

Allergy & Asthma Consultants of Central Florida  
793 Douglas Avenue  
Altamonte Springs, FL 32714  
407-862-5824

## NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Please review it carefully.

### **Our Commitment to your privacy:**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information

We realize that these laws are complicated, but we must provide you with the following information:

**Who will follow this notice:** This notice describes information about privacy practices followed by the Doctors, Employees, and Business Associates of Allergy & Asthma Consultants of Central Florida.

How we may use and disclose medical information about you:

**For Treatment:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to the practice's office personnel who are involved in taking care of you at the office or elsewhere. We also may disclose medical information about you to people outside our office who are involved in your care after you leave the office, such as family members or others we use to provide services that are part of your care provided you have consented to such disclosure. These entities include third party physicians, hospitals, nursing homes, pharmacies or clinical labs with whom the office consults or makes referrals.

**For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about procedures you received at the office so your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

**For Health Care Operations:** We may use and disclose medical information about you for medical office operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review medical treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional service the office should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to our physicians, staff, and other office personnel for review and learning purposes.

**Appointment Reminders:** We may use medical information to contact you as a reminder that you have an appointment for treatment or medical care at the office. You may be contacted by physician, nurse, post card, or automated appointment reminder system. If you choose not to be reminded of upcoming appointments in this manner you will be held responsible for missed appointments ("no-shows").

**Treatment Alternatives:** We may use medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

We may use information about you internally, to help determine if you might qualify for a patient study of new and/or existing drugs, products, or techniques. If we believe you qualify, we may contact you, but will NOT enroll you in any study, unless you consent to take part.

**Health Related Benefits and Services:** We may use medical information to tell you about health-related benefits or services that may be of interest to you.

**Individuals and/or Family Members Involved In Your Care or Payment For Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care provided you have consented to such disclosure. We may also give information to someone who helps pay for your care. Additionally, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

**As Required by Law:** We will disclose medical information about you when required to do so by federal, state, or local law.

**To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

### **SPECIAL SITUATIONS**

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

**Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may disclose medical information about you 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 medical information if asked to do so by a law enforcement official: in response to a court order, subpoena, warrant, summons or similar process; To identify or locate a suspect, fugitive, material witness, or missing person; About the victim of a crime if, under certain limited

circumstances, we are unable to obtain the person's agreement; About a death we believe may be the result of criminal conduct; About criminal conduct at the office; and In emergency circumstances 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 medical information for a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about the patients of the office to funeral directors as necessary to carry out their duties.

### **Your Rights Regarding Medical Information About You**

**Right to Inspect and Copy:** You have the right to inspect and/or receive a copy of your medical information that may be used to make decision about your care. To inspect and/or receive a copy of medical information that may be used to make decisions about you, you must request, in writing to the Allergy and Asthma Consultants of Central Florida, Attention Medical Records Department at the above address. There may be a fee for the costs of copying and mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain limited circumstances

**Right to Amend:** If you feel that the medical information we have about you 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 this office. To request an amendment, your request must be in writing and submitted to your physician. You also must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that: was not created by Allergy & Asthma Consultants of Central Florida, is not part of the medical information kept for our office, and is not part of the information which you would be permitted to inspect and copy, or; is accurate and complete.

**Right to Accounting of Disclosures:** You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing to Allergy & Asthma Consultants of Central Florida, Medical Records Department at the above address. You must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request in a 12 month period will be free. For additional lists, we may charge you a fee for costs of copying mailing or other supplies associated with your request.

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or a friend. For example, you could ask that we not disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restriction, you must make your requests in writing to the Allergy & Asthma Consultants of Central Florida Medical Records Department. In your request, you must tell us what information you want to limit; whether you want to limit our use, disclosure or both; and to whom you want the limits to apply, for example, disclosures to you spouse.

**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 at work or by mail. To request confidential communications, you must request in writing the Allergy & Asthma Consultants Office Manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**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. You may also obtain a copy of this notice on our website at [www.orlandoallergy.com](http://www.orlandoallergy.com). To have a paper copy of this notice mailed to you, you must make your request in writing to the Allergy & Asthma Consultants of Central Florida Office Manager.

### **CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office. The notice will contain on the first page, in the upper left corner, the effective date.

### **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a written complaint with the Privacy Officer at Allergy & Asthma Consultants of Central Florida, 793 Douglas Avenue, Altamonte Springs, Florida 32714 or with the US Department of Health and Human Services. You will not be penalized or retaliated against for filing a complaint.

### **OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.