

Fairfield County Allergy, Asthma & Immunology Associates, PC

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how health information about you as a patient of this practice may be used and disclosed, and how you can get access to your individually identifiable health information. Please review this notice carefully.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices.

We realize that these laws are complicated, but we must provide you with the following information:

How we may use and disclose identifiable health information.

Your privacy rights regarding your PHI.

Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will always post a copy of our current notice in our offices in a visible location, and you may request a copy of our most current notice at any time. If you have any questions about this notice, please contact the office manager.

We may use and disclose your individually identifiable health information (PHI) in the following ways. The following categories describe the different ways in which we may use and disclose your PHI:

1. **Treatment:** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine), and we will use the results to help us reach a diagnosis. We might use your PHI to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. The people who work in our practice, including but not limited to doctors and nurses, may use or disclose your PHI to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment:** Our practice may use and disclose your PHI to bill and collect payment from you. We may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits) and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items.
3. **Healthcare Operations:** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose information for our operations, we may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
4. **Appointment Reminders:** Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. **Treatment Options:** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. **Health-related Benefits and Services:** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you. **Release of Information to Family/Friends:** Our practice may release your PHI to a friend or family member involved with your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter/nanny take their child to the office for treatment. In this example, this person might have access to this child's medical information.
7. **Disclosures Required by Law:** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

Use and Disclosure of Your PHI in Certain Special Circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information.

Public Health Risks: Our practice may disclose your PHI to public health authorities authorized by law to collect information for maintaining vital records, reporting child abuse or neglect, preventing or controlling disease, injury, or disability. This includes notifying individuals of potential exposure to communicable diseases, risks for spreading diseases, reactions to drugs, problems with products or devices, and notifying appropriate government agencies regarding potential abuse or neglect of adult patients, including domestic violence. However, we will only disclose this information if the patient agrees or if required by authorized law to do so. We may also notify your employer under limited circumstances related primarily to workplace injury, illness, or medical surveillance.

Health Oversight Activities: Our practice may disclose your PHI to a health oversight agency for activities authorized by law, including investigations, audits, surveys, licensure, disciplinary actions, and other activities necessary for monitoring government programs and compliance with civil rights laws and the healthcare system.

Lawsuits and Similar Proceedings: Our practice may use and disclose your PHI in response to a court or administrative order, involvement in a lawsuit or similar proceeding, or in response to a discovery request, subpoena, or similar legal process by another party involved in the dispute.

Law Enforcement: We may release PHI if requested by law enforcement officials regarding a crime victim, death believed to result from criminal conduct, criminal conduct in our offices, or in response to a warrant, summons, court order, subpoena, or similar legal process.

Deceased Patients: Our practice may release PHI as requested or required according to office policy.

Serious Threats to Health or Safety: Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or that of another person.

Military: Our practice may disclose your PHI if you are a member of the military forces, including veterans, and if requested by the authorities.

National Security: Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law or to officials conducting formal investigations.

Worker's Compensation: Our practice may release your PHI for worker's compensation and similar programs.

YOUR RIGHTS REGARDING YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

You have the following rights regarding the PHI that we maintain about you:

Confidential Communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you only at home or only at work. To request a type of confidential communication, you must make a written request specifying the method or location where you wish to be contacted. Our practice staff will accommodate reasonable requests. You do not need to give a reason for your request.

Requesting Restrictions: You have the right to request a restriction on our use or disclosure of your PHI. Additionally, you may request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment of your care, such as family and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. To request a restriction in our use or disclosure of your PHI, you must make your request in writing. Your request must describe the information you wish restricted, whether you are requesting to limit our practice's use, disclosure, or both, and to whom you want the limits to apply.

Inspection and Copies: You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records (excluding psychotherapy notes). You must submit your request in writing to our practice to inspect and/or obtain a copy of your PHI. Our practice charges a fee for the costs of copying, mailing, labor, and supplies associated with your request. We may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial by another licensed healthcare professional chosen by us.

Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be in writing and submitted to our practice. You must provide us with a reason that supports your request for amendment. Our practice won't deny your request if you fail to submit it in writing and the reason supporting your request. We may deny your request if you ask us to amend information that is, in our opinion, accurate and complete; not part of the PHI which you would be permitted to inspect or copy; or not created by our practice unless the individual or identity that created the information is not available to amend the information.

Accounting of Disclosures: All our patients have the right to request an "accounting of disclosures", a list of certain non-routine disclosures made of your PHI for non-treatment or operations purposes. Use of your PHI as part of routine patient care in our practice is not required to be documented. To obtain an accounting of disclosures, you must submit your request in writing to our practice. The request for an accounting of disclosures must state a time which may not be longer than 6 years from the date of disclosure and may not include dates before April 14th, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. We will notify you of the costs involved with additional requests, and you may withdraw your request before incurring any costs.

Right to a Paper Copy of This Notice: You are entitled to receive a paper copy of our notice of privacy practices at any time. To obtain a paper copy of this notice, contact any member of our practice.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, which must be in writing, contact the office manager at the location you are normally seen in. You will NOT be penalized for filing a complaint.

Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time **IN WRITING**. After you revoke our authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please don't, we are required to retain records of your care.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE OR OUR HEALTH INFORMATION PRIVACY PRACTICES, PLEASE CONTACT OUR ADMINISTRATOR

Fairfield County Allergy, Asthma & Immunology Associates

I acknowledge that I have received a copy of the privacy practices for Fairfield County Allergy, Asthma & Immunology Associates. This acknowledgement will be kept on file by them.

PATIENT NAME

DOB

PARENT/GUARDIAN

SIGNATURE

DATE