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NOTICE

OF

PRIVACY POLICY

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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 CARE-FULLY.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (I-HPAA), you have a right to adequate notice of the uses and disclosures of your protected health information ("PHI") (i.e., information that discloses your identity or leads to disclosure of your identity) that may be made by this medical practice. You are also entitled to notice of your rights and the duties of this practice with respect to your personal health information.

We respect your right to privacy and understand that your medical information is personal to you. In order to provide medical services to you, we create paper and electronic records about your health and the care we provide. Your personal health information is confidential and this notice is intended to help you understand how our practice uses and discloses your personal health information and what rights you have with respect to your medical information.

Required by Law

My practice has the following duties with respect to your personal health information:

1. We are required by law to maintain the privacy of your personal health information.
2. We must provide you with notice of our legal duties and privacy practices with respect to personal health information.
3. We must abide by the terms of the notice of privacy practices that is currently in effect.

How We May Use and Disclose Your Information

The following describes how my practice is permitted by law to share your personal health information with others in order to provide you with medical care. This notice does not describe every use or disclosure our practice makes; it is intended as a general overview.

Medical Treatment. We may need to share information about you in order to provide medical care to you. For example, we may share information with other physicians, nurses or healthcare professionals entering information into your medical records relating to your medical care and treatment. We may share information about you including x-rays, prescriptions and requests for lab work.

Payment. We may need to disclose information about the treatment, procedures or care my practice provided to you in order to bill and receive payment for services I provided. We may share this information with you, an insurance company or any third party responsible for payment. We may also need to disclose personal health information about you with your health plan and/or referring physician in order to obtain prior authorization for treatment, to determine whether payment for the treatment is covered by your plan or to facilitate payment of a referring physician.

Healthcare Operations. In order to help me run my practice more efficiently and provide better care, I may use and disclose your personal health information to Business Associates who need to use or disclose your information to provide a service for my medical practice, such as my software vendor who occasionally provides assistance with data management on my behalf.

Required by Law. We will disclose medical information related to you if required to do so by state, federal or local law.

Public Health Activities/Risks. Your medical information may be disclosed to a public health authority that is authorized by law to collect or receive such information for public health activities. Certain disclosures may be made for public health activities in the following circumstances:

1. to prevent or control disease, injury or disability;
2. to report of births or deaths;
3. to report child abuse or neglect;
4. to report reactions to medications or product defects;
5. to notify individuals of product recalls;
6. to notify a person who may have been exposed to a communicable disease or at risk of contracting or spreading a disease or condition;
7. if our practice reasonably believes a person is the victim of abuse, neglect, or domestic violence, we may disclose personal health information to the appropriate authority. We will only make this disclosure if you agree to the disclosure or we are required or authorized to do so by law without your permission.

Appointment Reminders or Treatment Alternatives. My practice may use and disclose medical information about you to provide you with reminders that you are due for care or you have an upcoming appointment. We may also wish to provide you with information on treatment alternatives or other health related benefits that may be of interest to you. We may contact you by phone, fax or mail. We will make every effort to protect your privacy when leaving a message for you and try to reveal as little confidential information as possible (e.g., when leaving a message on your answering machine that may be heard by others).

Research. Under certain circumstances, my practice may use or disclose your personal health information for research purposes. My practice cannot use or disclose information about you without your written authorization, but we may if the authorization requirement has been waived by a Review Board who has assessed the effect of the research protocol on your privacy rights and interests and certified that there are adequate controls in place to protect your information from improper use and disclosure. My practice may also disclose information about you in preparing to conduct research (e.g., to help them find patients who may be qualified to participate in a particular study). We will make all attempts to make your information non-identifiable, but we may not always be able to guarantee this. If however, the researcher will have access to information that will identify you, we will seek to obtain your permission (though we cannot guarantee this). We will always obtain your specific authorization if required by law.

To Avert Serious Threat to Health or Safety. If my practice believes, in good faith, that a use or disclosure of your medical information is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, we may disclose your medical information.

Worker 's Compensation. We may release medical information about you for work-related illness or injury for workers' compensation or other related programs.

Health Oversight Activities. Your personal health information may be disclosed to federal, state or local authorities as part of an investigation or government activity authorized by law. This may include audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary actions or other activi-

ties necessary for the oversight of the health care system, government benefit programs and compliance with government regulatory programs or civil rights laws.

Law Enforcement. We may disclose your personal health information to law enforcement individuals if we are required to do so by law. We may also disclose medical information about you in compliance with a court order, warrant or subpoena or summons issued by the court. We will make best efforts to contact you about these types of requests so that you can obtain an order restricting or prohibiting disclosure of the information requested. We may also use such information to defend ourselves in actions or threatened actions that may be brought against our practice.

Coroners, Medical Examiners and Funeral Directors. We may release personal health information to a coroner or medical examiner for the purposes of identification, determining cause of death or other duties as authorized by law. We may also release medical information to funeral directors as necessary to carry out their duties with respect to the deceased.

Organ, Eye, Tissue Donation. If you are an organ donor, we may disclose your personal health information to organ procurement organizations, or other entities that facilitate tissue donation or transplantation.

Inmates. If you are an inmate of a correctional institution or within the custody of law enforcement officials, we may disclose medical information about you to allow the institution to provide you with medical care, to protect the health and safety of yourself and others, or for the safety and security of the correctional institution.

Other uses and disclosures will be made only with your written authorization and you may revoke your authorization at any time.

Patient Rights

You have the following rights with respect to your personal health information:

Right to Receive Personal Health Information Confidentially. You have the right to receive confidential communications of your personal health information by alternate means or at alternate locations.
For example, if you would like for us only to communicate with you at home, and never at your workplace, you may request this of our practice. You must make this request in writing but do not need to disclose the reason for your request. We will attempt to accommodate all **reasonable** requests. Please be specific as to how or where you wish us to communicate with you.

Right to Inspect and Copy. You have the right to inspect and copy your medical record that has been created to treat you and is used to make decisions about your care. This includes medical and billing records. Records related to your care may also be disclosed to an authorized person such as a parent or guardian upon proper proof of a legitimate legal relationship. You must submit your request in writing to inspect and copy your records. If you would like to copy your records, my practice may charge you fees for the cost of copying records, mail or other minimal costs associated with your request. In some cases, the physician reserves the right to give you a summary of records in place of the actual records.

Right to Amend. If you think there is information in your record that may be inaccurate or incomplete, you have the right to request an amendment or clarification of information in your record. Your request to make an amendment to your record must include the following and may be refused if the following elements are not met:

1. Submit your request in writing
2. Describe what you would like the amendment to say and your reasoning for why the change should be made
3. The amendment must be dated, signed by you and notarized

Please note that we will not change information created by third parties, if the information is not part of the medical information kept by our practice or we believe the information you provided to us is inaccurate or incomplete. We reserve the right to deny your request if we have reason to believe our prior information is accurate.

Right to Restrict Uses and Disclosures. You have the right to request restrictions on how our practice makes certain uses and disclosures of your personal health information for treatment, payment or healthcare operations. You may restrict how much information we may provide to family members regarding your treatment or payment for your care. You may also restrict certain types of marketing materials related to your care or treatment. **We are not required to agree to your request or we may not be able to comply with your request, but we will do all that we can to accommodate your request. If we agree to your request, we must comply. However, if the information is required to provide emergency treatment to you, we may not comply.** Your request must be in writing and include the following:

1. what information you would like to limit
2. whether you want to limit our use, or disclosure or both
3. to whom you want the limits to apply (e.g., disclosures to parents, children, spouse, etc.)

Right to an Accounting of Uses and Disclosures. You have the right to receive an accounting of the disclosures of your personal health information that my practice makes for purposes other than treatment, payment or healthcare operations. All requests must be submitted in writing. All requests must be for disclosures after April 14,2003. All requests must state a time period **not longer than six (6) years** back. One request in a twelve-month period will be provided to you at no charge. We may charge you a fee for all additional requests within a twelve-month period. We will notify you as to the cost of fulfilling your additional request and allow you the opportunity to modify it before fees are due.

All requests should be submitted to the reception desk for appropriate processing.

Right to Copy of Notice. You have the right to obtain a copy of my notice of privacy practices upon request at any time. Please call our office for a copy or ask for a copy at the reception desk.

Changes to this Notice. My practice is required to abide by the terms of this notice, which is currently in effect. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all personal health information we already have about you and may obtain in the future. If we change our notice, we will post notice of this change thirty (30) days prior to making the change effective. All revised notices will be promptly posted and made available to you in our waiting room. You may also request a current Notice when you visit our office. Changes to my notice will become effective on the date that is reflected at the bottom of the last page on the revised Notice.

Practice Contact. If you would like more information about this notice, please contact one of the office locations on the front of this brochure. If you have any complaints regarding our privacy practices, please address your complaint to the office manager in writing and follow the designated complaint process below.

Complaints. If you believe your privacy rights may have been violated or you become aware of a privacy concern you would like to report to my practice, please follow this complaint process:

1. Send a written letter to the practice contact named above, including the following information:
   a. Name and Address
   b. Social Security Number
   c. Detailed description of the circumstances surrounding your complaint including dates, times and any relevant information to help us understand your complaint.
   d. Contact information
   e. Signature and Date

2. Please allow thirty (30) business days for an answer from our practice regarding your complaint.

3. If you are not satisfied with my response to your complaint, you may notify the Secretary of the Department of Health and Human Services.

Please note, all concerns or complaints regarding your personal health information are important to my practice. We encourage you to let us know how we may improve our services to you.

Additional Privacy Protections. My practice is committed to protecting your privacy and proper use and disclosures of your personal health information. For example, when patients are treated with particularly sensitive conditions, even though the law allows disclosure of information for various reasons, we will diligently try to protect that information unless required by law to disclose it.

In the office, our policy is to call you by name. Please let us know if you prefer to be assigned a number at the time of check-in.

Effective Date. April 14, 2003.