Notice of Privacy Acknowledgment
4	Medical Records Release- *Complete if you would like us to request records from another provider*
5	Notice to Patient

You may complete your forms using either of the following options:

Complete & Email (Preferred)

Fill out the forms electronically using Adobe, then email all five completed sections to:

office@gilbertcenter.net

Include your name and appointment date in the subject line.

Print & Bring

Print the forms, complete all five sections by hand, and bring them to your appointment.

Please arrive 20 minutes early so we have time to process your paperwork before you are seen.

Please note: 4 of the 5 sections require completion prior to your appointment. Incomplete paperwork may result in the need to reschedule your appointment.

WHAT TO BRING TO YOUR APPOINTMENT

- **Photo ID —** driver's license, state ID, or passport
- **Insurance card(s) —** please bring all active insurance cards including pharmacy benefit cards
- **Payment method —** cash, check, or major credit/debit card (co-pays and balances are due at the time of service)
- **Completed paperwork —** if not submitted in advance by email

If you have any questions, please contact us at **office@gilbertcenter.net**.

We are happy to help and look forward to seeing you soon!

Warmly,

The Team at Gilbert Center for Family Medicine

Gilbert Center
For Family Medicine

Registration

Patient Information:

Last Name | First Name | Middle Name

Social Security | Birth Date | Gender

Marital Status: ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown

Race: ☐ Caucasian/ White ☐ African American/ Black ☐ American Indian/ Alaska Native ☐ Asian
☐ Hispanic/ Latino ☐ Middle Eastern ☐ Pacific Islander ☐ Declined to Specify ☐ Other:

Ethnicity: ☐ No Hispanic/ Latino Origin ☐ Hispanic/ Latino Origin ☐ Unknown ☐ Declined to specify

Address | Apt # | City | State | Zip

( ) - | ( ) - | ( ) -

Home Phone ☐ Primary | Day Phone ☐ Primary | Alternate Phone ☐ Primary

Email Address

Emergency Contact Last Name | Emergency Contact First Name | Relationship

Emergency Contact Phone | ☐ Home ☐ Work ☐ Cell Phone Type

How did you hear about our office?

Guarantor Information: ☐ Self

Guarantor Last Name | Guarantor First Name | Guarantor Middle Name

- - | / / | ☐ Female ☐ Male

Social Security | Birth Date | Gender

Address | Apt # | City | State | ZIP

( ) - | ( ) -

Guarantor Relationship | Home Phone ☐ Primary | Day Phone ☐ Primary

Insurance Information:

Policy Holder Last Name | Policy Holder First Name | Policy Holder Middle Name

- - | / / | ☐ Female ☐ Male

Social Security | Birth Date | Gender

Address | Apt # | City | State | ZIP

( ) - | ( ) -

Policy Holder Relationship | Home Phone ☐ Primary | Day Phone ☐ Primary

Primary Insurance Company | Policy Number | Group Number

Secondary Insurance Company | Policy Number | Group Number

Acknowledgement:

I certify that the above information is true and correct. I hereby authorize release of any and all medical information that may be requested by the above named insurance carrier(s) in order to process claim for benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am financially responsible for all charges accumulated from any missed appointments that were not cancelled by the patient at-least 24 hours prior to my scheduled appointment. In the event of default and account is placed with a collection agency, I agree to pay the fees of the collection agency equal to a maximum of 50% of the outstanding balance at the time the account is placed the agency and interest accrual of 10% per year on the principal balance. Should legal action be necessary to collect the account, I agree to pay attorney fees and court costs that occur.

Patient Signature (If Minor: Parent / Legal Guardian) | Date

Gilbert Center
For Family Medicine

Medical History 1

Patient Information:

First and Last Name _____ Birth Date _____

Pharmacy:

Primary: _____ **Cross Streets** _____

Secondary or Mail Order: _____ **Cross Streets** _____

Advanced Directives: Please provide a copy

Type ☐ None ☐ Refuse ☐ Do Not Resuscitate Effective Date: _____
☐ Living Will ☐ Power of Attorney ☐ Do Not Place on Life Support

Allergies: ☐ No Known Allergies

*** Please Specify Allergy & Reaction***

_____ _____ _____
_____ _____ _____

Medications: ☐ No Medications

Medication Name:	Strength:	Directions:

Past Medical History: ☐ No Relevant History

	Year		Year		Year
☐ Allergies		☐ COPD		☐ Liver Disease	
☐ Anemia		☐ Coronary Artery Disease		☐ Migraine Headaches	
☐ Angina		☐ Crohn's		☐ Myocardial Infarction	
☐ Anxiety		☐ Depression		☐ Osteoarthritis	
☐ Arthritis		☐ Diabetes		☐ Osteoporosis	
☐ Asthma		☐ Gallbladder Disease		☐ Peptic Ulcer Disease	
☐ Atrial Fibrillation		☐ GERD		☐ Renal Disease	
☐ Benign Prostatic Hypertrophy		☐ Hepatitis C		☐ Seizure Disorder	
☐ Blood Clots		☐ Hyperlipidemia		☐ Thyroid Disease	
☐ Cancer *Type:* _____		☐ Hypertension			
☐ Cerebrovascular Accident		☐ Irritable Bowel Disease			

Past Surgical History: ☐ No Relevant History

	Year		Year		Year
☐ Angioplasty		☐ Cholecystectomy		☐ Liver Biopsy	
☐ Angio w/ stent		☐ Colectomy		☐ ORIF	
☐ Appendectomy		☐ Colostomy		☐ Pacemaker	
☐ Arthroscopy- Knee Side: ____		☐ Gastric Bypass		☐ Small Bowel Resection	
☐ Back Surgery		☐ Hernia Repair Site:_____		☐ Thyroidectomy	
☐ CABG		☐ Hip Replacement Side:____		☐ Tonsillectomy	
☐ Carpel Tunnel Release		☐ Knee Replacement		☐ Other :	
☐ Cataract Extraction Side:_____		☐ Lasik		☐ Other:	

Gilbert Center For Family Medicine

Patient Name: _____
Date of Birth: _____

Medical History 2

Past Surgical History Continued:

Females Only	Year	Females only	Year	Males Only	Year
☐ Augmentation/ Mammoplasty		☐ Hysterectomy- Partial		☐ Prostate Biopsy	
☐ Bilat. Tubal Ligation		☐ Mastectomy		☐ TURP	
☐ Breast Biopsy Side _____		☐ Myomectomy		☐ Vasectomy	
☐ Cesarean Section		☐ Reduction Mammoplasty			
☐ D&C		☐ TAH/BSO			
☐ Hysterectomy- Total		☐ Vaginal Hysterectomy			

Additional History:

System	Disease	Year

Management	Outcome	Year

Family History: ☐ Adopted/ Unknown ☐ No Relevant History

Diagnosis	Relationship	Mother's Side	Father's Side	Onset Age	Death Cause
ADD/ADHD		☐	☐		☐ Yes
Alcoholism		☐	☐		☐ Yes
Allergies		☐	☐		☐ Yes
Alzheimer's Disease		☐	☐		☐ Yes
Asthma		☐	☐		☐ Yes
Blood Disease		☐	☐		☐ Yes
Coronary Artery Disease (CAD)		☐	☐		☐ Yes
CAD- Premature		☐	☐		☐ Yes
Cancer *Type:*_____		☐	☐		☐ Yes
CVA (Stroke)		☐	☐		☐ Yes
Depression		☐	☐		☐ Yes
Developmental Delay		☐	☐		☐ Yes
Diabetes		☐	☐		☐ Yes
Eczema		☐	☐		☐ Yes
Hearing Deficiency		☐	☐		☐ Yes
Hyperlipidemia		☐	☐		☐ Yes
Hypertension		☐	☐		☐ Yes
Irritable Bowel Disease		☐	☐		☐ Yes
Learning Disability		☐	☐		☐ Yes
Mental Illness		☐	☐		☐ Yes
Migraines		☐	☐		☐ Yes
Obesity		☐	☐		☐ Yes
Osteoarthritis		☐	☐		☐ Yes
Osteoporosis		☐	☐		☐ Yes
PVD		☐	☐		☐ Yes
Renal Disease		☐	☐		☐ Yes
Seizure Disorder		☐	☐		☐ Yes
Other _____		☐	☐		☐ Yes

Social History:

Race: ☐ African American/ Black ☐ Caucasian/ White ☐ Asian ☐ American Indian/ Alaska Native ☐ Hispanic/ Latino ☐ Other ☐ Pacific Islander/ Native Hawaiian ☐ Middle Eastern ☐ Do Not Wish To Disclose

Ethnicity: ☐ Hispanic/ Latino Origin ☐ No Hispanic/ Latino Origin ☐ Unknown

Primary Language Spoken: ☐ English ☐ Spanish ☐ Other: _____

Language Spoken at Home: ☐ English ☐ Spanish ☐ Other: _____

Country of Birth: ☐ USA ☐ Other: **Hand Dominance:** ☐ Right ☐ Left ☐ Ambidextrous

Gilbert Center For Family Medicine

Patient Name: _____
Date of Birth: _____

Medical History 3

Social History Continued:

Employer (Name) _____ **Occupation (Type of Work)** _____

Employment Status: ☐ Full Time ☐ Self Employed ☐ Other: _____
☐ Part Time ☐ Unemployed ☐ Retired Date: _____

Work Restrictions: ☐ Avoid dust/fumes ☐ No heavy lifting ☐ No climbing ☐ Other: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
☐ Life Partner ☐ Annulled ☐ Legally Separated ☐ Other: _____
Previously Widowed ☐ Yes ☐ No **Previous Divorce** ☐ Yes ☐ No

Children ☐ No ☐ Yes Number of Sons: _____ Number of Daughters: _____

Tobacco, Alcohol, and Caffeine

Tobacco Use ☐ Current ☐ Former ☐ Never ☐ Unknown
Ever Tried to Quit? ☐ No ☐ Yes **Year Quit:** _____ **Longest Tobacco Free:** _____
Passive Smoke Exposure? ☐ No ☐ Yes **Relapse Reason:** _____

Tobacco Type ☐ Chewing ☐ Pipe **Units/Day** _____
☐ Cigar ☐ Smokeless **Years Used** _____
☐ Cigarettes ☐ Snuff **Pack Years** _____

Smoker Status ☐ Current Everyday Smoker ☐ Current Some Day Smoker ☐ Social Smoker

Alcohol Use ☐ No ☐ Former ☐ Yes **# per day:** _____ **# per week:** _____ **# per year** _____

Caffeine Intake ☐ No ☐ Former ☐ Yes **Milligrams per day :** _____

Lifestyle

Activity Level: ☐ Moderate ☐ Sedentary ☐ Vigorous **Health Club/ Gym Member:** ☐ Now ☐ Previously ☐ Never

Type of Exercise: _____ **Exercise Frequency:** _____

Hours/ Week: _____ **Hobbies/ Activities:** _____

Diet History: ☐ Diabetic ☐ Vegan ☐ Vegetarian ☐ High Fiber ☐ Low Sodium ☐ High Protein ☐ Other:

Lifestyle: Home Environment and Safety

Animals in the Home: ☐ No ☐ Yes **Type:** _____
Smoke Detectors in Home: ☐ No ☐ Yes **Pool/Spa at Home:** ☐ No ☐ Yes
Carbon Monoxide Detectors in Home: ☐ No ☐ Yes **Seat Belt Use:** ☐ No ☐ Yes
Firearms at Home: ☐ No ☐ Yes ☐ No Answer **Home Heating Method:** ☐ Gas ☐ Electric
Falls in the Last Year: ☐ No ☐ Yes **Number of Falls:** _____
Radon in the Home: ☐ No ☐ Yes ☐ Treated ☐ Untested

Disease Management:

Health Maintenance

Test	Date	Test	Date	Female Testing	Date
☐ Physical Exam		☐ Flu Vaccine		☐ GYN Exam	
☐ Lipid Panel		☐ Tdap Vaccine		☐ Breast Exam	
☐ EKG				☐ PAP/ HPV	
☐ Colonoscopy		**Male Testing**		☐ Mammogram	
☐ FOBT		☐ PSA		☐ Dexa Scan	

Directions:

Thank you for completing your New Patient Packet prior to your appointment. Save this packet prior to closing out of the program to prevent losing your hard work. To ensure a smooth experience with your first appointment please email the packet. If you choose to print out physical copies, please arrive 20 minutes early for your appointment.

Email: office@gilbertcenter.net

We are delighted that you have chosen Gilbert Center for Family Medicine to partner with you in managing your health and wellness needs.

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For Family Medicine

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WWW.GILBERTCENTER.NET

MEDICAL RECORDS REQUEST/ RELEASE

_____ _____/_____/_____
Patient Full Name **Birth Date**

_____ _____-_____-_____
Address **Social Security Number**

PURPOSE OF DISCLOSURE:

☐ Continuation of care ☐ Transfer care ☐Other: _____

AUTHORIZATION:

☐ I authorize the release of my medical records **from another provider/facility to Gilbert Center for Family Medicine.** (Provider/Facility → GCFM)

☐ I authorize the release of my medical records **from Gilbert Center for Family Medicine to another provider/facility.** (GCFM → Provider/Facility)

Provider /Facility Information: OUTSIDE OF GCFM

_____ (_____)_____-_____
Provider/ Facility Name **Phone**

_____ (_____)_____-_____
Address **Fax**

RECORDS TO BE RELEASED:

☐ All medical records are authorized to be released.

☐ Other medical records authorized to be released: _____

FROM: _____ TO:_____

The following record types are protected by Arizona and federal law and require your separate, affirmative consent before they may be released. Please initial each category you wish to include. Categories left blank will be excluded from this release.

Initials	Record Category	Legal Authority
	HIV test results and related information	*A.R.S. § 36-664*
	Mental health and behavioral health treatment records	*A.R.S. § 36-509*
	Alcohol and substance use disorder treatment records	*42 CFR Part 2*

Consent: This consent will expire sixty (60) days after the signed date below. I may revoke this authorization at any time providing I notify Gilbert Center for Family Medicine in writing to that effect. I understand that any release which was made prior to my revocation is in compliance with this authorization and shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original**. I hereby release Gilbert Center for Family Medicine from all legal responsibility or liability that may arise from the act I have authorized above.**

_____ _____/_____/_____
Patient Name (If Minor: Parent / Legal Guardian) **Date**

_____ _____/_____/_____
Patient Signature (If Minor: Parent / Legal Guardian) **Date**

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NOTICE TO PATIENTS

CONTROLLED SUBSTANCE & NARCOTIC PRESCRIBING POLICY

Gilbert Center for Family Medicine has a **NO CHRONIC NARCOTICS / NO CHRONIC CONTROLLED SUBSTANCE** policy for **new patients**. We will not prescribe long-term or chronic narcotics, opioids, benzodiazepines, stimulants, sedative-hypnotics, or other controlled substances to new patients at the initial visit. This policy is consistent with **Arizona Revised Statutes §32-3248 and §32-3248.01**, the Arizona State Board of Pharmacy Controlled Substance Prescribing Monitor Program (CSPMP), and CDC Clinical Practice Guidelines for Prescribing Opioids (2022).

Controlled Substances Covered by This Policy (DEA Schedules II – IV):

Schedule II — Opioids / Narcotics	Schedule II — Stimulants	Schedule III / IV — Sedatives, Benzos & Other
Fentanyl (Duragesic, Actiq) Hydrocodone (Norco, Vicodin) Oxycodone (OxyContin, Percocet) Oxymorphone (Opana) Hydromorphone (Dilaudid) Morphine (MS Contin) Methadone Meperidine (Demerol) Codeine (high-dose)	Amphetamine/dextroamphetamine (Adderall, Dexedrine) Methylphenidate (Ritalin, Concerta) Lisdexamfetamine (Vyvanse) Methamphetamine (Desoxyn) Mixed amphetamine salts	Alprazolam/Xanax (Sch. IV) Clonazepam/Klonopin (Sch. IV) Diazepam/Valium (Sch. IV) Lorazepam/Ativan (Sch. IV) Temazepam/Restoril (Sch. IV) Zolpidem/Ambien (Sch. IV) Carisoprodol/Soma (Sch. IV) Tramadol/Conzip (Sch. IV) Butalbital compounds (Sch. III) Ketamine (Sch. III) Testosterone (Sch. III)

This list is not exhaustive. All DEA Schedule II–IV controlled substances are subject to this policy. Prescriptions are subject to mandatory CSPMP review per A.R.S. §36-2606.

EMOTIONAL SUPPORT ANIMAL (ESA) LETTERS

Gilbert Center for Family Medicine does **NOT** write letters for Emotional Support Animals (ESAs). Patients requesting an ESA letter will be referred to a psychiatrist or psychologist for evaluation. This is consistent with guidance from the American Academy of Family Physicians (AAFP) regarding scope-appropriate referral for mental health assessments.

I acknowledge that I have read and understand the above policies.

Patient Full Name (printed) _____ Date of Birth _____

Patient/ Legal Guardian Signature _____ Date _____

Relationship to Patient/ Representative's Authority (e.g. Power of Attorney, Guardian) _____

Gilbert Center
For Family Medicine

652 E. Warner Rd, Suite 107 Gilbert, AZ 85296
Phone: *480-539-8680* **Fax:** *480-539-1763*
WWW.GILBERTCENTER.NET

Patient Name: _____ Date of Birth: _____

RELEASE OF INFORMATION AND AUTHORIZATION

Purpose of Disclosure: ☐ Authorized contact for my care ☐ Other: _____

At the patients request, as indicated above, I authorize the staff of Gilbert Center for Family Medicine to release Protected Health Information (PHI) to the individuals listed below. PHI includes but is not limited to treatment records, medications/prescriptions, and test results. This authorization will be valid for one year from the signature dated below.

Authorized Person	Relationship to Patient	Contact Number

Sensitive Record Categories:

The following record types are protected by Arizona and federal law and require your separate, affirmative consent before they may be released. Please initial each category you wish to include. Categories left blank will be excluded from this release.

Initials	Record Category	Legal Authority
	HIV test results and related information	*A.R.S. § 36-664*
	Mental health and behavioral health treatment records	*A.R.S. § 36-509*
	Alcohol and substance use disorder treatment records	*42 CFR Part 2*

Right to Revoke: *You may revoke this authorization in writing at any time by contacting GCFM's Privacy Officer at 652 E. Warner Rd, Suite 107, Gilbert, AZ 85296. Revocation does not affect disclosures already made in reliance on this authorization.*

Treatment Not Conditioned on Signing: *Your treatment, payment, enrollment, or eligibility for benefits at GCFM is not conditioned on signing this authorization. (45 CFR §164.508)*

Re-disclosure Notice: *Information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA or Arizona law.*

I hereby acknowledge that I may review Gilbert Center for Family Medicine's Privacy Practice Notice by visiting www.gilbertcenter.net. A signed copy of this authorization will be provided to you at the time of signing.

CONCENT TO LEAVE VOICEMAIL

GCFM may leave general appointment and administrative messages by default. If you choose to authorize it, GCFM staff may also leave detailed medical information on your voicemail when calls are unanswered, including treatment recommendations, medications/prescriptions, and test results. HIV results and confidential alcohol, drug abuse, and mental health details require separate affirmative consent and will only be disclosed by voicemail if specifically authorized below.

☐ ***I AUTHORIZE detailed voicemail as described above.***

☐ ***I ALSO AUTHORIZE*** *HIV results, behavioral health, and substance use details by voicemail. (A.R.S. § 36-509 / 42 CFR Part 2)*

☐ ***I DECLINE*** *— Leave general/administrative messages only. (Default if unsigned)*

HEALTH INFORMATION EXCHANGE

By signing below, you consent to Gilbert Center for Family Medicine's participation in the Health Current (HC) Health Information Exchange, which allows your health information — including mental health details — to be securely shared with other participating providers for treatment, payment, care coordination, and healthcare operations. **HIV test results and substance use disorder records subject to 42 CFR Part 2 are excluded from Health Current sharing unless separately authorized.** If you wish to opt out, please notify a staff member; processing may take up to 30 business days.

☐ **I DECLINE** the HIE Agreement and would like to fill out the Opt-Out Form

_____ _____ _____

Patient Signature Date of Birth Date

_____ _____

Legal Representative Signature Relationship to Patient/ Representative's Authority (e.g. Power of Attorney)

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Ph: 480-539-8680 **Fx:** 480-539-1763 www.gilbertcenter.net

NOTICE OF PRIVACY PRACTICES

Prime Medical Group, LLC – Gilbert Center for Family Medicine

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.

YOUR RIGHTS	YOUR CHOICES	OUR USES & DISCLOSURES
• Copy of your medical record	• Share info with family/caregivers	• Treat and coordinate your care
• Correct your record	• Disaster relief sharing	• Bill for services
• Confidential communications	• Health Current HIE (opt-out)	• Run our practice
• Limit what we share	• Fundraising (opt-out)	• Public health reporting
• Accounting of disclosures	• Marketing — written permission required	• Health research
• Copy of this notice	• Sale of PHI — we will NOT do this	• Comply with law
• Choose someone to act for you		• Legal proceedings / court orders
• File a complaint		• Workers' compensation
		• Organ donation
		• Coroner/funeral director

About This Notice: This notice — including the integrated 42 CFR Part 2 Addendum (effective February 16, 2026) — explains how GCFM may use and disclose your Protected Health Information (PHI), including Substance Use Disorder (SUD) records, and your rights regarding this information. We must provide you with this notice, maintain the privacy of your PHI, and notify you of any breach within 60 days (or 45 days under Arizona A.R.S. §18-552, whichever is sooner). We may update this notice; current versions are posted at our office and at www.gilbertcenter.net.

YOUR RIGHTS — When It Comes to Your Health Information

Get a copy of your medical record: Ask to see or receive your medical records or other PHI. We respond usually within **30 days**. A reasonable, cost-based fee may apply.

Correct (amend) your record: Ask us to fix information you believe is incorrect or incomplete. We respond in writing within **60 days**. See our Request to Amend form.

Confidential communications: Ask us to contact you in a specific way (e.g., cell only, different address). We say yes to all reasonable requests.

Limit what we use or share: Ask us not to use or share certain PHI for treatment, payment, or operations — we are not always required to agree. If you pay entirely out-of-pocket, you may ask us not to bill your insurer; we must agree.

Accounting of disclosures: Request a list of times we have shared your PHI for the prior **six years**. One free list per year; additional requests may incur a fee.

Copy of this notice: Request a paper copy at any time, even if you agreed to receive it electronically.

Choose someone to act for you: A person with medical power of attorney or legal guardianship may exercise your rights. We verify authority before taking action.

File a complaint — we will NEVER retaliate: Contact our Privacy Officer (below) or HHS Office for Civil Rights · 1-877-696-6775 · www.hhs.gov/ocr

YOUR CHOICES — You Control Certain Uses of Your Information

Family, friends, and caregivers: We may share PHI with people involved in your care. If you are unable to communicate preferences, we may share if we believe it is in your best interest or to address a serious and imminent threat to health or safety.

Disaster relief: We may share your information with disaster relief organizations in an emergency.

Health Current HIE: GCFM participates in the **Health Current (HC) Health Information Exchange**, which allows your health information — including mental health details — to be shared with participating providers for treatment, payment, care coordination, and operations. You may opt out by notifying a staff member (processing takes up to 30 business days).

Fundraising: We may contact you for fundraising. Tell us to stop at any time — we will honor your request.

Marketing — written permission required: We will not use your PHI for marketing or accept payment to market to you without your written authorization.

Sale of PHI — we will NOT do this: We will not sell your protected health information.

OUR USES AND DISCLOSURES — How We Typically Use Your Information

Treatment: We use and share your PHI to provide, coordinate, and manage your care with physicians, nurses, pharmacies, labs, and specialists. *Ex: Your PCP sends records to a cardiologist.*

Payment: We use and share your PHI to bill for services and receive payment from your health plan. *Ex: We submit a claim describing your visit.*

Health care operations: We use PHI to run our practice, conduct quality reviews, train staff, and contact you about health-related services. *Ex: Quality improvement audits.*

Public health & safety: Reporting disease, product recalls, adverse drug reactions, suspected abuse or neglect, and serious threats to health or safety.

Health research: For research with proper institutional review board oversight and privacy protections.

Required by law: State or federal laws may require disclosure, including to HHS to verify HIPAA compliance.

Legal proceedings: Court orders, subpoenas, warrants, or other valid legal process.

Law enforcement: As permitted by law — e.g., reporting gunshot wounds or child abuse.

Ambient Artificial Intelligence (AI): used to support documentation and enhance the quality of care.

Workers' compensation: As authorized by workers' compensation laws for work-related injuries.

Organ / tissue donation: With organ procurement organizations as necessary.

Coroner / funeral director: When necessary for identification or official duties following a death.

Military & national security: As required with military command, VA, or government authorities.

SPECIAL PROTECTIONS — Certain Information Has Heightened Privacy Rights

The following categories receive protections beyond standard HIPAA under federal and/or Arizona law. In some cases your written authorization is required for disclosures that HIPAA would otherwise permit.

Mental & Behavioral Health — ARS §36-509: Records from behavioral health evaluation or treatment are confidential under Arizona law. Disclosure is permitted only for treatment, patient authorization, court orders, emergencies, or certain oversight needs.

HIV/AIDS Information: Arizona and federal law impose additional protections on HIV test results. Disclosure may require specific authorization beyond standard HIPAA consent.

Genetic Information — GINA & Arizona Genetic Privacy Act: We require written informed consent for genetic testing and restrict disclosure of genetic information beyond what HIPAA permits.

Psychotherapy & SUD Counseling Notes: Notes kept separately from the general medical record require specific written authorization for most disclosures and are never released for TPO purposes without permission.

SUBSTANCE USE DISORDER RECORDS — 42 CFR PART 2 (Effective February 16, 2026)

Substance use disorder treatment records and information that would identify you as having or having had a substance use disorder (**"Part 2 Records"**) receive protection under **42 CFR Part 2** in addition to HIPAA and Arizona law. Part 2 is more restrictive than HIPAA in important ways — the rules below govern any Part 2 Records GCFM creates, receives, or maintains, including SUD screening, referral, and treatment records received from other programs.

PERMITTED WITHOUT WRITTEN CONSENT

Medical emergency: May disclose when consent cannot be obtained.

Research: With proper IRB waiver of consent and privacy protections.

Court order + subpoena: Only after notice and opportunity to be heard; must be accompanied by a subpoena or other compulsory process.

Audit / program evaluation: To authorized oversight or funding authorities who agree in writing to protect the records.

SUD treatment coordination: Within GCFM for SUD diagnosis, treatment, or referral.

Qualified service organizations: Entities providing services on our behalf under a Part 2-compliant agreement (analogous to HIPAA Business Associates).

Law enforcement — crimes at facility only: Only to report a crime committed or threatened at our facilities. **SUD records may NOT be used to investigate or prosecute you** without your consent or a qualifying court order.

Child abuse reporting: As required by Arizona and federal law.

Public health (de-identified): To authorized public health authorities; contents de-identified per HIPAA before disclosure.

Arizona CSPMP: Prescription drug monitoring program reporting required by A.R.S. §36-2606.

REQUIRES YOUR WRITTEN CONSENT

Treatment, payment & operations (TPO): Part 2 requires written consent for TPO — unlike standard HIPAA. A single consent may cover all future TPO uses. TPO disclosures to other entities are then governed by their own HIPAA or Part 2 rules.

Proceedings against you — SEPARATE consent: Any use of your Part 2 Records in a civil, criminal, administrative, or legislative proceeding against you requires your written consent **separate from all other consents.** A court order alone is insufficient without the full Part 2 procedural protections.

SUD counseling notes — SEPARATE consent: Notes from SUD counseling sessions maintained separately from the general record require their own separate written consent.

Health information exchange disclosures: Sharing Part 2 Records through the Health Current HIE, ACOs, or other intermediaries requires your written consent. You have the right to an accounting of intermediary disclosures for the prior **3 years** (vs. 6 years for other PHI).

Revoking Consent: You may revoke any Part 2 consent in writing to our Privacy Officer at any time. Revocation stops future sharing but does not affect information already released. **Part 2 Complaint Rights:** You may file a complaint directly with HHS OCR for alleged Part 2 violations — OCR began accepting Part 2 complaints February 16, 2026. We will not retaliate against you for filing a complaint.

WRITTEN AUTHORIZATION REQUIRED FOR THESE USES

For the following, we obtain your written authorization before acting. You may revoke any authorization in writing at any time.

Psychotherapy / SUD counseling notes: Specific authorization required; cannot be used for TPO without it.

Marketing: We will not use PHI for marketing or accept payment to market to you without written authorization.

Sale of PHI: We will not sell your PHI without written authorization.

Part 2 records in legal proceedings: SUD records from Part 2 programs may not be used in civil, criminal, administrative, or legislative proceedings against you without written consent or a qualifying court order.

OUR LEGAL DUTIES

We are required by law to maintain the privacy of your PHI; provide you with this notice; follow the terms currently in effect; and notify you of a breach within 60 days federally (45 days under Arizona A.R.S. §18-552). We reserve the right to change this notice. If we make material changes, we will notify you and post the updated notice at our office and at www.gilbertcenter.net. Changes apply to all PHI we hold, including records created before the change. **Effective Date: July 1, 2026 · Version: 2026-01.**

CONTACT — PRIVACY OFFICER & COMPLAINTS

GCFM Privacy Officer	HHS Office for Civil Rights (Federal)	Arizona Department of Health Services
Gilbert Center for Family Medicine 652 E. Warner Rd, Suite 107 Gilbert, AZ 85296 Phone: 480-539-8680 Fax: 480-539-1763 office@gilbertcenter.net www.gilbertcenter.net	200 Independence Ave SW Washington, DC 20201 Phone: 1-877-696-6775 TTY: 1-800-537-7697 File: www.hhs.gov/ocr *Accepts Part 2 complaints effective Feb 16, 2026*	150 N. 18th Ave. Phoenix, AZ 85007 Phone: 602-542-1025 **Arizona AG Consumer Protection:** 602-542-5763

We will not retaliate against you in any way for filing a complaint — regarding HIPAA, 42 CFR Part 2, or any other privacy concern.

Regulatory Compliance: This Notice of Privacy Practices complies with: HIPAA Privacy Rule (45 CFR Parts 160 & 164); 42 CFR Part 2 Final Rule (eff. Feb 16, 2026); HIPAA Security Rule 2026 updates (mandatory encryption, MFA, 72-hr breach reporting); ARS §36-509 (Behavioral Health Confidentiality); A.R.S. §18-552 (AZ Breach Notification — 45 days); GINA & Arizona Genetic Privacy Act; CFPB 2025 Medical Debt Rule (12 CFR Part 1022). **Effective: July 1, 2026 · Includes 42 CFR Part 2 Addendum (eff. Feb 16, 2026) · Version 2026-01.**