HIPPA 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 REVIEW IT CAREFULLY.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is required by law to maintain the privacy of your identifiable Protected Health Information and to provide individuals with notice of our legal duties and privacy practices with respect to such information.

This Notice will provide you with information regarding our privacy practices and applies to all Protected Health Information created and/or maintained by the practice, including any information that we receive from other health care providers. This Notice describes the ways in which the practice may use or disclose your Protected Health Information and also describes your rights and our obligations regarding any such uses or disclosures. The practice will abide by the terms of this Notice, including any future revisions that we may make to the Notice as required or authorized by law.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

The following describes the ways we may use and disclose Protected Health Information that identifies you ("Protected Health Information"), except for the purposes described below. We will use and disclose Protected Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Protected Health Information for your treatment and provide you with treatment-related health care services. For example, we may disclose Protected Health Information to doctors, nurses, technicians, or other personnel, including people outside our office (for example, your pharmacy) who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Protected Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Protected Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our practice. For example, health care operations may include quality improvement activities, business management and administrative activities. We also may share information with other entities that have a relationship with your health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Protected Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Protected Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

USES OR DISCLOSURES PERMITTED BY LAW IN SPECIAL SITUATIONS

As Required by Law. We will disclose Protected Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Business Associates. We may disclose Protected Health Information to our business associates that perform functions on our behalf or provide us with services, if the information is necessary to such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Organ and Tissue Donation. If you are an organ donor, we may use or release Protected Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the military, we may release Protected Health Information as required by military command authorities.

Workers' Compensation. We may release Protected Health Information for workers' compensation or similar programs which provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Protected Health Information for public health activities. For example, we may disclose information to prevent or control disease, injury or disability or to notify you of a recall of a product you may be using.

Health Oversight Activities. We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure and certification surveys. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your Protected Health Information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Protected Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Protected Health Information to a coroner, medical examiner, or funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Protected Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Protected Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or for the conduct of special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Protected Health Information to the correctional institution or law enforcement official if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO AGREE OR OBJECT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close personal friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care or payment. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will not longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS

You have the following rights regarding Protected Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Protected Health Information, you must make a request, in writing, to the practice's Compliance Officer. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format, you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format, your request will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Request an Amendment. If you feel that Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our practice. To request an amendment, you must provide us with a reason that supports your request. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with the decision and we may give a rebuttal to your statement.

Right to Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Protected Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Privacy Officer. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment for health care operation purposes and such information you wish to restrict pertains solely to a health care system or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information will be held in confidence for the item or service and will not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice at our wesite, www.asthma-research.com. To obtain a paper copy of this Notice, please contact the Privacy Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice and make the new Notice apply to Protected Health Information we already have as well as any information we receive in the future. We will post a copy of our current Notice at our office and on our website. The Notice will contain the effective date on the last page.

COMPLAINTS

If you have any questions about this Notice or if you believe we have not properly protected your privacy, or have violated your privacy rights, you may contact our Privacy Officer. You also may send a written complaint to the US Department of Health and Human Services. The Privacy Officer can provide you with the appropriate address upon request. There will not be retaliation against those who choose to file a complaint.

To act on any of the information provided in this Notice or for more information about our privacy practices, you may contact our Privacy Officer at:

Allergy Associates Research Center Attention: Carol Pehl or Danielle Law
Phone: 503-238-6233
Fax: 503-231-7668
Email: dlaw@asthma-research.com or cpehl@asthma-research.com
Mail: 6327 SE Milwaukie Avenue 2nd Floor, Portland, OR 97202.

Effective Date: April 2014.

allergy associates research center

6327 SE Milwaukie Avenue, 2nd Floor
Portland, OR 97202

I understand that Allergy Associates Research Center, (referred to below as "This Practice") will use and disclose health information about me.

I understand that my health information both created and received by This Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care;
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care;
- including confirming appointments in advance and leaving that information on voice mail, answering machine, text or email.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of This Practice's Notice of Privacy Practices in effect, will be posted in waiting/reception area and available on the website at www.asthma-research.com.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree with such requests.

By signing below, I agree that I have reviewed and understand the information above and that <u>I have received</u> a copy of the Notice of Privacy Practices.

Print Name	Patient Signature	Date
Patient Representative	Description of Representative's Authority	Date