SHORT FORM - 2013

KENTUCKIANA ALLERGY, P.S.C.

HIPAA PRIVACY NOTICE

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.

USES AND DISCLOSURES

Kentuckiana Allergy, P.S.C. ("KA") is permitted to use and disclose your private and confidential health information for treatment, payment and health care operations of KA. For example, KA may disclose your protected health information to other physicians to facilitate treatment, and KA may use health information about you so that KA may bill and collect payment from an insurance company, health plan, or other third party payor. KA may disclose your health information to review treatment and services to evaluate performance of KA staff and other management and administrative purposes. In addition, KA may use or disclose your protected health information which is incident to a permitted use or disclosure. "Protected health information" is information about you that may identify you and relates to your past, present or future physical or mental health or condition and related health services.

You may request to receive a longer form HIPAA Privacy Notice from KA for a complete list of possible disclosures by contacting the Privacy Official identified below.

Business Associates. KA will share and disclose your health information with third party "business associates" (and their subcontractors) which perform various activities on behalf of KA (for example, billing, collections, and network and software servicing).

Uses and disclosures requiring an opportunity for you to agree or object:

KA may use and disclose your health information in the following instances. In each of these examples, you have the opportunity to agree to or prohibit or restrict the use or disclosure. If you are not present or able to agree or object to the use or disclosure, KA may determine whether the disclosure is in your best interest. Emergency disclosures may also be made -- due to your incapacity or emergency treatment situation -- if disclosure is consistent with your prior expressed preference and in your best interest as determined by KA.

Facilities Directory. Unless you object, KA will use and disclose certain of your health information to maintain a directory of patients.

Family Members. Unless you object, KA will disclose your health information to a family member, other relative, close friend, or other person you identify; such information disclosed will be directly relevant to such person's involvement with your health care. If you are unable or unavailable to agree or object, KA may disclose information as necessary if KA determines it is in your best interest. KA may use or disclose information to notify, or assist in the notification of (including identifying or locating), a family member, your personal representative or other responsible person for your care, your address or phone number, general condition, or death.

Disclosures made without your authorization or consent:

The following is a description of other purposes for which KA is permitted or required to use or disclose your protected health information without your consent, authorization or your opportunity to object; this is not a complete list of all possible disclosures.

1. By KA for training or to defend itself in a legal action or other proceeding brought by you.

2. For public health activities, social service or protective service agencies, and to a health oversight agency for oversight activities.

3. In the course of any judicial or administrative proceeding and for law enforcement purposes.

4. For identifying a deceased person, and to organ procurement organizations.

5. As authorized to comply with laws relating to workers= compensation, or similar programs, that provide benefits for workplace injuries.

Certain uses and disclosures will be made only with your written authorization, and you may revoke such authorization at any time, provided that the revocation is in writing, except to the extent that (i) KA has taken action in reliance thereon; or (ii) if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. Uses and disclosures which require your authorization include: certain uses/disclosures of psychotherapy notes; sale of your protected health information; and, use of your protected health information for KA=s marketing if it involves financial remuneration paid to KA. Also, uses and disclosures may be further limited by more stringent Kentucky or Indiana law involving privacy protection. Under Indiana law, the Practice may withhold information requested by a patient if the Practice reasonably determines that such information is (1) detrimental to the physical or mental health of the patient; or (2) likely to cause the patient to harm him/herself or another.

CERTAIN USES OR DISCLOSURES. KA may contact you to provide appointment reminders or information about treatment

INDIVIDUAL RIGHTS. The following are statements of your privacy rights. In each case, you may exercise these rights by filing a written request to the privacy contact listed below.

(A) You have the right to request restrictions on certain uses and disclosures of your protected health information. Specifically, you may restrict disclosure to a health plan under certain circumstances. KA is not required to agree to requested restrictions, except in the case of disclosures to a health plan if the protected health information pertains to a service which the patient, and not the health plan, has paid to KA in full.

(B) You have the right to receive confidential communications of your protected health information.

(C) You have the right to inspect and copy your protected health information.

(D) You have the right to amend your protected health information.

(E) You have the right to receive an accounting of certain disclosures of your protected health information.

(F) You have the right to obtain a paper copy of this notice from KA.

KA DUTIES.

(A) KA is required by law to maintain the privacy of your protected health information, provide you with this notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.

(B) KA is required to abide by the terms of the privacy notice currently in effect.

(C) KA reserves the right to change the terms of its privacy notice and to make the new notice provisions effective for all protected health information that KA maintains. Any such revised notice shall be provided to individuals in the same manner this notice is given.

COMPLAINTS AND CONTACT. If you believe that your HIPAA privacy rights have been violated, you may make a written complaint by delivery to KA and to the Secretary of HHS. You will not be retaliated against if you file a complaint. You should file your complaint at the following address and you may also request further information by written request to:

Compliance Officer: Practice Administrator
Kentuckiana Allergy, P.S.C.
9113 Leesgate Road
Louisville, Kentucky 40222
Phone: (502) 426-1621

EFFECTIVE DATE

This Privacy Notice is effective May 1, 2013.

KENTUCKIANA ALLERGY, P.S.C.

HIPAA PRIVACY NOTICE

ACKNOWLEDGMENT OF RECEIPT

This is to acknowledge my receipt of the HIPAA Privacy Notice delivered to me by Kentuckiana Allergy, P.S.C.

____________________________________ ____________________________________

Patient Name (please print) Date

____

Social Security Number

____________________________________ ____________________________________

Signature of individual or personal representative Personal Representative, if applicable (Please Print)

(If No Patient Signature Use This Form)

RECORD OF GOOD FAITH ATTEMPT TO DELIVER

This is to record my good faith effort to obtain a written acknowledgment of receipt of the HIPAA Privacy Notice to:

Patient's Name: ____________________________________
Date: ____________________________________
SSN: ____________________________________

Acknowledgment of receipt of the Privacy Notice from the patient named above was not obtained for the following reason(s):

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KENTUCKIANA ALLERGY, P.S.C.

____

(Signature)

____

Name (Please Print)

Title: ____________________________________

Date: ____________________________________