

ALLERGY ASSOCIATES OF CENTRAL IN
3266 North Meridian Street, P.O. Box 88380
Indianapolis, Indiana 46208
(317) 924-8206

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.

“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.”

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by writing to the Privacy Officer at P.O. Box 88380, Indianapolis, Indiana 46208 and requesting that a revised copy be sent to you in the mail.

How We May Use and Disclose Your Information

The following describes how our 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, healthcare professionals or other healthcare entities entering information into your medical records relating to your medical care and treatment. We may share information about you including x-rays, prescriptions, requests for lab work and other health care services. During the course of your care you may receive treatment in common patient areas.

Payment. We may need to disclose information about the treatment, procedures or care our practice provided to you in order to bill and receive payment for services we provided. We may share this information with you, an insurance company or any third party responsible for payment. We may also need to disclose relevant personal health information about you with your health plan, referring physician and/or other health care entities 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. We may need to disclose relevant personal health information to make a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations. We may use and disclose your personal health information to ancillary services who need to use or disclose your information to provide a service for our medical practice, such as our billing company or software vendors who provide assistance with data management on our behalf. We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and training of medical personnel.

Office Procedures. For example, we may disclose your protected health information to medical school students that see patients at

our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Our 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. 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).

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 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.

Research. We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research

proposal and established protocols to ensure the privacy of your protected health information. Under certain circumstances, our practice may use or disclose your personal health information for research purposes. Our 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 or Privacy 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. Our 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), but your information will not leave our practice. 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 our 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 activities necessary for the oversight of the health care system, government benefit programs and compliance with government regulatory programs or civil rights laws.

Law Enforcement and Legal Proceedings. 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 may also use such information to defend ourselves in actions or threatened actions that may be brought against our practice.

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

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities. These include but are not limited to the purpose of a determination by the Department of Veterans Affairs of your

eligibility for benefits, or to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

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. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to the Privacy Officer at P.O. Box 88380, Indianapolis, Indiana 46208.

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 or copy your records. If you would like to copy your records, our practice may charge you fees for the cost of copying records, mail or other minimal costs associated with your request per Indiana Law. This form is available by contacting the privacy officer.

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. This form is available by contacting the privacy officer.
- 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 the 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.

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 will not comply. This form is available by contacting the privacy officer.

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 our practice makes for purposes other than treatment, payment or healthcare operations. All requests must be submitted in writing. All requests must state a time period **not longer than six (6) years back**. All requests must be for disclosures dated **AFTER April 14, 2003**. One request in a twelve-month period; it 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.

This form is available by contacting the privacy officer.

Practice Contact: If you would like more information about this notice, please contact Privacy Officer at (317) 924-8206. If you have any complaints regarding our privacy practices, please address your complaint to Privacy Officer at PO Box 88380, Indianapolis, Indiana 46208 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 our practice, please follow this complaint process:

1. Send a written letter to the Privacy Officer named above, including the following information:
 - a. Name and Address
 - b. Social Security Number and date of birth
 - 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 fourteen (14) business days for an answer from our practice regarding your complaint.
3. If you are not satisfied with our 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 our practice. There will be no retaliation against you for filing a complaint with our office.

Privacy Officer Contact Information:

Privacy Officer

PO 88380

Indianapolis, IN 46208

Phone Number (317) 924-8206

Date of Last Revision. February 20, 2003

Effective Date. April 14, 2003.

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Acknowledgement and Receipt of Privacy Notice

First Name _____ Last Name _____ Date of Birth _____

Patient Number _____ (for office use only)

I, _____ acknowledge that I have received the Notice of Privacy Practices. If I have any questions, I may contact the Privacy Officer at Allergy Associates of Central Indiana 3266 North Meridian Street, P.O. Box 88380, Indianapolis, Indiana 46208

Date of Receipt _____

Office Use Only

Patient received copy of Privacy Notice without providing signature

Staff Signature _____ Date _____

Print Name _____