Adrienne M. Balsam, M.D.S.C
4711 Golf Road, Suite 1200
Skokie, Illinois 60076

NOTICE OF PRIVACY POLICIES

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.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have a right to adequate notice of how the practice maintains the privacy of your protected health information("PHI"), how we may use and disclose this information, and what your rights are with respect to this information.

HOW WE MAY USE AND DISCLOSE YOUR INFORMATION

Our practice uses and discloses PHI for the following purposes.

- **Treatment:** We may need to share information about you in order to provide medical care to you (for example, with other physicians, nurses, or employees who are part of this practice or who may be providing coverage in your physician's absence). Any other disclosure of your records for treatment-related purposes will require your signed authorization.
- **Payment:** We may need to disclose information about the treatment, procedures or care our practice provided to you in order to bill and receive payment for the services we provided. We may share this information with you, an insurance company or a third party responsible for payment.
- **Healthcare Operations:** We may need to use and disclose your personal health information to business associates who need to use or disclose your information to provide a service for our practice, such as our billing company and collection agency.

OTHER USES AND DISCLOSURES NOT REQUIRING YOUR AUTHORIZATION

Appointment Reminders/Treatment Alternatives/Incidental Uses and Disclosures: We may contact you regarding appointments or to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you by telephone, fax, or email. We will make every effort to protect your privacy when leaving a message for you.

Others Involved in Your Healthcare: We may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. 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.

Emergency Situations: The practice uses and discloses protected health information as appropriate to provide treatment in emergency situations. You will be allowed to object to future disclosures as soon as reasonably practicable after the delivery of treatment.

Required by Law: We may disclose your protected health information if required to do so by state, federal or local law, such as disclosure to a public health agency or official that is authorized by law to collect or receive such information, such as (but not limited to) communicable or sexually transmitted diseases; mandated reports of injury, illness, abuse, neglect or domestic violence; or to avert a serious threat to health or safety. This may also include notifying you of product recalls.

Research: Under certain circumstances, our practice may use or disclose your personal health information for research purposes when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Health Oversight Activities/Practice Management Issues: The practice uses and discloses PHI as required by law for health oversight activities and in other practice management issues. The information may be used and disclosed for audits, investigations, licensure issues, and other health oversight activities, including, but not limited to hospital peer review, managed care peer review, or Medicaid or Medicare peer review. The practice may communicate and disclose PHI to its professional liability insurance carrier and to counsel representing the physician and/or practice in legal matters concerning any care or treatment provided.

Judicial and Administrative Proceedings: If required by law, the practice may disclose information for judicial and administrative proceedings in response to a court order, subpoena, discovery request or other lawful process.

Disclosures for Law Enforcement Purposes: The practice may disclose the minimum necessary PHI for law enforcement purposes to law enforcement officials only as allowed by law.

Descendants: The practice uses and discloses the minimum necessary PHI to a coroner or medical examiner and funeral directors as required by law. The attending physician is required to sign the death certificate and provide the coroner with a copy of the decedent's PHI.

Specialized Government Functions: The practice uses and discloses protected health information for military and veteran activities, national security and intelligence activities, and other activities as required by law.

Marketing Purposes: The practice does not use or disclose any protected health information for marketing purposes. The practice may engage in communications about products and services that encourages recipients of the communication to purchase or use the product or service for treatment, to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual. These activities are not considered marketing.

PATIENT RIGHTS

You have the following rights with respect to your personal health information:

Right to Request Restrictions on Uses and Disclosures – You have the right to request restrictions or certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. Such requests must be made in writing. We are not required to agree to a restriction; however, if we do agree, we must abide by it unless you agree in writing to remove it (except when the restricted information is needed to provide emergency treatment).

Right to Request Confidential Communications – You have the right to reasonable requests to receive confidential communications of PHI from us by alternative means or at alternative locations. You must complete such a request in writing on the practice's Request for Confidential Communication Form.

Right to Inspect and Copy - You have the right to inspect and obtain a copy of your medical record that has been created to treat you and is used to make decisions about your care, including medical and billing records. You must submit your request in writing. The practice may charge you for the cost of copying records, the cost of mailing, or other minimal costs associated with your request.

Charges for copying records are as follows:

$20.00 handling fee
plus
.75 cents each for pages 1-25
.50 cents each for pages 26-50
.26 cents each for pages 51 to end

Right to Amend – You have the right to request that the practice amend your protected health information maintained in your medical record or billing record. We will document all requests, respond to your requests in a timely fashion, and inform you of your appeal rights if a request is denied in whole or in part. Your request must be in writing.

Right to an Accounting of Disclosures of Protected Health Information – You have the right to receive an accounting of the disclosures of your personal health information that our practice makes other than for purposes allowed under the

Privacy Rule. Requests must be in writing, can only be for disclosures after April 14, 2003, and can go back no more than 6 years. This practice charges $20.00 for more than one accounting within a 12-month period.

AUTHORIZATIONS

Our practice is committed to protecting your privacy and to the proper use and disclosure of your personal health information. In Illinois, a specific written authorization is required to disclose or release records of mental health treatment, alcoholism treatment, drug abuse treatment or HIV/Acquired Immune Deficiency Syndrome (AIDS) information.

The practice will obtain your written authorization for any other use or disclosure of protected health information.

The practice does not condition treatment of a patient on the signing of an authorization. You must revoke an authorization by submitting a request in writing. We are required to honor and abide by that written request, except to the extent that we have already taken actions based on your authorization.

WAIVER OF RIGHTS

The practice never requires an individual to waive any of his or her individual rights as a condition for the provision of treatment, except under very limited circumstances allowed under law.

RIGHT TO A COPY OF THIS NOTICE

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. If our privacy practices are revised, you will receive a copy in advance of the effective date of the change. You may request a current Notice when you visit our office. A copy of the current notice may be emailed to you upon your request.

PRACTICE CONTACT

If you would like more information about this notice, please contact Adrienne Balsam M.D. at (847) 933-0455. You have the right to file a written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201

(202) 619-0257
Toll-Free: 1-877-696-6775

Adrianne H. Balsam, M.D.S.C
4711 Golf Road, Suite 1200
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Dear Patient:

We are required to provide you with a copy of our Notice of Privacy Practices. Please sign below and give this sheet to your doctor so that we may document that you received our Notice.

You may take the attached Notice with you to read at your convenience.

Receipt of Notice of Privacy Practices Form

I, (print your name) _____, hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____

Copt to patient's file