ASTHMA, ALLERGY & IMMUNOLOGY INSTITUTE, PLC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain 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 must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 13, 2003, and will remain in effect until we replace it.

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

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing and competence or qualifications of the healthcare professions, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or health operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your healthcare or payment of your healthcare, but this must be submitted in writing.

Persons Involved in Care: We may use or disclose health information to notify, or to assist in the notification of (including identifying and locating) a family member, your personal representative or another person responsible for your health care, in your location, your general condition, or death. If you are present, the prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity of emergency circumstances, we will use professional judgment in disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interests in allowing a person to pick up filled prescriptions, medical supplies, x-rays or similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose your health information to defend the office or to respond to a court order.
Required by Law. We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence or other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, post cards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed in the end of this Notice. We will charge you a reasonable cost-based fee for such copies. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.75 per page of text copy.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes other than that of treatment, payment or healthcare operations and certain other activities, for the previous six years, but before April 14, 2003. If you request this accounting more than once in a twelve month period, we may charge a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information by alternative means or alternative locations. You must make your request in writing. Your request must specify the alternative means or locations, and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, 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 amend or restrict the use or disclosure of your health information or have us communicate with you by an alternative means or alternative locations, you may complain to us by using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint to the U.S. Department of Health and Human Services 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 the U.S. Department of Health and Human Services or us.

Privacy Officer: Annie Arrey-Mensah, M.D.
Asthma, Allergy & Immunology Institute, PLC
29275 Northwestern Highway, Suite 202
Southfield, Michigan 48034
Telephone (248) 304-8904
Fax (248) 304 - 8906

ASTHMA, ALLERGY & IMMUNOLOGY INSTITUTE, PLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT:

Name:_____

Address:_____

Telephone:_____

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent and Acknowledgement: By signing this form, you acknowledge that you have received a copy of this office's Notice of Privacy Practices and you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Acknowledgement and Consent. Our Notice Provides a description of our treatment, payment activities and healthcare operations, of uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Acknowledgement and Consent. We encourage you to read it carefully and completely before signing this Acknowledgement and Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Privacy Officer: **Annie Arrey-Mensah, M.D.**
Asthma, Allergy & Immunology Institute, PLC
29275 Northwestern Highway, Suite 202
Southfield, Michigan 48034
Telephone (248) 304-8904
Fax (248) 304 - 8906

Right to Revoke: You will have the right to revoke this Acknowledgement and Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Acknowledgement and consent will not affect any action we took in reliance on this Acknowledgement and Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Acknowledgement and Consent.

I, _____ have had full opportunity to read and consider the contents of this Acknowledgement and consent form and the ASTHMA, ALLERGY & IMMUNOLOGY INSTITUTE, PLC Notice of Privacy Practices. I understand that by signing this form, I am acknowledging receiving a copy of the Notice of Privacy Practices and am also giving my consent for ASTHMA, ALLERGY & IMMUNOLOGY INSTITUTE, PLC to use and disclose my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date:_____

If a personal representative on behalf of the patient signs this Acknowledgement and Consent, complete the following:
Personal Representative's Name:_____Relationship to the Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS ACKNOWLEDGEMENT AND CONSENT AFTER YOU SIGN IT