Premier
ALLERGY, ASTHMA & SINUS CARE
John G. Latall, MD Board Certified Allergy and Immunology
Lincoln Park • Loop
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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 November 12, 2026 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 on our website.

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 must obtain your written authorization for most uses and disclosures of psychotherapy notes, for uses and disclosures for marketing purposes and for any disclosure that is a sale of your health information.
- 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 contact you by phone, mail, text message, or email to remind you of appointments. We may leave voicemail messages for these reminders. Text messages and email may not be fully secure, so these reminders will include only basic details such as the date, time and location of your appointment, not information about your health. Message and data rates may apply. You may tell us at any time that you do not want to receive reminders by text or email.
- 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 to you or to others.
- To prevent or lessen a serious and imminent threat to the health or safety of you, another person or the public.
- 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.
- To health oversight agencies for activities authorized by law, such as audits, investigations, inspections and licensure.
- If you are a member of the armed forces or a veteran, as required by military command authorities; and to authorized federal officials for national security, intelligence, and protective services for the President and others.
- If you are an inmate of a correctional institution or in the custody of a law enforcement official, to the institution or official as necessary for your health and the health and safety of others.

Special Protections under Illinois Law

Some types of health information have additional protection under Illinois law, including HIV/AIDS test results and related information, genetic testing information, and mental health records, as well as certain information about minors. We will obtain your specific written consent before disclosing this information, except where Illinois law permits the disclosure without your consent. Where Illinois law protects your privacy more than federal law, we will follow Illinois law.

Patient Rights

In most cases, you have the right to get copies of your health information, including an electronic copy if we keep your records electronically, 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, within the limits set by federal and Illinois law.

You also have a right to receive a list of instances in the six years before your request where we have disclosed health information about you for reasons other than treatment, payment, or for healthcare operation purposes. The first list you request in any 12-month period is free. 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). However, if you pay for a service or item out of pocket in full, you may ask us not to share information about it with your health plan for payment or healthcare operations, and we will agree unless a law requires us to share it.

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.

You have the right to be notified if there is a breach of your unsecured health information.

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 at: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201; by calling 1-877-696-6775; or online at www.hhs.gov/ocr/complaints.

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: Premier Allergy, Asthma & Sinus Care

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

Phone: 773-665-4016 (main line- call for office specific phone numbers)

Fax: 773-360-6200 (main line- call for office specific fax numbers)

Website: www.premier-allergy.com

Acknowledgement of Receipt

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

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. As explained in our Notice of Privacy Practices, in some situations we may share information with family members or others involved in your care or payment for your care unless you object. Listing people below tells us who you want us to speak with. Initialing "I do NOT want this information to be shared" tells us you object. For patients under 18, we generally speak with a parent or legal guardian. 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_____