NOTICE OF PRIVACY PRACTICES

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.

A. MY OBLIGATION TO YOU

I am committed to protecting the privacy of your health care information. This Notice of Privacy Practices ("Notice") describes how I may use and disclose your "Protected Health Information." "Protected Health Information" also known as "PHI" includes information that identifies you and the health care you receive. I may use or disclose your PHI to provide treatment to you, to seek payment for the treatment provided, to support my health care operations, and for other purposes that are permitted or required by law. I am required by law to maintain the privacy of your PHI. I am required to give you this Notice to describe my legal duties and privacy practices concerning your PHI and your rights. I must abide by the terms of this Notice, as it may be changed from time-to-time.

There are other laws and rules that provide additional protections for health information related to treatment for mental health, alcohol and other substance abuse, and HIV/AIDS. I also follow the requirements of these laws.

B. HOW I USE AND DISCLOSE INFORMATION:

I will use and disclose your PHI for the following types of activities. Please note that not every type of use or disclosure is listed in this Notice.

For TREATMENT. "Treatment" means the provision, coordination, or management of your health care and related services by me and other health care providers involved in your care. It includes the coordination or management of health care by me with a third party, consultation between my practice and other health care providers relating to your care, or my practice's referral of you to another health care provider or facility, such as a laboratory. For example, I may *use* your PHI within my office for treatment with other health care providers. I may *disclose* your PHI outside my office, such as by sending your medical record to physician who is also providing you treatment. As between health care providers, requests for your PHI is assumed to be made for the minimum amount necessary for that treatment.

For PAYMENT. Payment means my activities to obtain reimbursement for the health care treatment provided to you, including billing, claims management, and collection activities. Payment also may include your insurance company's work to determine eligibility, for claims processing, to assess medical necessity, and for utilization review. For example, prior to providing treatment, I may *use* your PHI to confirm that your health insurer will pay for the treatment. I may *disclose* your payment information to a laboratory that provided treatment in order for the laboratory to bill for its services.

For HEALTH CARE OPERATIONS. Health care operations means my business activities that are necessary to run my office and to make sure clients receive quality care. These activities include, but are not limited to, quality assessment and improvement activities; peer review of health care professionals; medical review, legal services and auditing functions; business planning and development; and business management and general administrative activities. For example, I may *use* your PHI to review the treatment by my health care providers. Additionally, I may *use* a client sign-in sheet at the front desk. I may *disclose* your PHI to another health care provider for its operation activities under certain circumstances, such as for quality assessment.

To OTHER PROVIDERS. I may disclose your PHI for other health care providers' treatment, payment and operations relating to you.

To THIRD-PARTIES. I may disclose PHI to other persons and companies who perform services related to my treatment, payment or health care operations for you, such as billing or transcription services. These third-parties are my "Business Associates." I require these third-parties to protect your privacy based on the same legal standards I follow.

To PERSONS INVOLVED IN YOUR CARE OR INVOLVED IN PAYMENT FOR YOUR CARE, AND NOTIFICATION. Unless you object, I may disclose to a family member, other relative, close personal friend or any other person identified by you, your PHI related to that person's involvement in your health care or

payment related to your health care. I may also use PHI to notify a family member or other person responsible for your care (or a disaster relief organization) about your health condition or location. You may restrict disclosures of PHI to certain family members and other relatives, or to only such persons that you identify as permitted to receive PHI.

For APPOINTMENTS and SERVICES. I may use or disclose your PHI to notify or remind you of an appointment. I may call your home or business, leave a message for you, or mail a post-card. I may also use or disclose your PHI to contact you about treatment alternatives or health-related benefits or services that may be of interest to you.

For FUNDRAISING AND MARKETING. With your written authorization, I may use and disclose contact information and the dates of your care, *but not your treatment information*, to contact you for fundraising. If I do, you will be told how you may request not to be contacted in the future. I may receive written authorization to use or disclose your PHI for marketing or sales purposes.

C. USES AND DISCLOSURES WITH YOUR WRITTEN AUTHORIZATION. *Except as otherwise described in this Notice, I may not use or disclose PHI without your written authorization, which you may revoke*.

You may request that I use or disclose all or part of your PHI. Use and disclose may be authorized to specified individuals or other recipients for a defined purpose over a particular timeframe. Authorizations will be required to disclose sensitive PHI, such information about mental health or psychiatric treatment (unless an emergency situation exists), HIV status, substance abuse treatment, or for Psychotherapy Notes. While most authorizations must be in writing, in certain circumstances, I will accept oral authorizations to the extent permitted by Maine law. The minimum necessary amount of your PHI will be disclosed to comply with your authorization.

You may revoke your authorization at any time, but only regarding future uses or disclosures and only to the extent I have not already used or disclosed your PHI in reliance on your authorization. If your authorization was provided as a condition of your obtaining insurance coverage, then if the insurer has a right to contest a claim, the revocation may be ineffective. I may also accept oral revocations and certain electronic revocations of authorizations, but I request that you follow this with a revocation in writing.

D. USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION

In EMERGENCIES. If you are unable to provide an authorization or otherwise incapacitated, and require emergency medical treatment, I will use and disclose your PHI for you to receive health care treatment. I will attempt to obtain your authorization, as soon as practical.

As REQUIRED BY LAW. In certain circumstances, I may disclose your PHI to the extent and under the circumstances Required by Law.

For PUBLIC HEALTH ACTIVITIES. I may disclose your PHI for public health activities such as keeping birth or death records, preventing or controlling communicable disease, ensuring the safety of drugs and medical devices, reporting child abuse or neglect, or for workplace surveillance or work related illness and injury.

To REPORT ADULT ABUSE OR NEGLECT; DOMESTIC VIOLENCE; RISK OF HARM. I may disclose your PHI in connection with reports that I may be required or authorized to make regarding abuse, neglect or domestic violence. Such disclosure will be limited to the extent required by law, or if disclosure is authorized but not required, will be made as necessary to prevent serious harm to you or others. I may also make such disclosure if you agree. To the extent that the disclosure will be made, I will promptly inform you or your Personal Representative, unless I believe informing you or your Personal Representative would place you at risk of serious harm.

For HEALTH OVERSIGHT ACTIVITIES. I may disclose your PHI to health oversight agencies for activities authorized by law, including audits, civil, administrative or criminal investigations, licensure or disciplinary actions, and monitoring of compliance with applicable civil rights law and government benefit programs such as Medicaid and Medicare.

In JUDICIAL PROCEEDINGS. I may, under certain circumstances, disclose your PHI in response to court or administrative orders; or subpoenas, discovery requests

or other process after reasonable efforts to notify you or obtain a qualified protective order.

To LAW ENFORCEMENT. I may disclose your PHI if the disclosure is required by law or in compliance with certain warrants or subpoenas, court or administrative orders; to identify or locate suspects, fugitives, witnesses or missing persons; and regarding victims or perpetrators of crimes or suspected crimes (with your consent in some circumstances).

To CORONERS, MEDICAL EXAMINERS, and FUNERAL DIRECTORS. I may disclose your PHI to identify a deceased person, to determine cause of death, or as reasonably necessary to permit them to carry out their lawful duties.

To ORGAN DONATION ORGANIZATIONS. I may disclose your PHI for organ procurement, eye or tissue transplantation or an organ donation bank as necessary to facilitate organ, eye or tissue donation and transplantation.

For RESEARCH PURPOSES. I may disclose your PHI for certain medical or scientific research, provided that an institutional review board authorized by law or a privacy board waives the authorization requirement or that measures are being taken to protect your PHI, or that the researcher makes certain representations regarding the use and protection of the PHI to be disclosed. In most circumstances you must sign a separate form specifically authorizing me to use and/or disclose your PHI for research. Identification of a client in a research report will continue to be prohibited.

To PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY. I may disclose your PHI in a manner that is consistent with applicable laws and professional ethics, to prevent or lessen a serious and imminent threat to the health or safety of any person or the public, and disclose PHI to someone in a position to prevent or lessen the threat, including to the target of the threat. Disclosure may also be made to law enforcement officials to identify or apprehend a person involved in a violent crime involving serious physical harm to a person, or if escape from a correctional institution or lawful custody is believed to have occurred.

To MILITARY AND VETERANS. I may disclose your PHI if you are in the armed forces, as required by command authorities, for the proper execution of a military mission.

For NATIONAL SECURITY, INTELLIGENCE ACTIVITIES, AND PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS. I may disclose your PHI to officials as authorized by law to perform their duties and conduct investigations.

To CORRECTIONAL FACILITIES. Regarding inmates, I may disclose your PHI to a correctional institution or law enforcement official to the extent required by law, by court order or as authorized by law or rule.

For WORKERS COMPENSATION. I may disclose your PHI as authorized by and to the extent necessary to comply with the Maine Workers' Compensation Act or other similar programs that provide benefits for work-related injuries or illness without regard to fault.

To THE U.S. DHHS. I must disclose your PHI to the Secretary of the U.S. Department of Health & Human Services to investigate or determine my compliance with the federal privacy laws and regulations.

E. YOU HAVE THE FOLLOWING RIGHTS: *To exercise these rights see the Contact Information in this Notice.*

To Obtain a Copy of this Notice on Request. You may request a paper copy of this Notice.

To Request a Restriction on Certain Uses and Disclosures. You have the right to request that I restrict uses or discloses of your PHI to carry out treatment, payment and health care operations. I am not required to agree to any restrictions that you may request. If I agree with your request, I will comply, except to the extent that disclosure has already occurred or if disclosure is needed to provide emergency treatment. I have the right to terminate my agreement to the restriction, if certain conditions are met.

To Inspect and Request a Copy of Your Health Record. Except for limited circumstances under State or Federal laws or regulations, you have the right to inspect and obtain a copy of your "Designated Record

Set" (the treatment information and billing records used in your treatment) that is part of your PHI. Your right to inspect and obtain a copy to your Designated Record Set may be limited under law or rule, or if disclosure is detrimental to the health of the client, in which case, I will ask you to appoint a Personal Representative to whom the Designated Record Set will be disclosed.

A fee may be charged to disclose a copy of your record. You may be provided with a narrative of your PHI, if you agree to receive one. You will be required to sign an authorization to receive your Designated Record Set. I will respond to your request within a reasonable time, but no later than 30 days from the date of your request, unless I provide you with written notice regarding a delay.

If you are denied access to your designated record set for any reason, I will inform you about the reason and your rights to challenge this decision. I am not required to provide you with access to your Psychotherapy Notes or personal notes not related to your health care. I also am not required to provide you with information compiled in connection with a civil, criminal or administrative action or proceeding, or information obtained in other certain limited circumstances.

To Request an Amendment to Your Health Record. You have the right to request that I amend the PHI in your "Designated Record Set" (the treatment information and billing records used in your treatment) that is part of your PHI. If you believe that your PHI is incorrect or needs clarification, you may request that I correct or clarify your health information, and you may provide information that corrects or clarifies your health information. Your request must be in writing and give a reason. I will respond to your request no later than 60 days from the date of your request, unless I provide you with written notice regarding any delay. I may deny your request in certain circumstances, such as a request to amend billing information created by another health care provider. (If this occurs, I will provide you with a denial in writing and your rights to address the denial.)

I will not delete any health information or PHI in your records. I may charge reasonable costs for correcting or clarifying your health information or amending your Designated Record Set. I may add a statement to your PHI in response to your correction or clarification, and if so, I will provide you with a copy of this statement.

I will require that you identify persons who have received disclosure of the PHI that you have corrected, clarified or amended and will request your agreement to share the corrected, clarified or amended PHI with such person(s) and with my Business Associates or others that may have relied on the PHI to your detriment.

To Request an Accounting of Disclosures of Your Protected Health Information. Subject to certain limitations, you have the right to a written accounting of disclosures that I have made of your PHI. Accounting of Disclosures will not include disclosures that occurred prior to April 14, 2003 or for more than 6 years prior to the date of your request for accounting. This accounting will not include disclosures made for purposes of treatment, payment or health care operations. It will also not include disclosures to you or authorized by you; disclosures incidental to a permitted disclosure; or certain other disclosures excluded by regulation. The right to receive an accounting is subject to certain other exceptions, restrictions and limitations set forth in applicable statutes and regulations. I will respond to your request for an accounting no later than 60 days from the date of your request, unless I provide you with written notice regarding any delay. I will provide you with one accounting every 12 months free of charge. I will charge a fee for any additional accounting of disclosures within a one-year period.

To Request that I Contact you by Alternate Means. You have the right to reasonable accommodation of a request to receive communications of PHI by alternative means (for example, fax versus mail) or contact at an alternate location (address or phone number). Your request must be in writing, and I will agree if the request is reasonable. I will not require an explanation of your reason for the request as a condition to agreeing to your request, but I may require you to provide information regarding how payment will be handled and that you specify an alternative address or other method of contact.

F. CONTACT. To exercise any of the above rights, or if you have any questions, contact me at (207) 967-4929. If you believe your privacy rights have been violated, you may file a complaint with me, in writing, addressed to

Christy A. Cole
2 Christensen Lane, Suite 2
Kennebunk, ME 04043

There will be no retaliation for filing a complaint. You also may complain to the Secretary of the Department of Health and Human Services.

G. CHANGES TO THIS NOTICE I reserve the right to change this Notice. I reserve the right to make the revised or changed Notice effective for PHI I already have about you as well as for any PHI I receive in the future. I will post a copy of the current Notice at my office. You may obtain a paper copy of the current Notice in effect by calling me at any time and requesting that one be sent to you by mail or by asking for one when you are in the office.

EFFECTIVE DATE April 14, 2003

I will ask that you acknowledge receipt of this Notice, because I am required to make a good faith effort to obtain your signed acknowledgement.

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Patient/Guardian Signature