Premier
ALLERGY, ASTHMA & SINUS CARE
John G. Latall, MD Board Certified Allergy and Immunology
2073 N. Clybourn Ave., Chicago, IL 60614 T 773.665.4016 / F 773.360.6200
1 N. LaSalle St., Ste 1130, Chicago, IL 60602 T 312.796.2241 / F 312.796.2333

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 READ IT CAREFULLY.

Our Legal Duty

We are required by law to protect the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We will follow the privacy practices that are described in this notice while it is in effect. This notice is effective beginning August 1, 2012 and will remain in effect until we replace it.

We reserve the right to change our policies and the terms of this notice at any time. Any changes we make will be effective for all of the information we maintain, including the information we created or received before we made the changes. If this notice is changed, the new notice will be posted in the waiting area.

You can request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, contact us using the information listed at the end of this notice.

Uses and Disclosures of Your Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. This means that we may use or disclose your health information:

● To a physician or other healthcare provider who is providing treatment to you.

● To obtain payment for services that we provide to you.

● To assess the care that was provided and monitor the quality and effectiveness.

We will also use and disclose your health information for reasons listed below:

● When you specifically request and authorize us to do so in writing. If you do so, you can revoke (or cancel) your authorization at any time by submitting your request in writing. Once you revoke the authorization, no future uses or disclosures will occur related to your original authorization request. Without your written authorization we will not use or disclose your information except as listed in this notice.

● We may release your health information to a friend or family member who is involved in your care or who assists in taking care of you unless you object. If you are incapacitated or in emergency circumstances, we will release your health information if we believe, using our professional judgment and experience, it is in your best interest.

● We may want to contact you to provide appointment reminders via phone or mail. We may leave messages on your answering machine for these reminders.

● We may also contact you by mail or phone to provide results of medical tests that were performed or requested by your doctor. We will not leave results on an answering machine but we will leave a message to call us back. If you prefer not to receive this information by phone or mail, please inform us.

● We will share your health information with our business associates. A business associate is a company that provides certain services to our practice. To protect you, we have signed agreements in place that require our business associates to keep your information private.

● When we are required by law to do so.

● When required for certain public health activities, such as disease control or public health investigations.

● If we believe that you are a possible victim of abuse, neglect, domestic violence, or other crimes. We will disclose information if we determine the disclosure is necessary to prevent serious harm or you or to others.

● When law enforcement or federal officials request information or as required by certain judicial or administrative court proceedings.

● For research purposes when the research has been approved by an institutional review board that has reviewed proposals and established protocols to ensure the privacy of your health information.

● When required for certain FDA investigations and activities, such as investigation of product defects or to permit product recalls, repairs, or replacement.

● To a coroner or funeral director if necessary to complete their legal duties.

● If you are an organ, eye, or tissue donor, we will disclose information to facilitate donation.

● When authorized by and to the extent necessary to comply with workers' compensation laws.

Patient Rights

In most cases, you have the right to get copies of your health information and may do so by completing our request form. If you request copies, we will charge a reasonable cost-based fee for the copies made.

You also have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or for healthcare operation purposes. If you request this information more than once in a 12-month period, we will charge a reasonable cost-based fee for fulfilling any additional requests.

You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree with your restriction, but if we do, we will abide by our agreement (except when required by law or in an emergency).

If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. You must request this in writing and we may deny your request in certain circumstances.

You have the right to receive confidential communication from us. You must submit a written request to have us communicate with you about your health information by alternative means or at an alternative location.

If you received this notice electronically, you have the right to receive a paper copy.

Questions and Complaints

If you would like more information about our privacy practices or have questions, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to restrict or amend the use or disclosure of your health information, or if we cannot accommodate your request to communicate with you by alternate means or at an alternate location, you may file a written complaint using the contact information at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services and we will provide that address upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information: Practice Manager, Premier Allergy, Asthma & Sinus, S.C.

Address: 2073 N. Clybourn Ave, Chicago, IL 60614/ 1 N. LaSalle St., Ste 1130, Chicago, IL 60602

Phone: 773-665-4016 (Lincoln Park)/ 312-796-2241 (Loop)

Fax: 773-360-6200 (Lincoln Park)/ 312-796-2333 (Loop)

--- Notice of Privacy Practices ---

Acknowledgement of Receipt

I acknowledge that I have received a copy of the Notice of Privacy Practices from Premier Allergy, Asthma & Sinus, S.C.

Print Name of Patient: _____

Patient, Parent, or Guardian Signature: _____ Date_____

Print Name of Person Signing: _____

Relationship to Patient: _____

How I want my Protected Health Information handled:

Please let us know if you would like your Protected Health Information to be shared with anyone else. Please understand we cannot speak with anyone, even family, friend, or partner, regarding your medical information or your financial information unless you specifically give us permission to do so. Please take a minute to consider who you might want/need to have your information shared with and then complete this form accordingly. Please remember you may revoke this in writing at any time.

Please INITIAL your choices below.

Healthcare information regarding **medical** conditions such as diagnosis, treatment, results, etc.

_____ I give my permission for this information be shared with the following person or persons:

Name _____ Phone # _____ Relationship to patient _____

Name _____ Phone # _____ Relationship to patient _____

_____ I do NOT want this information to be shared.

Healthcare information regarding **financial** considerations such as insurance, payments, balances due etc.

_____ I give my permission for this information be shared with the following person or persons:

Name _____ Phone # _____ Relationship to patient _____

Name _____ Phone # _____ Relationship to patient _____

_____ I do NOT want this information to be shared.

Patient, Parent, or Guardian Signature: _____ Date_____