GREENVILLE COUNTY SCHOOLS

Building College and Career-Ready Graduates

Inspired | Supported | Prepared

Forms Needed to Participate in GCSD EACH YEAR

In order to participate in a high school sport in GCSD each athlete must have the following forms completed, signed, and submitted. These forms may be submitted through PlanetHS or directly to the head coach.

COVID Waiver - parent signature
Physical Form - completed by a doctor after April 1st for coming year
Medical History Form - completed and signed by the parent and athlete
Concussion Statement - completed and signed by the parent and athlete
GCSD Parent/Athlete Risk Acknowledgment Form - signed by parent and athlete
Steadman Hawkins Consent to Treat Form - signed by parent
**Birth Certificate - only need to turn in once, it will be kept on file
Insurance Check - checks made out to the school (please write “Insurance” in the memo)

- HS $33
- MS $17

GREENVILLE COUNTY SCHOOLS

ASSUMPTION OF RISK AND WAIVER OF LIABILITY RELATED TO COMMUNICABLE DISEASES/COVID-19 (CORONAVIRUS)

PLEASE READ CAREFULLY AND ENTIRELY BEFORE SIGNING

I understand that COVID-19 (Coronavirus) is considered to be extremely contagious and can result in a range of symptoms, which include, but are not limited to, fever, shortness of breath, fatigue, loss of taste or smell, and nausea or vomiting. These symptoms can be mild or severe, sometimes resulting in death. For additional information on the spread and effect of COVID-19 please visit: https://www.cdc.gov/coronavirus/2019-ncov/index.html.

I acknowledge that COVID-19 is primarily spread by person-to-person. A person does not have to be showing signs of illness in order to spread this virus. I understand that the risk of person-to-person spread of the virus is increased by close physical contact and activities associated with athletic events, such as perspiration and the touching of sports equipment. I acknowledge that participation in sporting events and athletic activities could increase the risk of transmitting COVID-19.

I affirm that I have not been diagnosed with, demonstrated any symptoms of or have in any way been exposed to any communicable diseases (including but not limited to the virus commonly referred to as COVID-19) within the past thirty days. I also affirm that I will adhere to all safety precautions communicated by the coach/school administration when engaging in athletic activities.

By signing this Agreement, I acknowledge that I understand the risks related to COVID-19 and other communicable diseases and understand that the risk of contracting COVID-19 may be increased by participation in athletic activities. I voluntarily assume the risk of allowing my child to participate in athletic activities, including, but not limited to, practicing, training, and participating in games and competitions. I understand that my child is not required to participate in athletic activities. I voluntarily agree to assume all risks and accept sole responsibility for any injury or illness up to and including permanent disability or death for my child and/or myself and others arising out of the participation in athletic events. On behalf of myself, my child, and any successor guardian of my child, I hereby release, covenant not to sue, and agree to hold harmless the School District of Greenville County, its Board of Trustees, employees, agents, insurers, and representatives for any and all claims, liabilities, harm, damages, costs, or expenses related to any injury or illness, including the contraction of COVID-19, arising out of athletic activities connected with the event/sport listed below.

By signing this Agreement, I acknowledge that I have read the foregoing fully and understand the contents of the Waiver. I acknowledge the risks associated with participation in athletic activities and the possible contraction of COVID-19 or other communicable diseases and wish for my child (Named Student below) to participate in athletic activities.

_____
Athletic Event/Sport

_____
Printed Name of Student

_____ _____
Printed Name of Parent/Guardian Signature of Parent/Guardian

_____
Date

Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight	☐ Male ☐ Female	
BP / (/) Pulse	Vision R 20/ L 20/	Corrected ☐ Y ☐ N
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____ Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete had been cleared for participation, the physician may rescind the clearance until the problem is resolve and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Preparticipation Physical Evaluation
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

GREENVILLE COUNTY SCHOOLS

Athlete/Parent Concussion Statement

PARENTS AND ATHLETE please initial in each box

Parent	Athlete	
☐	☐	I understand that it is my responsibility to report all injuries and illnesses to my athletic trainer.
☐	☐	I have read and understand the *CDC Concussion Fact* sheet for parents.
☐	☐	I have read and understand the *CDC Concussion Fact* sheet for athletes.

After reading the Concussion fact sheet, I am aware of the following information:

☐	☐	A concussion is a brain injury that I am responsible for reporting to my athletic trainer, physician, or coach.
☐	☐	A concussion can affect everyday activities, athletic performance balance, sleep, reaction time, and classroom performance.
☐	☐	If I suspect a teammate has a concussion I am responsible for reporting the injury to my athletic trainer.
☐	☐	I will not return to activity on the same day if I have received a blow to the head or body that results in concussion related symptoms.
☐	☐	Following a concussion the brain needs time to heal. You are much more likely to have another concussion if you return to play prior to your symptoms resolving.
☐	☐	In rare cases, repeat concussions can cause permanent brain damage or even death.
☐	☐	I understand that physician clearance, and completion of ***Return-to-Play Protocol*** must be completed before an athlete returns to full participation.

Student Athlete Signature	Parent Signature	Date
Printed Name of Student	Printed Name of Parent	

GREENVILLE COUNTY SCHOOLS

PARENTS'/GUARDIANS'/ATHLETE'S Risk Acknowledgement

Athlete's Name: _____Date of Birth: _____

My/Our child wishes to participate in the athletic program at _____high school.
(name of school)
I/We realize that there are risks involved in this participation and attended a group meeting on _____
(date)
where these risks were discussed and explained. The meeting was run by _____.
(name of school person)
We had the opportunity to have all our questions answered.

I/We understand that the risks include a full range of injuries, from minor to severe. I/We recognize the possibility that my/our child might die, become paralyzed, or suffer brain damage or other serious, permanent injury as a result of participation in this sports program. I/We realize that neither the protective equipment and padding used in athletics programs, the safety rules and procedures of the various sports, the coaching instruction received, nor the sports medicine care provided to athletes will guarantee safety or prevent all injuries he/she might sustain. I/we agree to accept these risks as a condition of my/our child's participation in this program.
In consideration for my/our child's participation in the program, I/we hold harmless and release Greenville County Schools and its employees, agents, coaches, volunteers, trustees, and USA Football, Inc., from all present and future liabilities, expenses, damages, losses, injuries, judgments, and claims, of whatsoever, in equity or at law, which I/we or my child may have, whether known or unknown, suspected or unsuspected, asserted or not asserted, arising out of participation by my/our child in the program.

ADDITIONAL OR SPECIAL CONDITIONS Risk Acknowledgement

(NOTE: Fill this box out ONLY if your child has a pre-existing condition that may increase risk of injury and/or illness. If this section does not apply to you, then write "not applicable" or "NA" in the first space.)

I also realize that my/our child's _____creates additional risks and
(condition)
I/we discussed these risks with the athletic director, coach(es), and the sports medicine provider(s) in a meeting on
. They explained to me/us that, because of this condition, the special risks for my/our child are (List all concerns. Should you need more room, write on the back of this form. Write legibly.):

I/we understand these concerns and agree to follow all directions and recommendations of my/our physicians and sports medicine providers in this program. I/we also agree to accept these additional risks as a part of my/our child's participation in the program.

_____ _____
Date Signature of Parent/Guardian

_____ _____
Date Signature of Athlete/Participant

GREENVILLE COUNTY SCHOOLS

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

Name (please print) _____

As a parent or legal guardian of the above named student-athlete. I give permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

Signature of Athlete _____ _____
Date

Signature of Parent/Guardian _____ _____
Date

PRISMA HEALTH

STEADMAN HAWKINS SPORTS MEDICINE SERVICES
CONSENT AND AUTHORIZATION

I, _____, parent/legal guardian of _____ a student/participant at _____ (the "School/Event") authorize Prisma Health staff to provide my child any healthcare services offered by Steadman Hawkins Sports Medicine ("SHSM") and to make appropriate referrals for my child to receive any additional health services that my child's condition may indicate. To protect and improve the health of athletes, Prisma Health will provide athletic trainers to provide on-site treatment and consultation to student/participants. These services will be overseen by a physician serving as Medical Director for SHSM.

In addition, in the event my child needs urgent or emergency treatment off-site, I authorize staff of SHSM to arrange for such care, including appropriate transportation. I understand that SHSM staff will contact me as soon as possible in the event my child has an urgent or emergency condition. I agree to complete all health history, family history, and other informational requests necessary for my child's participation in the SHSM program. I understand that I may contact the Athletic Trainer assigned to the School or the Medical Director for SHSM to discuss my child's care or to discuss any questions I may have about the program. I consent to the release by Prisma Health/SHSM staff of information about my child's medical condition obtained through SHSM Services to physicians, coaches, and other employees or agents of Prisma Health or to whom I am referred. I also consent to the release of information about my child's medical condition to necessary staff at the school, should accommodations be needed to aid in my child's education.

I understand that I will not be charged for services rendered on-site by the medical staff, but that I or my child's insurance carrier may be charged for services rendered by other healthcare providers. I consent for information in my child's medical record to be released for the purpose of filing health insurance claims with third-party payers. I hereby authorize Prisma Health to submit claims for services rendered to my child and assign to Prisma Health my rights to any reimbursement for such services.

In consideration for the services provided to my child by SHSM, I hereby release Prisma Health System, its trustees, officers, employees, and agents from and against any claim, liability, and cause of action or other expense arising out of the services provided by Prisma Health Sports Medicine Services.

I acknowledge by signing below that I have received a copy of the Prisma Health System Notice of Privacy Practices.

I have read and understand the above information and consent to my child's participation in Prisma Health Sports Medicine Services.

_____ _____

Name of Parent/Guardian (please print) Signature of Parent/Guardian

_____ _____

Name of Student (First, Middle, Last) Witness/Date

STEADMAN HAWKINS SPORTS MEDICINE

Athlete's Name _____ DOB _____ Grade ___
(First/ Middle/ Last)

School _____ Sport(s) _____

Guardian(s) _____ Phone#'s (h) _____ (c) _____
Relationship(s) _____

Address _____
Street City State Zip

Guardian(s) Email _____ Student Athlete's Email _____
(For SHSM Emails of Athletic Training/Conditioning Topics)

Emergency contact _____ Phone#'s (h) _____ (c) _____
(Guardians will be contacted first in case of emerg ency, please list individual other than listed above)

Ins. Carrier _____ HMO/PPO Group/Policy# _____
(circle one)

Insurance Preferred Network/Provider: **yes/no** (circle one) Whom _____

Does your child have any of the following? (List details as appropriate)		Yes	No
Asthma	_____	☐	☐
Inhaler	_____	☐	☐
Heart condition	_____	☐	☐
Vision loss	_____	☐	☐
Epilepsy	_____	☐	☐
Diabetes	_____	☐	☐
Kidney condition	_____	☐	☐
Hearing loss	_____	☐	☐
Allergies	_____	☐	☐
Medication Allergy	_____	☐	☐
Severe headaches	_____	☐	☐

Previous injuries/surgeries (month/year) _____
_____

Is your child on any medication that is taken on a regular basis? (List) _____
_____

Does your family have a primary care physician? (Name & phone#}_____

Does your family have an orthopaedic doctor? (Name & phone#} _____

My child may take any over-the-counter medication such as Tylenol®/Advil® YES NO

_____ _____
Parent/Guardian Signature Date

PRISMA HEALTH®

PrismaHealth.org

Notice of Privacy Practices

This Notice describes how medical information about you may be used and released and how you can get this information. Please read it carefully.

Prisma Health makes every effort to keep your health information private. Each time you visit a Prisma Health facility (doctor's office, clinic, hospital or outpatient center), a record is made. This health or medical record often includes your symptoms, exams and tests, diagnoses, treatment, and care plan. We need this record to give you high-quality care and to meet legal requirements.

This *Notice of Privacy Practices* (hereafter referred to as Notice) applies to all health records produced at Prisma Health, including those received from other providers. It outlines how we may use and give out information about you for treatment, payment or healthcare operations, and other purposes granted or required by law. It also describes your rights to get and control your record, and legal requirements we have on its use and release.

This Notice applies to all Prisma Health sites, including offices of physicians employed by Prisma Health, and to all physicians and other healthcare providers who deliver healthcare services at any Prisma Health site (please see end for participating facilities*). It does not apply to care you receive from physicians or other healthcare providers at their private offices (unless the physician or other healthcare provider is employed by Prisma Health) or at any non-Prisma Health site.

We also participate in Prisma Health Networks in the Midlands and Upstate (formerly Palmetto Health Quality Collaborative and MyHealth First Network, respectively): We may share your records with physicians and other healthcare providers who are members of a Prisma Health Network. Members of the Prisma Health Networks are operationally or clinically integrated and may participate jointly in utilization review, quality assessment and improvement, or payment activities. If you would like a list of members in the Prisma Health Midlands Network, please go to **https://Doctors.thephqc.org/Search**. For a list of members in the Prisma Health Upstate Network, please go to **www.PHUpstateNetwork.org/Directory**.

Availability of your health information to providers outside Prisma Health

Your medical records at Prisma Health are primarily maintained in an electronic medical record system called Epic; however, there may also be legacy systems that house your medical records from previous sites. Your health information may be available to other healthcare providers who also use Epic. For example, if you are in an accident in another state and are taken to an emergency room, that facility may access your record through Epic's Care Everywhere to learn about your allergies and important medical history. If you do not want your electronic medical record to be available to non-Prisma Health providers in this way, you may request to opt out in MyChart or contact the Prisma Health Health Information Management Department, and request to "opt out of Care Everywhere."

We also share a common medical record with certain unaffiliated healthcare providers through Epic's Community Connect. Community Connect may improve your patient care experience by providing other healthcare facilities with your complete medical history. All Community Connect users are guided by the same privacy and security standards as Prisma Health. A complete list of these Community Connect participants is available at **www.PrismaHealth.org/CommunityConnect**.

The law requires Prisma Health to do the following:

- Maintain the privacy of your health information
- Describe our legal duties and privacy obligations related to your health information
- Abide by the terms of the current Notice of Privacy Practices
- Notify you if there is a breach of your unsecured personal health information (PHI)
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- Notify you if we are unable to agree to a requested restriction

We reserve the right to change the practices and terms of this Notice, and the changes will be effective for the information we already have about you as well as any information we receive in the future. The Notice will list the effective date in the top right-hand corner of the first page. Each time you register at or are admitted to Prisma Health as an inpatient or outpatient, you may have a copy of the Notice. We will post it in our facilities and on our website. You may also call our Privacy Office at **864-797-7755** for a copy or download a PDF version of this document at **www.PrismaHealth.org/PrivacyPractices**.

Routine uses and disclosures of your health record

The following sections describe how we use and release medical information. Each section explains what we mean and gives a few examples. (Note: These examples are not all-inclusive.)

Treatment

We use medical information about you to provide, coordinate and manage your treatment or services. We may give this information to doctors, nurses, specialists, technicians, students of affiliated healthcare programs, volunteers or other team members who care for you. Such people may share information about you to coordinate your needs, such as lab work or prescription drugs.

Examples of how your health record might be used for treatment reasons:

- A doctor treating your broken leg may need to know if you have diabetes, which slows healing. Also, the doctor may need to tell the dietitian that you have diabetes so as to arrange special meals for you.
- We may send your record to specialists your doctors here may want to consult.
- Your record may be sent to a doctor to whom you have been referred.
- We would share your record with a facility you are being transferred to or one that you are considering transfer to once you leave Prisma Health.
- We may use and release your health record to provide material on treatment options.

Payment

We use and release health information so that treatment and services you receive may be billed to and payment collected from you, an insurance company or a third party.

Examples of how your health record might be used for payment purposes:

- We may call your health plan for pre-approval of a service to determine whether your treatment will be covered.
- We may give your health plan details about your care, so it will pay us or reimburse you. For example, if you have a broken leg, we may need to give your health plan(s) information about your condition and supplies used.
- We may use and disclose your health information to other providers so that they may bill and collect payment for treatment and services they provided to you.
- We may share your health information with billing and collection departments or agencies, insurance companies and health plans to collect payment for services, departments that review the appropriateness of the care provided and the costs associated with that care, and to consumer-reporting agencies (for instance, credit bureaus).

Healthcare operations

We may use and release your record to support our business functions (such as administrative, financial and legal activities). These uses and disclosures are needed to run the hospital, support treatment and payment, and help patients receive high-quality care. Activities may include measuring quality, reviewing employee performance and training students.

Examples of how your health record might be used for healthcare operations:

- Reviewing and improving the quality, efficiency, and cost of care that we provide to you and other patients
- Evaluating the skills, qualifications and performance of healthcare providers taking care of you
- Providing training programs for students, trainees, healthcare providers and non-healthcare professionals (for example, billing clerks) to help them practice or improve their skills

Facility directory

We may include certain facts about you in our directory while you are a patient at a Prisma Health hospital, clinic or doctor's office. These facts may include your name, location, general condition (such as fair or stable) and religious affiliation. They also may be shared with those who ask for you by name (except for religious affiliation). Your affiliation may be given to clergy members – even if they don't ask for you by name – so family members, friends and clergy can visit you or know how you are doing. However, if you do not want your information listed in the hospital directory, please notify Registration when you arrive or call the facility's Admitting Office.

People involved in your care or payment for your care

We may share your health information with a family member, friend, or other person you identify or is involved in your care or payment for details about you relating to that person's involvement in your care. However, Prisma Health respects your right to choose not to have your information shared. If you cannot physically or mentally agree or object to a disclosure, we may supply information where necessary. We may also share facts with someone helping in a disaster relief effort so that family can know of your condition, status and location.

Business associates

Business associates of Prisma Health provide some services related to treatment, payment and business operations. For example, we may use a copy service to make copies of your medical record. When we hire companies to perform these services, we may disclose your health information to these companies so that they can perform the job we have asked them to do. We have a written agreement that requires associates to protect your health information in the course of performing their job.

Photographs, video and audio recordings

We may take photographs, video and/or audio recordings during the course of your treatment. These photographs and recordings will only be used for treatment, payment and healthcare operations unless you provide us written authorization permitting other use.

Email and text messaging

To help coordinate your care, you may receive email and text messages that include reminders for scheduling and scheduled appointments, recommended tests, and other information to help you manage your health. These messages may come from your provider, Prisma Health or from our partners who are helping manage your care. Such email notices and text messages are unencrypted and are, therefore, considered unsecure communications. As a result, they will not include information specific to your clinical information. However, they may include information that would be of interest to you because of your health condition.

When we send text messages, we will never transmit your full name or address in the text message. You may opt out

of our text messages by notifying a Prisma Health team member, responding to the "Opt Out" in the text message or choosing your communication preferences in our MyChart patient portal.

Special uses and disclosures of your health record

Emergencies
We may use or release your health information during emergencies.

Research
Under certain circumstances, we may use and disclose health information about you for research purposes. All research projects, however, are subject to a special approval process. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We may, however, use health information about you in preparing to conduct a research project, for example, to look for patients with specific needs.

Fundraising
Prisma Health is a not-for-profit health organization that relies on generous support from patients and families to continue vital healthcare, research and education operations. We may use your demographic information such as name, address and birthday to contact you regarding fundraising opportunities. We may also use the dates you received treatment or services, department of service, outcomes information and treating information. You have the right to elect not to receive fundraising communications. Please call us at **864-797-7755** (Privacy Line) if you wish to have your name removed from the list to receive fundraising requests supporting Prisma Health in the future. Your decision not to receive fundraising communications will have no impact on your ability to receive healthcare services at any Prisma Health facility.

Workers' compensation
We may release information about you to comply with workers' compensation laws or similar programs.

Legal proceedings
We may release health information about you for the following reasons:
- Court or administrative order
- Subpoena, discovery request or other lawful process

Legal requirements
We will give out medical information about you when required to do so by federal, state or local law.

Serious threat to health or safety
We may use and release information about you to prevent a serious threat to your health and safety or the health and safety of others.

Health oversight activities
We may supply information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. These activities help the government oversee healthcare systems, benefit programs and civil rights laws.

Public health risks
We may release information about you to local, state or federal public health agencies (such as the Food and Drug Administration and the Department of Health and Environmental Control) for reasons such as the following:
- To prevent or control disease, injury or disability
- To report births and deaths
- To report adverse events, product defects or problems, or drug reactions
- To note product recalls
- To notify a person who may have been exposed to a disease or may be at risk for getting or spreading one

To avert a serious threat to health or safety and to report abuse
We may disclose your health information to a government agent if we believe you have been the victim of abuse, neglect or domestic violence. We also may disclose your information where necessary to protect your health and safety or the health and safety of the public or another person. Disclosures are made only to those people able to help prevent or reduce the threat.

Sensitive information
Certain types of personal or medical information may be used or disclosed to the individuals described in this Notice, including (but not limited to):
- Information about genetic testing, such as lab tests of DNA or chromosomes, conducted to discover diseases or illnesses of which you are not showing symptoms at the time of the test and that arise solely as a result of defects or abnormalities in genetic material.
- Information showing (1) whether you have been diagnosed as having AIDS, (2) whether you have been or are currently being treated for AIDS, (3) whether you have been infected with HIV, (4) whether you have submitted to an HIV test, (5) whether an HIV test has produced a positive or negative result, (6) whether you have sought and received counseling regarding AIDS and (7) whether you have been determined to be a person at risk of being infected with AIDS.
- Information about suspicion of, diagnosis for, or treatment of mental illness or developmental disability.
- Information about communicable, venereal, infectious and/or sexually transmitted diseases (HIV/AIDs, hepatitis, syphilis, tuberculosis, chancroid, gonorrhea, etc.).
- Information about pregnancy, prevention of pregnancy (including birth control), childbirth or abortions.
- Information about diagnosis, treatment, detoxification, or rehabilitation for alcohol or drug use or abuse.

Coroners, funeral directors and organ donors
We may release information to coroners or medical examiners to identify a deceased person, find cause of death, or carry out duties as required by law. We may also give information to funeral directors to meet their duties and may share such information in the reasonable anticipation of death. We may supply your health record to organ donor groups as approved by you or consistent with the law. A deceased person's health information remains under privacy protection for 50 years after death.

Military, veterans and national security

If you are a member of the armed forces, we may release information about you as required by military authorities. We may also share information about foreign military personnel to the appropriate foreign military authority. We may give information about you to federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Law enforcement

We may release your health information to a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar legal process
- To identify or locate a suspect, fugitive, witness or missing person
- To provide information about the victim of a crime if, under certain cases, we cannot get the person's agreement or as required by law
- In case of a death we believe may be the result of criminal conduct
- In response to criminal conduct at the hospital
- In an emergency to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

Inmates

If you are an inmate of a correctional institution or in custody of a law enforcement official, we may release medical information about you to that facility or person.

Telemedicine

Healthcare services may be provided via telemedicine, which means an image, video recording and/or audio of you may be used to allow healthcare providers at different locations to see you on a computer screen or view your medical records. Telemedicine may be used for diagnosis, therapy, follow-up and/or education, and may include: your medical records, medical images, live two-way audio and video, output data from medical devices, and sound and video files. Electronic systems used will incorporate network and software security protocols to help protect the confidentiality and integrity of your identity and imaging data.

Marketing

Prisma Health may use your information to contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. From time to time, your healthcare provider or designee may contact you to request your permission to take part in health education and/or promotion. If Prisma Health receives compensation for a marketing-related activity, your authorization is required.

Your health information rights

Review and copy

You have the right to review and request a copy of your health record in either an electronic or paper form. This information may include medical and billing records but, under federal law, excludes psychotherapy notes (access to psychotherapy notes is restricted to the treatment team only). To request electronic access to your records, please request access to your patient portal during the registration process at any Prisma Health facility. You may also request consideration of other electronic means by contacting the Health Information Management Department of Prisma Health using the contact information listed at the end of this Notice.

To request a paper copy of your health record, write to the Health Information Management Department of Prisma Health at the address listed at the end of this Notice. There may be a fee for costs involving copying, mailing and related supplies. We will respond to you within 30 days of receiving your written request if your record has been maintained in our facility. If your record has been maintained in a secure off-campus location, we will respond within 45 days.

We may deny your request to inspect and copy in certain cases. If we deny your request, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. Another licensed healthcare professional chosen by Prisma Health will examine your request. The reviewer will not be the person who denied your request. Prisma Health will comply with the outcome of the review.

Amend

If you believe that information we have about you is incorrect or incomplete, you may ask us to modify or add to the information. You have the right to request a change or addition for as long as the record is kept by Prisma Health. Request your change in writing to the Health Information Management Department. You must give a reason that supports your request. To obtain a form to amend, please contact the Health Information Management Department (contact information appears at the end of this Notice).

We may deny your request if it is not in writing or does not include a reason to support the request. We also may deny a request to modify a medical record in these cases:

- The current information is accurate and complete.
- It is not part of the medical information kept by or for Prisma Health.
- It is not part of what you would be allowed to view and copy.
- It was not created by us.

If we deny this request, you have the right to file a statement of disagreement. We may then prepare a rebuttal. We will give you a copy of the rebuttal and maintain your request to modify in your medical record.

Accounting of disclosures

You have the right to request an "accounting of disclosures" (a list of disclosures made about you for reasons other than treatment, payment, healthcare operations or national security). We are required to respond to your request within 60 days.

We are required to provide a listing of all disclosures except the following:

- For your treatment
- For billing and collection of payment for your treatment
- For our healthcare operations

- Occurring as a byproduct of permitted uses and disclosures
- Made to or requested by you or that you authorized
- Made to individuals involved in your care, for directory or notification purposes, or for disaster relief purposes
- Allowed by law when the use and/or disclosure relate to certain specialized government functions or relates to correctional institutions and in other law enforcement custodial situations
- As part of a limited set of information that does not contain certain information which would identify you

The list will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed and the purpose of the disclosure. Request this list in writing to the Health Information Management Department at the appropriate address listed at the end of this Notice. Your request must state a period of time, which may not be longer than six years before the date of your request.

The first list you request within a 12-month period will be free. Additional lists may involve a charge. We will notify you of the cost, and you may cancel or adjust your request before any fees are incurred.

Request restrictions

You have the right to request that we limit information we use or give out about you for treatment, payment or healthcare operations. You also have the right to request a limit on what we release to someone involved in your care or payment for your care, such as a family member. For example, you could ask that we not use or give out information to your family about a surgery that you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the material is needed for emergency treatment. Requests for restrictions should be sent to the facility's Health Information Management Department found at the end of this Notice. We will respond to your request in writing within 30 days.

You have the right to request that we not disclose to your health plan health information or services for which you paid out of pocket before the performance of those services.

Request confidential communications

You have the right to request that we interact with you about medical matters in a certain way or place. For example, you can ask that we contact you only by mail or at work. To request confidential communications, notify a Prisma Health team member during admission or registration. You may also communicate your request in our MyChart patient portal. You must indicate how or where you wish to be contacted. We will try to meet all reasonable requests.

Electronic copy of this notice

In addition to a paper copy of this notice, you may download a PDF version of this document at **www.PrismaHealth.org/PrivacyPractices**.

Complaints

If you believe your privacy has been violated, you may file a complaint with Prisma Health, with the Secretary of the Department of Health and Human Services or with the South Carolina Department of Health and Environmental Control (DHEC).

To file a complaint with Prisma Health, call our Privacy Office at **864-797-7755** or Patient & Family Relations at **864-455-7975**. To file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights, send a letter to 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201; call **1-800-368-1019**, TDD **1-800-537-7697**; or visit **www.hhs.gov/hipaa/filing-a-complaint**.

To file a complaint with DHEC, send a letter to 2600 Bull St., Columbia, SC 29201; call **1-803-898-3316**; or go to **adacomplaints@dhec.sc.gov**.

Other uses

Other uses and disclosures of medical information not covered by this Notice or relevant laws will be made only with your written consent. If you allow us to use or release health information about you, you may cancel that consent, in writing, at any time. If you revoke it, we will no longer use or release information for the reasons covered by your written consent. (Note: We cannot take back disclosures already made with your consent.)

To request a copy of, review of, or amendment to your health record, please write to:

Health Information Management (Columbia)
Prisma Health Baptist Hospital
Taylor at Marion St. · Columbia, SC 29220
P 803-296-5864

Health Information Management (Sumter)
Prisma Health Tuomey Hospital
129 N. Washington St. · Sumter, SC 29150
P 803-774-8710

Health Information Management (Upstate)
Prisma Health Medical Records Department
255 Enterprise Blvd., Ste. 120 · Greenville, SC 29615
P 864-455-4566

Prisma Health participating facilities include, but are not limited to, all Prisma Health hospitals, surgery centers, clinics, laboratories, pharmacies, Lila Doyle, Cottingham Hospice House and Prisma Health Medical Group. For a complete list, please visit **www.PrismaHealth.org/Locations.*