ASSIGNMENT OF INSURANCE BENEFITS

Medicare and Supplemental Insurance

I authorize any holder of medical information about me to release to the centers for Medicare & Medicaid Services ("CMS") and its agents any information needed to determine benefits or the benefits payable to related services. I request that payment of authorized benefits be made to Naples Heart Rhythm Specialists, PA on my behalf for any services furnished me by or in Naples Heart Rhythm Specialists, PA, including physician services. I authorize Naples Heart Rhythm Specialist, PA to act as my agent to help me assure payment from Medicare and any supplemental insurance companies. As part of treatment Naples Heart Rhythm Specialists, PA may prescribe testing, procedures to be performed here. I understand the physicians of Naples Heart Rhythm Specialists, PA are owners, and I have been advised that according to Florida Law I am under no obligation to use this facility. I authorize any holder of medical information about me to release to CMS and/or any supplemental insurance companies any information needed to determine these benefits or the benefits payable for related services. **I understand that I am responsible for payment of any non-covered service, deductible, and/or co-payment due.**

____________________________
Patient Signature

____________________________
Date

Commercial Insurance

I request that payment of authorized benefits be made on my behalf to Naples Heart Rhythm Specialists, PA for any services provided by Naples Heart Rhythm Specialists, PA physicians. I authorize the release of medical information that is necessary to process claims. I understand that some, and perhaps all, of the services may be non-covered services and may not be considered medically necessary under my insurance contract. **I understand that I am responsible for payment of any charges in full, including non-covered services, deductible and/or co-payments due.** I further understand that I am responsible to notify this office of any pre-authorization or pre-certification required by my insurance company. It is my responsibility to ensure that an authorization is on file with Naples Heart Rhythm Specialists, PA prior to having my procedure performed. **When applicable I understand that I am responsible for payment of all charges in full due to no authorization.**

____________________________
Patient Signature

____________________________
Date
Consent for Purposes of Treatment, Payment and Healthcare Operations

I, __________________________, consent to the use or disclosure of my protected health information by Naples Heart Rhythm Specialists, P.A. (NHRS) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of NHRS. I understand that diagnosis or treatment of me by NHRS may be conditioned upon my consent evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. NHRS is not required to agree to the restrictions that I may request. However, if NHRS agrees to a restriction that I request, the restriction is binding on NHRS.

I have the right to revoke this consent, in writing at any time, expect to the extent that NHRS has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review NHRS’s Notice of Privacy Practices prior to signing this document. NHRS’s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of NHRS. The Notice of Privacy Practices for NHRS is also available with our front desk. This Notice of Privacy Practices also describes my rights and NHRS’s duties with respect to my protected health information.

NHRS’s reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office, requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

______________________________  ________________________________
Signature of Patient or Personal Representative Name of Patient or Personal Representative

______________________________
Date

______________________________
Description of Personal Representative’s Authority
Request for Limitations and Restrictions of Protected Health Information

Patient Name: ___________________________ Date of Birth: ___________________________

Which of the following communication means are appropriate/acceptable for NHRS to communicate with you: (Please check all that apply.)

____ Home phone #: __________________ - may leave detailed message? Yes___ No___
____ Work phone #: __________________ - may leave detailed message? Yes___ No___
____ Cell phone #: __________________ - may leave detailed message? Yes___ No___
____ Email Address: __________________ - may leave detailed message? Yes___ No___
____ Other: ___________________________ - may leave detailed message? Yes___ No___

Who are you authorizing NHRS to discuss your health situation with: (Please list all names.)

No one _____

Spouse (Name: ___________________________)

Child (Name: ___________________________)

Sibling (Name: ___________________________)

Other (Name: ___________________________)

Other (Name: ___________________________)

IN CASE OF AN EMERGENCY, OR IF WE ARE UNABLE TO REACH YOU, WHOM MAY WE CONTACT?

Name: ___________________________ Relationship: ___________________________

Phone(s): ___________________________

_____________________________ ___________________________
Signature of Patient or Authorized Representative Date
PATIENT EMAIL COMMUNICATION CONSENT FORM

I allow Naples Heart Rhythm Specialist, P.A. to use electronic mail (e-mail) to communicate clinical information to me pertaining to health care services that I have received. I acknowledge and understand that e-mail communication may contain my personal and private medical information including, but not limited to, my name, address, date of birth, types and dates of health care services received, medication, insurance coverage information, and/or test results.

I understand that although the Provider and NHRS may attempt to protect the privacy of the contents of email sent to me and will take reasonable measures to protect my privacy, the e-mail messages sent to me are not encrypted and travel over the Internet. As a result, there is a risk that e-mail will be intercepted and read by unauthorized third parties. In allowing the Provider to send me e-mail, I assume this risk.

I also acknowledge and understand the following as it relates to this e-mail communication:
1. E-mail is not appropriate for convey information relating to emergency medical matters.
2. If an e-mail has not been answered, I may make an appointment to see/speak with the health care provider to discuss the e-mail message.
3. I will not use e-mail for discussion of sensitive or highly confidential issues; for example, mental health issues, etc.
4. Employees of NHRS other than the Provider may have access to my e-mail address and e-mail content, such as triage nurses, consulting physicians, and other health care providers that are permitted access to my medical records.
5. I, and not the Provider or NHRS, am responsible for the security of e-mail communications sent from or stored on my computer.
6. My decision to allow the Provider to communicate with me by e-mail is voluntary, and that treatment is not conditioned upon my election to do so.
7. The Provider or I may stop e-mail communication at any time for any reason.
8. I agree to notify the provider when my e-mail addresses changes.
9. I will not hold the Provider or NHRS responsible for damages resulting from their use of e-mail or the failure of any NHRS information systems used to facilitate the e-mail communication.

The Provider may send medical information to my e-mail address, which is: (please complete below)

Email Address

The provider may communicate via email to the designated individual listed below.

Patient Name: ___________________________  Patient Signature: ___________________________

Patient DOB: ___________________________  Patient MRN: ___________________________

Relationship to patient: ___________________________  Date: ___________________________

ELECTROPHYSIOLOGY SERVICES
PHYSICIANS REGIONAL MEDICAL CENTER
6101 PINE RIDGE RD
NAPLES, FLORIDA 34119
OFFICE: 239.263.0849

CARDIAC IMAGING & CARDIAC PET CENTER
THE BAKER CENTER
201 8TH ST. S. SUITE 102
NAPLES, FL 34102
OFFICE: 239.682.6603
WWW.NAPLESCARDIACPET.COM
Release of Information

Your physician has remote access to the electronic medical record of the NCH Healthcare System and can view any testing or treatments provided to you at an NCH facility. Your permission is required to allow your physician remote access to your medical records.

I ___________________________(print name) with a date of birth of: ____________
authorize my physician ___________________________ remote access to my NCH electronic medical record (or that of my child under the age of 18) for care treatment.

________________________________________  ________________________________
Signature                                                                 Date

This form is to be retained by the physician and available to NCH upon request.
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize ________________________________ ("provider") to disclose protected health information ("PHI") regarding:

Patient Name: ____________________________ Patient Date of Birth: __________________

Patient Address: __________________________

I authorize the PHI be disclosed at my individual request to NAPLES HEART RHYTHM SPECIALISTS, P.A. at the following location:

6101 Pine Ridge Rd Desk 12 & 13 Naples FL 34119/ 201 8th St South Naples FL 34102 Phone: (239)263-0849 Fax: (239)263-2376

Check one:
I authorize the following PHI to be released:

☐ All health information about the patient in the possession of Provider, including but not limited to psychiatric, mental health treatment information excluding psychotherapy notes ¹, HIV test results genetic testing information or alcohol or drug treatment information;

☐ For a limited time period beginning __________ and ending __________ all health information about the patient in the possession of Provider, including, but not limited to psychiatric, mental health treatment information excluding psychotherapy notes, HIV test results, genetic testing information or alcohol or drug treatment information;

☐ Limited PHI about the patient in the possession of Provider to exclude the following information which I request not be disclosed ²

☐ Other, as described here: ____________________________

I understand and acknowledge the following statements:

1. I may revoke this authorization at any time by notifying the Provider in writing of the revocation, unless the Provider has already relied on the authorization to disclose PHI;
2. PHI disclosed may be subject to re-disclose and no longer be protected by federal or state privacy laws;
3. I am signing this authorization voluntarily. I may decline to sign this authorization. However, refusal to sign does not stop the Provider’s disclosure por PHI that is otherwise permitted to be disclosed by law without my specific authorization;
4. Provider will not condition my treatment on whether I sign, or refuse to sign, this authorization;
5. I will receive a signed copy of this form;
6. I understand that unless otherwise revoked, this authorization will expire one year after the patient is discharged from the provider’s care.

Check one:

☐ I am the patient and I understand and agree to the provisions of this authorization.

☐ I understand and agree to the provisions of this authorization on behalf of the patient named above. I have signed my name individually as the parent of a minor OR as the representative of the adult patient and have attached, or previously provided, a copy of the document authorizing me to serve as the patient’s legal representative.

_____________________________ ____________________________
Signature of Patient or Legal Representative Date

_____________________________ ____________________________
Signature of Parent/ Legal Representative/ Competent Adult (if applicable) Date

_____________________________
Signature of witness

¹ Psychotherapy notes by a mental health professional documenting private counseling stored separately from the chart. To release them requires a separate release.
² The provider is authorized by law to use or disclose PHI for a variety of reasons without the patient’s authorization. Please see the Provider’s Notice of Privacy for details.

This authorization was developed to comply with Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act to the American Recovery and Reinvestment Act of 2009 and associated regulations.
Naples Heart Rhythm Specialists

Patient Name: ___________________________ Date: ___________________________

Are you allergic to any medications? □ NO □ YES Please list: ___________________________

Past Medical History □ No change

<table>
<thead>
<tr>
<th>Past Medical History</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
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<tr>
<td>Chest Pain/Angina</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Heart Disease</td>
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<tr>
<td>Heart Attack</td>
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<tr>
<td>High Cholesterol</td>
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<tr>
<td>Pacemaker/ICD</td>
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<tr>
<td>Headaches</td>
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<tr>
<td>Kidney Stones</td>
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<tr>
<td>Kidney Disease</td>
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<tr>
<td>Cancer</td>
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</tbody>
</table>

Current Medications □ No change

<table>
<thead>
<tr>
<th>Current Medications</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Clots</td>
<td></td>
<td></td>
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<tr>
<td>Peripheral Vascular Disease</td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Congestive Heart Failure</td>
<td></td>
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<tr>
<td>Thyroid Disease</td>
<td></td>
<td></td>
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<tr>
<td>Stomach Ulcer</td>
<td></td>
<td></td>
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<tr>
<td>Other (Please list below)</td>
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<tr>
<td>Liver Disease</td>
<td></td>
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<tr>
<td>Heart Palpitations</td>
<td></td>
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<tr>
<td>Arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Surgery</td>
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</tbody>
</table>

Review of System (-) Please check all CURRENT positive findings

Constitutional

□ Fevers □ Chills □ Poor appetite □ Fatigue □ Weight gain □ Insomnia □ Night sweats □ Weight loss

□ Eye pain □ Eye discharge □ Eye redness □ Decrease in vision □ Dry eyes □ Double vision □ Blurry vision

□ Hoarseness □ Ear pain □ Hearing loss □ Ear discharge □ Nose bleeds □ Tinnitus □ Sinus problems □ Sore throat

□ Palpitations □ Rapid heart rate □ Heart murmur □ Poor circulation □ Swelling in the legs or feet □ Chest pain

□ Chronic cough □ Coughing up blood □ History of Tuberculosis □ Excess sputum production □ Shortness of breath

□ Vomiting □ Diarrhea □ Constipation □ Blood in the stool □ Frequent heartburn □ Trouble swallowing □ Nausea

□ Blood in the urine □ Incontinence □ Painful urination □ Urinary retention □ Frequent UTIs □ Increased urinary frequency

□ Hives □ Hair loss □ Skin sores or ulcers □ Itching □ Skin thickening □ Nail changes □ Mole changes □ Rash

□ Muscle aches □ Frequent leg cramps □ Muscle weakness □ Bone pain □ Joint swelling □ Back pain □ Joint pain

□ Heat intolerance □ Cold intolerance □ Increased thirst □ Change in skin pigment □ Excess sweating □ Goiter

□ Tremors □ Migraines □ Numbness □ Dizziness/Vertigo □ Loss of balance □ Slurred speech □ Stroke □ Seizures

□ Easy bruising □ Swollen lymph nodes □ Transfusions □ Prolonged bleeding □ Blood clots □ Low blood count

□ Hay fever □ Frequent infections □ Hepatitis □ HIV positive □ Positive tuberculin skin test (PPD) □ Allergic reactions

Social History: □ No change

Marital Status: ___________________________ Occupation (or most recent job held): ___________________________

□ Non-Smoker (never smoked) □ Ex-Smoker Quit: ___________________________ □ Current Smoker □ How many packs/day? __________

Alcohol consumption: __________ drinks/day __________ drinks/week Caffeine consumption: __________ drinks/day __________ drinks/week

Family History: (Please list any known medical problems) □ No change

Father: ___________________________ Age: __________

Mother: ___________________________ Age: __________

Any Siblings: ___________________________

Your children: ___________________________

Have you ever fainted suddenly and unexpectedly during exercise? YES □ NO

Any sudden and unexpected deaths in your family members who were less than 50 years of age? YES □ NO

Additional Information: Use this space to provide any additional information which may be important to your health care.

Height: __________ Weight: __________

Signature of Reviewing Physician: ___________________________ Date: __________

Signature of Patient: ___________________________ Date: __________
NAPLES HEART RHYTHM SPECIALISTS, P.A.
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
Revised as of July 1, 2013

By law, we are required to make available to you a copy of our Notice of Privacy Practices ("Notice"). By signing below you acknowledge that you received, or been offered and declined, a copy of the Notice.

A current copy of the Notice is also posted in our office, or is available to you upon request. If the Notice is revised, you may review and obtain the new version at any time.

You may decline to sign this acknowledgement.

I have □ received or □ declined a copy of the Notice of Privacy Practices.

Patient Name (Print): ______________________________

Signature of Patient or Legal Representative: ______________________________

If Legal Representative, list Relationship to Patient: ______________________________

Date: ______________________________

For Office Use Only

We were unable to obtain this written acknowledgement because:

________________________________________________________________________

________________________________________________________________________

Initials: _______________ Date: _______________
NAPLES HEART RHYTHM SPECIALISTS, P.A.
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
Revised as of July 31, 2013

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.

If you have any questions or wish to receive additional information about the matters covered by this Notice of Privacy Practices ("Notice"), please contact the Privacy Officer for NAPLES HEART RHYTHM SPECIALISTS, P.A. ("NHRS"), LINA MIR at 700 2nd AVE., STE. 202, NAPLES, FL 34102 or call: (239) 263-0849.

This Notice is provided to you in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") and associated regulations, as may be amended (collectively referred to as "HIPAA") describing NHRS's legal duties and privacy practices with respect to your Protected Health Information ("PHI"). NHRS is required to abide by the terms of this Notice currently in effect, and may need to revise the Notice from time to time. Any required revisions of this Notice will be effective for all PHI that NHRS maintains. A current copy of the Notice will be posted in each office and you may request a paper, or electronic, copy of it.

PHI consists of all individually identifiable information which is created or received by NHRS and which relates to your past, present or future physical or mental health condition, the provision of health care to you, or the past, present or future payment for health care provided to you.

USE AND DISCLOSURE OF PHI FOR WHICH YOUR CONSENT OR AUTHORIZATION IS NOT REQUIRED

HIPAA permits NHRS to use or disclose your PHI in certain circumstances, which are described below, without your authorization. However, Florida law may not permit the same disclosures. NHRS will comply with whichever law is stricter.

1. Treatment: NHRS may use and disclose your PHI to provide, coordinate or manage your health care and related services, including consulting with other health care providers about your health care or referring you to another health care provider for treatment. For example, NHRS may discuss your health information with a specialist to whom you have been referred to ensure that the specialist has the necessary information he or she needs to diagnose and/or treat you. Further, NHRS may contact you to remind you of a scheduled appointment.

2. Payment: NHRS may use and disclose your PHI, as needed, to obtain payment for the health care it provides to you. For example, NHRS may disclose to a third-party payer the treatment you are going to receive to ensure that the payer will cover that treatment. Additionally, NHRS may disclose to a third party payer or grant funding service, as necessary, the type of services you received to reimbursement for your treatment.

3. Health Care Operations: NHRS may use or disclose your PHI in order to carry out its administrative functions. These activities include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualification of health care professionals, conducting training programs in which students provide treatment under the supervision of one of NHRS's health care professionals, business planning and development, business management and general administrative activities. For example, NHRS may disclose your PHI to accreditation agencies reviewing the types of services provided.

4. Required by Law: NHRS may use or disclose your PHI to the extent that such use or disclosure is required by law.

5. Public Health: NHRS may disclose your PHI to a public health authority, employer or appropriate governmental authority authorized to receive such information for the purpose of: (a) preventing or controlling disease, injury or disability; reporting disease or injury; conducting public health surveillance, public health investigations and public health interventions; or at the direction of a public health authority, to an official of a foreign government agency in collaboration with a public health authority; or reporting child abuse or neglect; (b) activities related to the quality, safety or effectiveness or activities or products regulated by the Food and Drug Administration; (c) notifying a person who may have been exposed to a communicable disease or may otherwise be at risk of spreading a disease or condition.

6. Abuse, Neglect or Domestic Violence: NHRS may disclose your PHI to a government authority authorized to receive reports of abuse, neglect or domestic violence if it reasonably believes that you are a victim of abuse, neglect or domestic violence. Any such disclosure will be made: 1) to the extent it is required by law; 2) to the extent that the disclosure is authorized by statute or regulation and NHRS believes the disclosure is necessary to prevent serious harm to you or other potential victims; or 3) if you agree to the disclosure.

7. Health Oversight Activities: NHRS may disclose your PHI to a health oversight agency for any oversight activities authorized by law, including audits; investigations; inspections; licensure or disciplinary actions; civil, criminal or administrative actions or proceedings; or other activities necessary for the oversight of the health care system, government benefit programs, compliance with government regulatory program standards or applicable laws.

8. Judicial and Administrative Proceedings: NHRS may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, or in response to a subpoena, discovery request, or other lawful process upon receipt of "satisfactory assurance" that you have received notice of the request.

9. Law Enforcement Purposes: NHRS may disclose limited PHI about you for law enforcement purposes to a law enforcement official: (a) in compliance with a court order, a court-ordered warrant, a subpoena or summons issued by a judicial officer or an administrative request; (b) in response to a request for information for the purposes of identifying or locating a suspect, fugitive, material witness or missing person; (c) in response to a request about an individual that is suspected to be a victim of a crime, if, under limited circumstances, NHRS is not able to obtain your consent; (d) if the information relates to a death NHRS believes may have resulted from criminal conduct; (e) if the information constitutes evidence of criminal conduct that occurred on the premises of NHRS; or (f) in certain emergency circumstances, to alert law enforcement of the commission and nature of a crime, the location and victims of the crime and the identity, or description and location of the perpetrator of the crime.

10. Coroners, Medical Examiners and Funeral Directors: NHRS may disclose your PHI to a coroner or medical examiner for the purpose of identification, determining a cause of death or other duties authorized by law. NHRS may disclose your PHI to a funeral director, consistent with all applicable laws, in order to allow the funeral director to carry out his or her duties.

11. Research: NHRS may use or disclose your PHI for research purposes, provided that an institutional review board authorized by law or a privacy board waives the authorization requirement and provided that the researcher makes certain representations regarding the use and protection of the PHI.

12. Serious Threat to Health or Safety: NHRS may disclose your PHI, in a manner which is consistent with applicable laws and ethical standards, if the disclosure is necessary to prevent or lessen a serious threat to health or safety of a person or the public, or the information is necessary to apprehend an individual.

13. Specialized Government Functions: NHRS may also disclose your PHI, (a) if you are a member of the United States or foreign Armed Forces, for activities that are deemed necessary by appropriate military command authorities to assure the proper execution of a military mission; (b) to authorized federal officials for the conduct of lawful intelligence, counter-intelligence and other national security activities authorized by law; (c) to authorized federal officials for the provision of protective services to the President, foreign heads of state, or other people authorized by law and to conduct investigations authorized by law; or (d) to a correctional institution or a law enforcement official having lawful custody of you under certain circumstances.
14. **Workers' Compensation:** NHRS may disclose your PHI as authorized by, and in compliance with, laws relating to workers' compensation and other similar programs established by law.

**USES AND DISCLOSURES TO WHICH YOU MAY OBJECT**

15. If you do not object to the following uses or disclosures of your PHI, NHRS may: 1) disclose to a family member, other relative, a close personal friend, or other person identified by you the information relevant to their involvement in your care or payment related to your care; 2) notify others, or assist in the notification, of your location, general condition, or death; or 3) disclose your PHI to assist in disaster relief efforts.

**OTHER USES AND DISCLOSURES OF PHI**

16. Any use or disclosure of your PHI that is not listed herein will be made only with your written authorization. You have the right to revoke such authorization at any time, provided that the revocation is in writing, except to the extent that: 1) NHRS has taken action in reliance on the prior authorization; or 2) If the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

**YOUR RIGHTS REGARDING YOUR PHI**

17. **Restriction of Use and Disclosure:** You have the right to request that NHRS restrict the PHI it uses and discloses in carrying out treatment, payment and health care operations. You also have the right to request that NHRS restrict the PHI it discloses to a family member, other relative or any other person identified by you, which is relevant to such person's involvement in your treatment or payment for your treatment. By law, NHRS is not obligated to agree to any restriction that you request. If NHRS agrees to a restriction, however, it may only disclose your PHI in accordance with that restriction, unless the information is needed to provide emergency health care to you. If you wish to request a restriction on the use and disclosure of your PHI, please send a written request to the Privacy Officer which specifically sets forth: 1) that you are requesting a restriction on the use or the disclosure of your PHI; 2) what PHI you wish to restrict; and 3) to whom you wish the restrictions to apply (e.g., your spouse). NHRS will not ask why you are requesting the restriction. The Privacy Officer will review your request and notify you whether or not NHRS will agree to your requested restriction. You also have the right to request to restrict disclosure of your PHI to a health plan, if the disclosure is for payment or health care operations and the disclosure pertains to a health care item or service for which you have paid out of pocket in full.

18. **Authorization Required:** Most uses and disclosures of PHI for marketing and the sale of PHI require your authorization. In addition, disclosure of psychotherapy notes is prohibited without your authorization, except as allowed by law.

19. **Funding:** NHRS may contact you for purposes of fundraising to support its programs. You have the option to opt-out of this type of communication.

20. **Confidential Communications:** You have the right to receive confidential communications of your PHI. You may request that you receive communications of your PHI from NHRS in alternative means or at alternative locations. NHRS will accommodate all reasonable requests, but certain conditions may be imposed.

To request that NHRS make communications of your PHI by alternative means or at alternative locations, please send a written request to the Privacy Officer setting forth the alternative means by which you wish to receive communications or the alternative location at which you wish to receive such communications. NHRS will not ask why you are making such a request.

21. **Access to PHI:** You have the right to inspect and obtain a copy of your PHI maintained by NHRS. Under HIPAA, you do not have the right to inspect or copy information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding, or information that NHRS is otherwise prohibited by law from disclosing.

If you wish to inspect or obtain a copy of your PHI, please send a written request to the Privacy Officer. If you request a copy of your PHI, NHRS may charge a fee for the cost of copying and mailing the information. You may also request that a copy of your PHI be transmitted to you electronically.

HIPAA permits NHRS to deny your request to inspect or obtain a copy of your PHI for certain limited reasons. If access is denied, you may be entitled to a review of that denial. If you receive an access denial and want a review, please contact the Privacy Officer. The Privacy Officer will designate a licensed health care professional to review your request. This reviewing health care professional will not have participated in the original decision to deny your request. NHRS will comply with the decision of the reviewing health care professional.

22. **Amending PHI:** You have the right to request that NHRS amend your PHI. To request that an amendment be made to your PHI, please send a written request to the Privacy Officer. Your written request must provide a reason that supports the request amendment. NHRS may deny your request if it does not contain a reason that supports the requested amendment. Additionally, NHRS may deny your request to have your PHI amended if it determines that: 1) the information was not created by NHRS and amendment may be made elsewhere; 2) the information is not part of a medical or billing record; 3) the information is not available for your inspection; or 4) the information is accurate and complete.

23. **Notification of Breach:** NHRS will notify you following a breach of your PHI as required by law.

24. **Accounting of Disclosure of Your PHI:** You have the right to request a listing of certain disclosure of your PHI made by NHRS during the period of up to six (6) years prior to the date on which you make your request. Any accounting you request will not include: 1) disclosures made to carry out treatment, payment or health care operations; 2) disclosures made to you; 3) disclosures made pursuant to an authorization given by you; 4) disclosures made to other people involved in your care or made for notification purposes; 5) disclosures made for national security or intelligence purposes; 6) disclosure made to correctional institutions or law enforcement officials; or 7) disclosures made prior to April 14, 2003. The right to receive an accounting is subject to certain other exceptions, restrictions and limitations set forth in applicable statutes and regulations.

To request an accounting of the disclosures of your PHI, please send a written request to the Privacy Officer. Your written request must set forth the period for which you wish to receive an accounting. NHRS will provide one free accounting during each twelve (12) month period. If you request additional accountings during the same twelve (12) month period, you may be charged for all costs incurred in preparing and providing that accounting. NHRS will inform you of the fee for each accounting in advance and will allow you to modify or withdraw your request in order to reduce or avoid the fee.

25. **Obtaining a Copy of this Notice:** You have the right to request and receive a paper or electronic copy of this Notice at any time.

**COMPLAINTS**

26. If you believe that your privacy rights have been violated, you may file a complaint with NHRS or with the Secretary of Health and Human Services. To file a complaint with NHRS, please contact the Privacy Officer at the address listed on page 1 of this notice. All complaints must be submitted in writing. NHRS WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.