

PEACHTREE ALLERGY AND ASTHMA CLINIC, P.C.

NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMATION

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.

Federal regulations developed under the Health Insurance Portability and Accountability Act (HIPAA) require that the practice provide you with this Notice Regarding Privacy of Personal Health Information. The Notice describes (1) how the practice may use and disclose your protected health information, (2) your rights to access and control your protected health information in certain circumstances, and (3) the practices' duties and contact information.

I Protected Health Information

"Protected health information" is health information created or received by your health care provider that contains information that may be used to identify you, such as demographic data. It includes written or oral health information that relates to your past, present or future physical or mental health; the provision of health care to you; and your past, present, or future payment for health care.

II The Use and Disclosure of Protected Health Information in Treatment, Payment, and Health Care Operations

Your protected health information may be used and disclosed by the practice in the course of providing treatment, obtaining payment for treatment, and conducting health care operations. Any disclosures may be made in writing, electronically, by facsimile, or orally. The practice may also use or disclose your protected health information in other circumstances if you authorize the use or disclosure, or if state law or the HIPAA privacy regulations authorized the use or disclosure.

Treatment. The practice may use and disclose your protected health information in the course of providing or managing your health care as well as any related services. For the purpose of treatment, the practice may coordinate your health care with a third party. For example, the practice may disclose your protected health information to a pharmacy to fulfill a prescription medication, to an X-ray facility to order an X-ray, or to another physician who is administering your allergy shots, which we prepared. In addition, the practice may disclose protected health information to other physicians or health care providers for treatment activities of those other providers.

Payment. When needed, the practice will use or disclose your protected health information to obtain payment for its services. Such uses or disclosures may include disclosures to your health insurer to get approval for a recommended treatment or to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. When obtaining payment for your health care, the practice may also disclose your protected health information to your insurance company to demonstrate the medical

necessity of the care or for utilization review when required to do so by your insurance company. Finally, the practice may also disclose your protected health information to another provider where that provider is involved in your care and requires the information to obtain payment.

Operations. The practice may use or disclose your protected health information when needed for the practice's health care operations for the purposes of management or administration of the practice and of offering quality health care services. Health care operations may include: (1) quality evaluations and improvement activities; (2) employee review activities and training programs; (3) accreditation, certification, licensing, or credentialing activities; (4) reviews and audits such as compliance reviews, medical reviews, legal services, and maintaining compliance programs; and (5) business management and general administrative activities. For instance, the practice may use, as needed, protected health information of patients to review their treatment course when making quality assessments regarding allergy care or treatment. In addition, the practice may disclose your protected health information to another provider or health plan for their health care operations.

Other Uses and Disclosures. As part of treatment, payment, and healthcare operations, the practice may also use or disclose your protected health information to: (1) remind you of an appointment including the leaving of appointment reminder information on your telephone answering machine; (2) inform you of potential treatment alternatives or options; or (3) inform you of health-related benefits or services that may be of interest to you.

III Additional Uses and Disclosures Permitted Without Authorization or an Opportunity to Object

In addition to treatment, payment, and health care operations, the practice may use or disclose your protected health information without your permission or authorization in certain circumstances, including:

When Legally Required. The practice will comply with any Federal, State or local law that requires it to disclose your protected health information.

When There Are Risks to Public Health. The practice may disclose your protected health information for public health purposes, including to, as permitted or required by law:

1. Prevent, control, or report disease, injury, or disability;
2. Report vital events such as birth or death;
3. Conduct public health surveillance, investigations, and interventions;
4. Collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs, or replacements, and conduct post marketing surveillance;
5. Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease; and
6. Report to an employer information about an individual who is a member of the workforce for worker's compensation and similar programs.

To Report Abuse, Neglect or Domestic Violence. As required or authorized by law or with the patient's agreement, the practice may inform government authorities if it is believed that a patient is the victim of abuse, neglect or domestic violence.

To Conduct Health Oversight Activities. The practice may disclose your protected health

For Worker's Compensation. The practice may disclose your protected health information to comply with worker's compensation laws or similar programs.

IV Uses and Disclosures Permitted With An Opportunity to Object

Subject to your objection, the practice may disclose your protected health information (1) to a family member or close personal friend if the disclosure is directly relevant to the person's involvement in your care or payment related to your care; or (2) when attempting to locate or notify family members or others involved in your care to inform them of your location, condition or death. The practice will inform you orally or in writing of such uses and disclosures of your protected health information as well as provide you with an opportunity to object in advance. Your agreement or objection to the uses and disclosures must be in writing, and must describe in a clear and concise fashion:

- a. The information you wish restricted;
- b. Whether you are requesting to limit our practice's use, disclosure or both; and
- c. To whom you want the limits to apply

If you do not object to these disclosures, the practice is able to infer from the circumstances that you do not object, or the practice determines, in its professional judgment, that it is in your best interest for the practice to disclose information that is directly relevant to the person's involvement with your care, then the practice may disclose your protected health information. If you are incapacitated or in an emergency situation, the practice may exercise its professional judgment to determine if the disclosure is in your best interest and, if such a determination is made, may only disclose information directly relevant to your health care.

V Uses and Disclosures Authorized by You

Other than the circumstances described above, the practice will not disclose your health information unless you provide written authorization. You may revoke your authorization in writing at any time except to the extent that the practice has taken action in reliance upon the authorization.

VI Your Rights

You have certain rights regarding your protected health information under the HIPAA privacy regulations. These rights include:

The right to inspect and copy your protected health information. For as long as the practice holds your protected health information, you may inspect and obtain a copy of such information included in a designated record set. A "designated record set" contains medical and billing records as well as any other records that your physician and the practice uses to make decisions regarding the services provided to you. The practice may deny your request to inspect or copy your protected health information if the practice determines in its professional judgment that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referred to in the information. You have the right to request a review of this decision.

In addition, you may not inspect or copy certain records by law, including: (1) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and (2) protected health information that is subject to a law that prohibits access to protected health information. You may have the right to have a decision to deny access reviewed in some situations.

information to a health oversight agency for use in (1) audits; (2) civil, administrative, or criminal investigations, proceedings or actions; (3) inspections; (4) licensure or disciplinary actions; or (5) other necessary oversight activities as permitted by law. However, if you are the subject of an investigation, the practice will not disclose protected health information that is not directly related to your receipt of health care or public benefits.

Lawsuits and Similar Proceedings. The practice may disclose your protected health information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your protected health information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

For Law Enforcement Purposes. The practice may disclose your protected health information to a law enforcement official for law enforcement purposes when:

1. Required by law to report certain types of physical injuries;
2. Required by court order, court-ordered warrant, subpoena, summons, or similar process;
3. Needed to identify or locate a suspect, fugitive, material witness, or missing person;
4. Needed to report a crime in an emergency situation;
5. You are the victim of a crime in a specific limited instances; and
6. Your death is suspected by the practice to be the result of criminal conduct.

To Coroners, Funeral Directors, and for Organ Donation. The practice may disclose protected health information to a coroner or medical examiner for the purpose of (1) identification, (2) determination of cause of death, or (3) performance of the coroner or medical examiner's other duties as authorized by law. In addition, as permitted by law, the practice may disclose protected health information, including when death is reasonably anticipated, to a funeral director to enable the funeral director to carry out his or her duties. Protected health information may also be used and disclosed to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

To Prevent or Diminish A Serious and Imminent Threat to Health or Safety. If in good faith the practice believes that use or disclosure of your protected health information is necessary to prevent or diminish a serious and imminent threat to your health or safety or to the health and safety of the public, the practice may use or disclose your protected health information as permitted under law and consistent with ethical standards of conduct. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

For Specified Government Functions. As authorized by the HIPAA privacy regulations, the practice may use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, and medical suitability determinations.

To Law Enforcement Officials or Correctional Institutions. The practice may also disclose your protected health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (1) for the institution to provide health care services to you, (2) for the safety and security of the institution, and/or (3) to protect your health and safety or the health and safety of other individuals.

You must submit a written request to the practice's Privacy Officer to inspect and copy your health information. The practice may charge you a fee for the cost of copying, mailing, or other costs incurred by the practice in complying with your request. Please contact our Privacy Officer if you have questions about access to your medical record at the number given on the last pages of this Notice.

The right to request a restriction on uses and disclosures of your protected health information. You may request that the practice not use or disclose specific sections of your protected health information for the purposes of treatment, payment, or health care operations. Additionally, you may request that the practice not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Notice. In your request, you must specify the scope of restriction requested as well as the individuals for which you want the restriction to apply. Your request should be directed to the practice's Privacy Officer.

The practice may choose to deny your request for a restriction, in which case the practice will notify you of its decision. Once the practice agrees to the requested restriction, the practice may not violate that restriction unless use or disclosure of the relevant information is needed to provide emergency treatment. The practice may terminate the agreement to a restriction in some instances.

The right to request to receive confidential communications from the practice by alternative means or at an alternative location. You have the right to request that the practice communicate with you through alternative means or at an alternative location. The practice will make every effort to comply with reasonable requests. However, the practice may condition its compliance by asking you for information regarding the procurement of payment or specific information regarding an alternative address or other method of contact. Our practice will accommodate reasonable requests. You are not required to provide an explanation for your request. Requests should be made in writing to the practice's Privacy Officer.

The right to request an amendment of your protected health information. 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 made in writing and submitted to the practice's Privacy Officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request, and the reason supporting your request, in writing. Also, we may deny your request if you ask us to amend information that is, in our opinion: (a) accurate and complete; (b) not part of the protected health information kept by or for the practice; (c) not part of the protected health information which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

The right to request an accounting of certain disclosures. You have the right to request an accounting of the practice's disclosures of your protected health information made for purposes other than treatment, payment, or health care operations as described in this Notice. The practice is not required to account for disclosures (1) which you requested; (2) which you authorized by signing an authorization form; (3) for a facility directory; (4) to friends or family members involved in your care; and (5) certain other disclosures the practice is permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer and should state the time period for which you wish the accounting to include up to a six-year period. The practice is not required to provide an accounting for disclosures that take place prior to April 14, 2003. The practice will not charge you for the first accounting you request of any 12-month period. Subsequent accountings may require a fee based on the practice's reasonable costs for compliance of the request.

The right to obtain a paper copy of this Notice. The practice will provide a separate paper copy of this Notice upon request even if you have already been given a copy of it or have agreed to review it electronically.

VII The Practice's Duties

The practice is required to ensure the privacy of your health information and to provide you with this Notice of your rights and the practice's duties and procedures regarding your privacy. The practice must abide by the terms of this Notice, as may be amended periodically. The practice reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that the practice collects and maintains. If the practice alters its Notice, the practice will provide a copy of the revised Notice through regular mail or in-person contact.

VIII Complaints

If you believe that your privacy rights have been violated, you have the right to 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, submit your complaint in writing to the practice's Privacy Officer. The practice encourages you to relate any concerns you may have regarding the privacy of your information and you will not be retaliated against in any way for filing a complaint.

IX Contact Person

The practice's contact person regarding the practice's duties and your rights under the HIPAA privacy regulations is the Privacy Officer. The Privacy Officer can provide information regarding issues related to this Notice by request. Complaints to the practice should be directed to the Privacy Officer at the following address:

Peachtree Allergy and Asthma Clinic
ATTN: Privacy Officer
1938 Peachtree Rd. NW
Suite 507
Atlanta, Georgia 30309

The Privacy Officer can be contacted by telephone at: 404-351-7520

X Effective Date

This notice is effective on April 14, 2003.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I have received a copy of Peachtree Allergy and Asthma Clinic's Notice of Privacy Practices containing a complete description of my rights to privacy and the uses and disclosures of health information. I understand that Peachtree Allergy and Asthma Clinic has the right to change its Notice of Privacy Practices from time to time and that I may contact the practice's Privacy Officer at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

Patient Name: _____

Signature of Patient or
Authorized Person: _____

Relationship
to Patient: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

1938 Peachtree Road NW
Suite 507
Atlanta, Georgia 30309-1296
Telephone 404.351.7520
Fax 404.355.2048
Fax 404.350.7285

820 Ebenezer Church Road
Suite 101
Sharpsburg, Georgia 30277
Telephone 770.254.8502
Fax 770.254.1769

2740 Bert Adams Road NW
Suite 150
Atlanta, Georgia 30339
Telephone 678.305.9871
Fax 678.305.1065

150 Henry Burson Drive
Suite 102
Carrollton, Georgia 30117
Telephone 770.832.1984
Fax 770.832.9235



PEACHTREE ALLERGY AND ASTHMA CLINIC, P.C.

1938 Peachtree Rd., N.W.
Suite 507, Atlanta, Ga. 30309
404-351-7520

820 Ebenezer Church Rd.
Suite 101, Sharpsburg, Ga. 30277
770-254-8502

2740 Bert Adams Rd.
Suite 150, Atlanta, Ga. 30339
678-305-9871

PATIENT CONSENT FOR USE AND DISCLOSURE OF (PHI) PROTECTED HEALTHCARE INFORMATION

I consent to use or disclosure of my protected healthcare information (PHI) to Peachtree Allergy and Asthma Clinic, P.C., to carry out treatment, payment and healthcare operations (TPO). By my signature on this document, I understand that diagnosis or treatment, obtaining payment for my healthcare bills from third party payors, and conducting healthcare operations is conditioned on my consent.

My "protected healthcare information" means individually identifiable health information held or disclosed by the practice. This information may be communicated electronically, verbally, or written and may be created or received by my physician, another health care provider, a health plan, or a health care clearinghouse. This protected healthcare information relates to my past, present or future physical or mental health or condition and identifies me.

With this consent, Peachtree Allergy and Asthma Clinic, P.C., may call my home or other alternate location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance, billing or collection matters, and any calls pertaining to my clinical care, including laboratory results, prescription calls (or faxes) to pharmacists, etc.

With this consent, Peachtree Allergy and Asthma Clinic, P.C., may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, billing and insurance items, etc.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Peachtree Allergy and Asthma Clinic, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the privacy officer at:

Peachtree Allergy and Asthma Clinic, P.C.
Luci Gross/ Privacy Officer
1938 Peachtree Road, N.W., Suite 507
Atlanta, Georgia 30309

I have the right to request that Peachtree Allergy and Asthma Clinic, P.C., restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By my signature on this form, I consent that Peachtree Allergy and Asthma Clinic, P.C. may use and disclose my protected healthcare information (PHI) to carry out treatment, payment, and operations (TPO).

I may revoke my consent in writing except to the extent the practice has already made disclosures in good faith upon my prior consent. If I do not sign this consent, or later revoke it, Peachtree Allergy and Asthma Clinic, P.C., may decline to provide treatment to me.

Print Patient Name

Signature of Patient or Legal Guardian

Date

Print Name of Person Signing Form

Relationship to Patient