I hereby authorize APS Pharmacy and their employees, agents and contractors (collectively "**APS Pharmacy**"), to use or disclose, as specified in this Authorization, my "**protected health information**" **(PHI)** that is covered under privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA Privacy Rule**"). I understand that "protected health information" includes records disclosed to APS Pharmacy by health care providers and facilities that previously provided treatment to the Patient. I also understand that "protected health information" may include information and records protected under the HITECH Act.

APS PHARMACY 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.

As part of the federal Health Insurance Portability and Accountability Act of 1996, known as HIPAA, the Facility has created this Notice of Privacy Practices (Notice). This Notice describes the Facility's privacy practices and the rights you, the individual, have as they relate to the privacy of your Protected Health Information (PHI). Your PHI is information about you, or that could be used to identify you, as it relates to your past and present physical and mental health care services. The HIPAA regulations require that the Facility protect the privacy of your PHI that the Facility has received or created.

This Facility will abide by the terms presented within this Notice. For any uses or disclosures that are not listed below (Including Marketing and Selling of PHI), the Facility will obtain a written authorization from you for that use or disclosure, which you will have the right to revoke at any time, as explained in more detail below. **The Facility reserves the right to change the Facility's privacy practices and this Notice.**

HOW THE FACILITY MAY USE AND DISCLOSE YOUR PHI

The following is an accounting of the ways that the Facility is permitted, by law, to use and disclose your PHI.

Uses and disclosures of PHI for Treatment: We will use the PHI that we receive from you to fill your prescription and coordinate or manage your health care.

Uses and disclosures of PHI for Payment: The Facility will disclose your PHI to obtain payment or reimbursement from insurers for your *health care services.*

Uses and disclosures of PHI for Health Care Operations: The Facility may use the minimum necessary amount of your PHI to conduct quality assessments, improvement activities, and evaluate the Facility workforce.

The following is an accounting of additional ways in which the Facility is permitted or required to use or disclose PHI about you without your written authorization.

Uses and disclosures as required by law: The Facility is required to use or disclose PHI about you as required and as limited by law.

Uses and disclosure for Public Health Activities: *The Facility may use or disclose PHI about you to a public health authority that is authorized by law to collect for the purpose of preventing or controlling disease, injury, or disability. This includes the FDA so that it may monitor any adverse effects of drugs, foods, nutritional supplements and other products as required by law.*

Uses and disclosure about victims of abuse, neglect or domestic violence: The Facility may use or disclose PHI about you to a government. *authority if it is reasonably believed you are a victim of abuse, neglect or domestic violence.*

Uses and disclosures for health oversight activities: The Facility may use or disclose PHI about you to a health oversight agency for oversight activities which may include audits, investigations, inspections as necessary for licensure, compliance with civil laws, or other activities the health oversight agency is authorized by law to conduct.

Disclosures to Individuals Involved in your Care: The Facility may disclose PHI about you to individuals involved in your care.

Disclosures for judicial and administrative proceedings: The Facility may disclose PHI about you in the course of any judicial or administrative proceedings, provided that proper documentation is presented to the Facility.

Disclosures for law enforcement purposes: The Facility may disclose PHI about you to law enforcement officials for authorized purposes as *required by law or in response to a court order or subpoena.*

Uses and disclosures about the deceased: The Facility may disclose PHI about a deceased, or prior to, and in reasonable anticipation of an individual's death, to coroners, medical examiners, and funeral directors.

Uses and disclosures for cadaveric organ, eye or tissue donation purposes: The Facility may use and disclose PHI for the purpose of *procurement, banking, or transplantation of cadaveric organs, eyes, or tissues for donation purposes.*

Uses and disclosures for research purposes: The Facility may use and disclose PHI about you for research purposes with a valid waiver of authorization approved by an institutional review board or a privacy board. Otherwise, the Facility will request a signed authorization by the individual for all other research purposes.

Uses and disclosures to avert a serious threat to health or safety: The Facility may use or disclose PHI about you, if it believed in good faith, *and is consistent with any applicable law and standards of ethical conduct, to avert a serious threat to health or safety.*

workers' compensation laws or programs established by law.

Disclosures for disaster relief purposes: The Facility may disclose PHI about you as authorized by law to a public or private entity to assist in disaster relief efforts and for family and personal representative notification.

Disclosures to business associates: The Facility may disclose PHI about you to the Facility's business associates for services that they may provide to or for the Facility to assist the Facility to provide quality health care. To ensure the privacy of your PHI, we require all business associates to apply appropriate safeguards to any PHI they receive or create.

OTHER USES AND DISCLOSURES

The Facility may contact you for the following purposes:

Information about treatment alternatives: The Facility may contact you to notify you of alternative treatments and/ or products.
Health related benefits or services: The Facility may use your PHI to notify you of benefits and services the Facility provides.
Fundraising: If the Facility participates in a fundraising activity, the Facility may use demographic PHI to send you a fundraising packet, or the Facility may disclose demographic PHI about you to its business associate or an institutionally related foundation to send you a fundraising packet. No further disclosure will be allowed by the business associates or an institutionally related foundation without your written authorization. You will be provided with an opportunity to opt out of all future fundraising activities.

FOR ALL OTHER USES AND DISCLOSURES

The Facility will obtain a written authorization from you for all other uses and disclosures of PHI, and the Facility will only use or disclose pursuant to such an authorization. In addition, you may revoke such an authorization in writing at any time. To revoke a previously authorized use or disclosure, please contact APS Privacy Officer to obtain a *Request for Restriction of Uses and Disclosures.*

YOUR HEALTH INFORMATION RIGHTS

The following is a list of your rights in respect to your PHI. Please contact the Privacy Officer for more information about the below.

Request restrictions on certain uses and disclosures of your PHI: You have the right to request additional restrictions of the Facility's uses and disclosures of your PHI; however, the Facility is not required to accommodate a request. This includes the right to restrict disclosures to Insurances for those products and services you pay out-of-pocket for.

The right to have your PHI communicated to you by alternate means or locations: You have the right to request that the Facility communicate confidentially with you using an address or phone number other than your residence. However, state and federal laws require the Facility to have an accurate address and home phone number in case of emergencies. The Facility will consider all reasonable requests.

The right to inspect and/or obtain a copy your PHI: You have the right to request access and/or obtain a copy of your PHI that is contained in the Facility for the duration the Facility maintains PHI about you. There may be a reasonable cost-based charge for photocopying documents. You will be notified in advance of incurring such charges, if any.

The right to amend your PHI: You have the right to request an amendment of the PHI the Facility maintains about you, if you feel that the PHI the Facility has maintained about you is incorrect or otherwise incomplete. Under certain circumstances we may deny your request for amendment. If we do deny the request, you will have the right to have the denial reviewed by someone we designate who was not involved in the initial review. You may also ask the Secretary, United States Department of Health and Human Services ("HHS"), or their appropriate designee, to review such a denial.

The right to receive an accounting of disclosures of your PHI: You have the right to receive an accounting of certain disclosures of your PHI made by the Facility.

The right to receive additional copies of the Facility's Notice of Privacy Practices: You have the right to receive additional paper copies of this Notice, upon request, even if you initially agreed to receive the Notice electronically.

Notification of Breaches: You will be notified of any breaches that have compromised the privacy of your PHI.

REVISIONS TO THE NOTICE OF PRIVACY PRACTICES

The Facility reserves the right to change and/or revise this Notice and make the new revised version applicable to all PHI received prior to its effective date. The Facility will also post the revised version of the Notice in the Facility.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Facility and/or to the Secretary of HHS, or his designee. If you wish to file a complaint with the Facility, please contact the Privacy Officer if you wish to file a complaint with the Secretary, please write.
to: http://www.hhs.gov/ocr/office/about/rgn-hqadd__resses.html

The Facility will not take any adverse action against you as a result of your filing of a complaint.
APS will notify patient of complaint status within 5 business days and will attempt to resolve the complaint within 7 business days of receipt.

CONTACT INFORMATION

If you have any questions on the Facility's privacy practices or for clarification on anything contained within the Notice, please contact:

Samuel Lee
slee@aps-rx.net
949-348-7900

Federal Law (such as alcohol and drug abuse treatment information) and/or protected under State Law (such as mental health treatment or related communications, or information relating to testing or treatment for AIDS (acquired immunodeficiency syndrome) or HIV (Human Immunodeficiency Virus)). I specifically request and authorize the release of information in my records regarding HIV and/or AIDS, if such information is contained in my records.

Information to be Used or Disclosed:

- ☐ Complete records, including all prescriptions and billing records.
- ☐ The following selected items (Please Specify):

Person(s) Authorized to Make the Use or Disclosure:

The following persons or class of persons are authorized to make the specified disclosures of my protected health information:

- ☐ All APS Pharmacy staff, including pharmacists, technicians, navigators, and clinical staff.
- ☐ Only the following persons (Please Specify):

Recipient(s) of Use or Disclosure:

My protected health information may be disclosed to the following persons or class of persons:

Name:	**Relationship:**

Purpose(s) of the Disclosures:

- ☐ Inability or unavailability to respond to APS-specific questions and services.
- ☐ I am requesting the disclosure of my PHI pursuant to this Authorization, and the information will be used and disclosed at my request.
- ☐ Other (Please Specify): _____

Expiration

This Authorization will expire on the following date or event_____.

Revocation

I understand that I may revoke this Authorization by submitting a written revocation to the Pharmacy Manager of the APS Pharmacy location which serves me, provided that such revocation shall not be effective with respect to any use or disclosure made by APS Pharmacy in reliance on this Authorization prior to the date of APS Pharmacy's receipt of my revocation.

I understand that APS Pharmacy cannot require me to sign this Authorization in order receive treatment unless the provision of health care by APS Pharmacy is solely for the purpose of creating protected health information for disclosure to a third party or for research-related treatment, in which situations APS Pharmacy will not provide the service unless I sign this Authorization.

I understand that the information used or disclosed by APS Pharmacy pursuant to this Authorization may be subject to redisclosure by the recipient in which case it might no longer be protected under the HIPAA Privacy Rule. However, I understand that in some cases, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I authorize APS Pharmacy to copy this Authorization and to send the recipient the re-disclosure notice required under the Federal Substance Abuse Confidentiality Requirements, whether my records contain information protected by those laws.

Applicable if Authorization is Requested by APS Pharmacy

I understand that if this Authorization is being requested by APS Pharmacy, APS Pharmacy must provide me with a copy of the Signed Authorization.

I have read and understood this Authorization and my questions have been answered. I certify that I am the Patient listed above or a person authorized to permit release of records on Patient's behalf. I hereby release APS Pharmacy (as defined above) from any liability arising in connection with the use or disclosure of my protected health information pursuant to this Authorization.

Patient Name (Print):_____ Patient Signature: _____

Patient Representative (Print):_____ **Representative Signature:** _____

Date: _____

Patient Acknowledgement: Notice of Privacy Practices, Patient Rights and Responsibilities

Please sign below that you have received a copy of the APS Pharmacy's Notice of Privacy Practices and Patient Rights and Responsibilities.

Patient Signature _____

Patient Name (Print) _____

Patient Representative Name (Print) _____

Patient Representative (Signature) _____

Date _____

(To rescind any of the above information, please notify APS Pharmacy immediately)

(***You may refuse to sign this acknowledgement***)

Please fill out and return this form to APS Pharmacy in the enclosed envelope.