AURORA ENT, LLC
Dr. Mary C. Totten, M.D.

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 read it carefully.

If you have questions in regards to the notice, please contact:

The Privacy Officer
Aurora ENT, LLC
3340 Providence Dr. Ste 461
Anchorage, AK 99508

PURPOSE OF THE NOTICE

Effective 3/3/2008
Updated 9/23/2013

We are required by law to preserve the privacy and confidentiality of your health information; both state and federal laws and regulations require us to implement and abide by the practice of this Notice, unless more stringent laws or regulations apply. This Notice describes the ways in which we may use or disclose your health information and also describes your rights and our obligations concerning such uses or disclosures.

The terms of this notice apply to all records containing your personal health information (PHI) that are created or retained by our practice. We reserve the right to revise or amend this Notice for health information we already have created or maintained in the past and for any of your records that we may create or maintain in the future, including any information that we receive from other health care providers or facilities. Our practice will post a copy of our current Notice in our office in a visible location and you may have a copy of our most current Notice at any time.

The privacy practices described in this Notice will be followed by: (1) Any health care professional authorized to enter information into your medical record created and/or maintained at our clinic; (2) All employees, students, residents, and other services providers who have access to your health information at out clinic; and (3) Any member of a volunteer group which is allowed to help you while receiving services at our clinic.

The individuals identified above will share your health information with each other for purposes of treatment, payment and health care operations, as further described in the Notice.

DISCLOSURES OF YOUR HEALTH INFORMATION THAT WE MAY MAKE WITHOUT YOUR AUTHORIZATION

Treatment: We may use your health information to provide you with health care treatment and services. We may disclose your health information to doctors, pharmacists, nurses, nursing assistants, technicians, medical and nursing students, and/or other personnel involved in your care. For example: we may need to refer you to a sleep specialist and it may be necessary to share your health information with them so that we can coordinate services and develop a plan of care. We also may need to refer you to another health care provider to receive certain services and will share information with that health care provider in order to coordinate your care and services. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may use or disclose your health information so that we may bill and receive payment from you, an insurance company, or another third party for the health care services you receive from us. This may include disclosing health information about you to your health plan in order to obtain prior authorization for the services we provide to you, or to determine that your health plan will pay for the treatment. This information may also be used for billing, claims management and collection purposes and related healthcare data processing through our system. For example: we may need to give health information to your health plan in order to obtain prior

approval to perform a procedure. This is only an example of how we may use and disclose your medical information for payment purposes.

Health Care Operations: We may use or disclose your health information in order to perform the necessary administrative, educational, quality assurance and business functions of our clinic. For example: we may use your health information to evaluate the performance of our staff in caring for you. We also may use your health information to evaluate whether certain treatment or services offered by our clinic are effective. We also may disclose your health information to other physicians, nurses, technicians or health profession students for teaching and learning purposes.

USES AND DISCLOSURES OF HEALTH INFORMATION IN SPECIAL SITUATIONS

We may use or disclose your health information in certain special situations as described below. For these situations, you have the right to limit these uses and disclosures as provided for in this Notice.

Appointment Reminders: We may use or disclose your health information for the purposes of contacting you to remind you of a health care appointment.

Treatment Alternatives & Health-Related Products and Services: We may use or disclose your health information for purposes of contacting you to inform you of treatment alternatives or health-related products or services that may be of interest to you. For example, if you are diagnosed with a specific condition, we may contact you to inform you for an instruction class that is offered for your condition.

Family Members and Friends: We may disclose your health information to individuals, such as family members and friends, who are involved in your care or who help pay for your care. We may make such disclosure when: (a) we have your verbal agreement to do so; (b) we make such disclosures and you do not object; or (c) we can infer from the circumstances that you would not object to such disclosures. For example, if your spouse comes into the exam room with you, we will assume that you agree to our disclosure of your information while your spouse is present in the room.

We may also disclose your health information to family members or friends in instances when you are unable to agree or object to such disclosures, provided that we feel it is in your best interests to make such disclosures and the disclosures relate to the family members or friend's involvement in your care. For example, if you present to our clinic with an emergency medical condition, we may share information with the family member or friend that comes with you to our clinic. We also may share your health information with a family member or friend who calls us to request a prescription refill for you.

OTHER DISCLOSURES THAT WE MAY MAKE WITHOUT YOUR AUTHORIZATION

As required by law. We may disclose your health information when required by federal, state, or local law. For example, we are required by the Department of Health and Human Services (DHHS) to disclose your health information in order to allow DHHS to evaluate whether we are in compliance with the federal privacy regulations.

Public Health Activities. We may disclose your health information to public health authorities that are authorized to collect or receive health information for the purpose of preventing or controlling disease, injury, or disability; to report births, deaths, suspected abuse or neglect, reactions to medications; or to facilitate product recall.

Health Oversight Activities. We may disclose your health information to a health oversight agency that is authorized by law to conduct oversight activities including audits, investigations, inspections or licensure and certification surveys. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws and the health care system in general.

Victims of abuse, Neglect or Domestic Violence. Your health information may be disclosed to appropriate government authorities regarding victims of abuse, neglect, or domestic violence.

Judicial or Administrative Proceedings. We may disclose your health information to courts or administrative agencies charged with the authority to hear and resolve lawsuits or disputes. We may disclose your health information pursuant to a court order, a subpoena, a discovery request, or other lawful process issued by a judge or other person involved in the dispute, but only if efforts have been made to (1) notify you of the request for disclosure (2) obtain an order protecting your health information.

Law Enforcement Official. We may disclose your health information in response to a request received from the law enforcement official to report criminal activity or to respond to a subpoena, court order, warrant, summons, or similar process.

Worker's Compensation. We may disclose your health information to worker's compensation programs or similar programs which provide benefits for work-related injuries, illnesses, or disabilities.
Coroners, Medical Examiners, or Funeral Directors. We may disclose your health information to a coroner or medical examiner for the purpose of identifying deceased individual or to determine the cause of death. We also may disclose your health information to a funeral director for the purpose of carrying out their necessary activities.

Organ and Tissue Donation. If you are an organ donor, we may disclose your health information to organizations that handle organ procurement.

Research. We may use or disclose your health information for research purposes under certain limited circumstances. We will not disclose your health information for research purposes without going through a special approval process. Although, we may disclose your healthcare information to individuals preparing to conduct the research project; for example, to help the researcher identify patients with specific medical needs that would relate to the proposed research. Information used for this purpose will not leave our clinic. In most instances, we will ask for your specific permission to use or disclose your health information if the researcher will have access to your name, address, or other identifying information.

To Avert a Serious Threat to Health or Safety. We may use or disclose your health information when necessary to prevent a serious threat to the health or safety of you or other individuals.

Military and Veterans. If you are a member of the armed forces, we may use or disclose your health information as required by military command authorities

National Security and Intelligence Activities. We may use or disclose your health information to authorized federal officials for purposes of intelligence, counterintelligence, and other national security activities, as authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may use or disclose your health information to the correctional institution or the law enforcement official as may be necessary (1) for the institution to provide you with health care; (2) to protect the health or safety of you or another person; (3) for the safety and security of the correctional institution.

Limited Data Set Information. We may disclose limited healthcare information to third parties for purposes of research, public health and healthcare operations. Before disclosing this information, we must enter into an agreement with the recipient of the information that limits who may use or receive the data and requires the recipient to agree not to re-identify the data or contact you. The recipient of your information is required to have appropriate safeguards to prevent inappropriate use or disclosure of your information.

AUTHORIZED USES AND DISCLOSURES

Except for the purposes identified previously in our Notice, we will not use or disclose your health information for any other purposes unless we have your specific written authorization, unless otherwise permitted or required by law. You may revoke the authorization, at any time, in writing, and we will not longer use or disclose your health information for the purposes identified in the authorization, except to the extent that we have already taken some action in reliance on the use or disclosure indicated in the authorization.

Psychotherapy Notes. Except where required or allowed by law, we will not disclose your psychotherapy notes without your written authorization.

Marketing. We will not use your protected health information for marketing purposes without your written authorization.

Sale of PHI. We will not sell your protected health information without your written authorization.

Out-of-Pocket Rule. You may request in writing that we restrict disclosure of your protected health information to a health plan if the disclosure is for payment or health care operations purposes. If you pay for the item or service in full at the time the service is rendered, we have to comply with your request. "Payment in full at the time of service" means that you will pay cash or with a credit or debit card for the full amount due at the time service is rendered and there will not be a refund. Payment by check or other means is not allowed.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights with respect to your medical information that we maintain.

Right to Access. You have the right to inspect and obtain a copy of your health information, in paper or electronic form, which we maintain, with some limited exceptions. Your may submit your request in writing to **Aurora ENT**, 3340 Providence Dr., Suite 461, Tower A, Anchorage, AK 99508 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstance; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

Right to Amend. You have the right to request an amendment of your health information that is maintained by or for our clinic and is used to make health care decisions about you. We may deny your request if it is not properly submitted or does not include a reason to support your request. We may also deny your request if the information sought to be amended: (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the information that is kept by or for our clinic (3) is not part of the information which you are permitted to inspect and copy; or (4) is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request a list accounting, in writing, for any disclosure of your health information we have made, except for uses and disclosures for treatment, payment, or health care operations or pursuant to a written authorization that you have signed. If you would like to receive an accounting of your disclosures, you should contact our business office.

Notification following a Breach. You have the right to be notified following a breach involving your health information.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health 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 health information we disclose about you to someone, such as a family member or friend, who is involved in your care or in the payment of your care. For example, you could ask that we do not use or disclose information regarding a particular treatment that you received. We are not required to agree to your request. If we do agree, that agreement must be in writing and signed by you and us.

In addition, you can request to restrict disclosure of a healthcare item or service you received by our clinic, for payment or healthcare operations, in which you paid for in full out-of-pocket.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your health care in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

Right to a paper Copy of this Notice. You have the right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

QUESTIONS AND COMPLAINTS

If you have any questions regarding this Notice or wish to receive additional information about our privacy practices, please contact our Privacy Officer at 907-277-6673. If you believe your privacy rights have been violated, you may file a complaint with our clinic or with the Secretary of Health and Human Services (HHS). To file a complaint with our clinic, contact our Privacy Officer at 3340 Providence Dr., Suite 461, Tower A, Anchorage, AK 99508 or HHS at:

Office for Civil Rights
U.S. Department of Health and Human Services
2201 Sixth Avenue – M/S: RX-11
Seattle, WA 981211831

All complaints must be in writing. You will not be penalized for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & ACKNOWLEDGEMENT OF NOTICE OF NON-DISCRIMINATION

I, (Name of patient) _____, acknowledge and agree that I have received a copy of Aurora ENT's "Notice of Privacy Practices" & "Notice of non-discrimination".

_____	_____
Patient Signature	**Date**
_____	_____
Patient Legal Representative (if applicable)	**Date**
_____	_____
Print Name of Legal Representative	**Relationship to Patient**

FOR CLINIC USE ONLY

Aurora ENTmade the following good faith efforts to obtain the above-referenced individual's written acknowledgment of receipts of the "notice of Privacy Practices":

(Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if know) why the written acknowledgement was not obtained.)