

Notice of Privacy Practices **Health Insurance Portability and Accountability Act (HIPAA)**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Western University of Health Sciences Patient Care Center is the teaching and practice location for the health professional schools of Western University of Health Sciences and its faculty members. It includes Western University Medical Center, Eye Care Institute at Western University, Western University Dental Center, Western University Foot & Ankle Center, Western University Pharmacy and Western University Travel Health Center.

All patient care provided at the Patient Care Center is provided by a team of faculty physicians and other health care professionals. Graduate students of Western University of Health Sciences may participate in examinations or procedures and in the care of patients as a part of the clinical training programs of Western University of Health Sciences.

This Notice of Privacy Practices applies to your health care information and records maintained at the Patient Care Center.

WHO MUST ABIDE BY THIS NOTICE? All Patient Care Center employees, healthcare providers/faculty and students providing care, and healthcare staff authorized to enter information into your medical or health record.

- Selected Patient Care Center employees responsible for payment and operational support.
- All providers that the above named individuals contract with to provide healthcare services.

All of the above-named individuals will follow the terms of this Notice. In addition, all of the above may share medical information with each other for treatment, payment, or health care operations purposes as described in this Notice.

OUR COMMITMENT REGARDING YOUR MEDICAL INFORMATION The Patient Care Center documents the care and services you receive in written and electronic records. In this Notice, we will refer to those records as “medical information.” We need this information to provide you with quality health care and customer service; evaluate benefits and claims; administer health care coverage; measure performance; and, to fulfill legal and regulatory requirements. We understand that medical information about you and your health is personal. We are committed to protecting your medical information and following all state and federal laws related to the protection of your medical information. This Notice tells you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to:

- make sure that medical information that identifies you is kept private (with certain exceptions);
- give you this Notice describing our legal duties and privacy practices with respect to medical information about you;
- follow the terms of the Notice that are currently in effect.

HOW WE MAY USE OR DISCLOSE YOUR MEDICAL INFORMATION Sometimes we are allowed by law to use and disclose your medical information without your permission. We briefly describe these uses and disclosures and give you some examples. Some medical information, such as certain mental health and drug and alcohol abuse patient information, and HIV and genetic tests have stricter requirements for use and disclosure, and your permission will be obtained prior to some uses and disclosures. However, there are still circumstances in which these types of information may be used or disclosed without your permission. How much medical information is used or disclosed without your permission will vary depending on the intended purpose of the use or disclosure. When we send you an appointment reminder, for example, a very limited amount of medical information will be used or disclosed. At other times, we may need to use or disclose more medical information such as when we are providing medical treatment.

FOR TREATMENT We may use medical information about you to provide you with treatment or services. We may disclose medical information about you to healthcare providers, nurses, therapists, technicians, interns, medical students, residents or other health care personnel who are involved in taking care of you, including offering you medical advice, or to interpreters needed in order to make your treatment accessible to you. For example, a healthcare provider may use the information in your medical record to determine what type of medications, therapy, or procedures are appropriate for you. The treatment plan selected by your healthcare provider will be documented in your record so that other health care professionals can coordinate the different things you need, such as prescriptions, lab tests, referrals, etc. We also may disclose medical information about you to people outside our facilities who may be involved in your continuing medical care, such as skilled nursing facilities, other health care providers, case managers, transport companies, community agencies, family members, and contracted/affiliated pharmacies.

TO OBTAIN PAYMENT FOR HEALTH CARE SERVICES We may use and disclose your medical information so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company, or other third party payer. For example, we may need to give your health plan information about a treatment you received so your health plan will pay us. We may also tell your health plan about a proposed treatment to determine whether your plan will cover the treatment or medication. We

may also share your information, when appropriate, with other government programs such as Medicare or Medi-Cal in order to coordinate your benefits and payments. We may use or disclose medical information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits. We may also provide your medical information to our business associates who assist us with billing, such as billing companies, claims processing companies and others that process our health care claims. We will only disclose the minimum amount of information needed to obtain payment.

FOR HEALTH CARE OPERATIONS We may use and disclose medical information about you for certain health care operations. For example, we may use your medical information to review the quality of the treatment and services we provided, to educate our health care professionals, and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services we should offer, or whether certain new treatments are effective. Your medical information may also be used or disclosed for licensing or accreditation purposes. We may use and disclose health information about you to carry out necessary insurance-related activities. Examples include, underwriting, premium rating, conducting or arranging medical review, legal and audit services, fraud and abuse detection, business planning, management, and general administration.

Organized Health Care Arrangement. Western University of Health Sciences is part of an organized health care arrangement that includes participants in the Oregon Community Health Information Network (OCHIN). A current list of OCHIN participants is available at www.ochin.org. As a business associate of Western University of Health Sciences, OCHIN supplies information technology and related services to Western University of Health Sciences and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of Western University of Health Sciences and other OCHIN participants. For example, OCHIN coordinates clinical review activities on behalf of participants to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by Western University of Health Sciences with other OCHIN participants or a health information exchange when necessary for the medical treatment or for the health care operations purposes of the organized health care arrangement. Health care operations can include, among other things, geocoding your residence location (i.e., translating your human-readable address into a location on a map) to improve the clinic benefits you receive. Personal health information may include past, present and future medical information as well as information outlined in the HIPAA Standards for Privacy of Individually Identifiable Health Information set forth at 45 C.F.R. Subtitle A, Subchapter C, Parts 160 and 164 (the "Privacy Rules"). The information, to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.

FOR REMINDERS We may contact you to remind you that you have an appointment, or that you should make an appointment at the Patient Care Center.

FOR HEALTH-RELATED BENEFITS & SERVICES We may contact you about benefits or services that we provide. We will not sell or give your information to an outside agency for the purposes of marketing their products to you.

FOR TREATMENT ALTERNATIVES We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

FOR FUND-RAISING We may contact you to provide information about raising money for the Center and its operations through a foundation related to the Center. We would only use demographic information, such as your name, address, phone number, and the dates you received treatment or services at Western University of Health Sciences, Patient Care Center. If you do not want us to contact you for fund-raising efforts, write to: Western University of Health Sciences, University Advancement, 359 E. Second St., Pomona, CA 91766.

TO FAMILY AND OTHERS WHEN YOU ARE PRESENT Sometimes a family member or other person involved in your care will be present when we are discussing your medical information. If you object, please tell us and we won't discuss your medical information, or we will ask the person to leave.

TO FAMILY AND OTHERS WHEN YOU ARE NOT PRESENT There may be times when it is necessary to disclose your medical decision-making capacity to agree or object. In those instances, we will use our professional judgment to determine if it is in your best interest to disclose your medical information. If so, we will limit the disclosure to the medical information that is directly relevant to the person's involvement with your health care. For example, we may allow someone to pick up a prescription for you.

FOR RESEARCH Research of all kinds may involve the use or disclosure of your medical information. Your medical information can generally be used or disclosed for research without your permission if an Institutional Review Board (IRB) approves such use or disclosure. An IRB is a committee that is responsible, under federal law, for reviewing and approving human subject's research to protect the safety and welfare of the participants and the confidentiality of medical information. Your medical information may be

important to further research efforts and the development of new knowledge. For example, a research study may involve a chart review to compare the outcomes of patients who received different types of treatment. We may disclose medical information about you to researchers preparing to conduct a research project. On occasion, researchers contact patients regarding their interest in participating in certain research studies. Enrollment in those studies can only occur after you have been informed about the study, had an opportunity to ask questions, and indicated your willingness to participate by signing a consent form.

AS REQUIRED BY LAW We will disclose medical information about you when required to do so by federal, state, or local law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY We may use and disclose your medical information if a serious and imminent threat to your health or safety or someone else's exists. Any disclosure would be to someone able to help stop or reduce the threat.

FOR DISASTER RELIEF We may disclose your name, city where you live, age, sex, and general condition to a public or private disaster relief organization to assist disaster relief efforts, and to notify your family about your location and status, unless you object at the time.

FOR ORGAN AND TISSUE DONATION If you are an organ or tissue donor, we may release your medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ-donor bank, as necessary to facilitate organ or tissue donation and transplantation.

FOR MILITARY ACTIVITY AND NATIONAL SECURITY We may sometimes use or disclose the medical information of armed forces personnel to the applicable military authorities when they believe it is necessary to properly carry out military missions. We may also disclose your medical information to authorized federal officials as necessary for national security and intelligence activities or for protection of the president and other government officials and dignitaries.

FOR WORKERS' COMPENSATION We may release medical information about you to workers' compensation or similar programs, as required by law. For example, we may communicate your medical information regarding a work-related injury or illness to claims administrators, insurance carriers, and others responsible for evaluating your claim for workers' compensation benefits.

FOR PUBLIC HEALTH DISCLOSURES We may use or disclose medical information about you for public health purposes. These purposes generally include the following:

- to prevent or control disease (such as cancer or tuberculosis), injury, or disability;
- to report births and deaths;
- to report suspected child abuse or neglect, or to identify suspected victims of abuse, neglect, or domestic violence;
- to report reactions to medications or problems with products or medical devices;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to comply with federal and state laws that governs workplace safety.

FOR HEALTH OVERSIGHT ACTIVITIES As health care providers we are subject to oversight by accrediting, licensing, federal, and state agencies. These agencies may conduct audits on our operations and activities, and in that process they may review your medical information.

FOR LAWSUITS AND OTHER LEGAL ACTIONS In connection with lawsuits, or other legal proceedings, we may disclose medical information about you in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, summons, or other lawful process. We may disclose your medical information to courts, attorneys, and court employees in the course of conservatorship and certain other judicial or administrative proceedings. We may also use and disclose your medical information, to the extent permitted by law, without your consent to defend a lawsuit.

FOR LAW ENFORCEMENT If asked to do so by law enforcement, and as authorized or required by law, we may release medical information:

- to identify or locate a suspect, fugitive, material witness, or missing person;
- about a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death suspected to be the result of criminal conduct;
- about criminal conduct at one of our facilities; and
- in case of a medical emergency, to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

TO CORONERS AND FUNERAL DIRECTORS We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

INMATES If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution for certain purposes, for example, to protect your health or safety or someone else's. Note: Under the federal law that requires us to give you this Notice, inmates do not have the same rights to control their medical information as other individuals.

ALL OTHER USED AND DISCLOSURES OF YOUR MEDICAL INFORMATION REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. Please note that the revocation will not apply to any authorized use or disclosure of your medical information that took place before we received your revocation. Also, if you gave your authorization to secure a policy of insurance, including health care coverage from us, you may not be permitted to revoke it until the insurer can no longer contest the policy issued to you or a claim under the policy.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION Your medical information is the property of the Medical Center. You have the following rights, however, regarding your medical information, such as your medical and billing records. This section describes how you can exercise these rights.

RIGHT TO INSPECT AND COPY With certain exceptions, you have the right to see and receive copies of your medical information that was used to make decisions about your care, or decisions about your health plan benefits. If you would like to see or receive a copy of such a record, please write us at the address where you received care. If you don't know where information to a family member or other person involved in your care is located, please write us at Western University of Health Sciences, Patient Care Center, 795 E. Second St., Pomona, CA 91766-2007. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. If we don't have the record you asked for but we know who does, we will tell you who to contact to request it. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, in most cases, you may have the denial reviewed. Another licensed health care professional chosen by the Patient Care Center will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

RIGHT TO CORRECT OR UPDATE YOUR INFORMATION If you feel that your medical information is incorrect or important information is missing, you may request that we correct or add to (amend) your record. Please write to us and tell us what you are asking for and why we should make the correction or addition. Submit your request to the Western University of Health Sciences Patient Care Center, 795 E. Second St., Pomona, CA 91766-2007. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us;
- is not a part of the medical information kept by or for us;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete in the record.

We will let you know our decision within 60 days of your request. If we agree with you, we will make the correction or addition to your record. If we deny your request, you have the right to submit an addendum, or piece of paper written by you, not to exceed 250 words, with respect to any item or statement you believe is incomplete or incorrect in your record. If you clearly indicate in writing that you want the addendum to be made part of your medical record, we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

RIGHT TO AN ACCOUNTING OF DISCLOSURES You have the right to receive a list of the disclosures we have made of your medical information. An accounting or list does not include certain disclosures, for example, disclosures to carry out treatment, payment, and health care operations; disclosures that occurred prior to January 1, 2010; disclosures which you authorized us in writing to make; disclosures of your medical information made to you; disclosures to persons acting on your behalf. To request this list or accounting of disclosures, you must submit your request in writing to the Western University of Health Sciences Patient Care Center, 795 E. Second St., Pomona, CA 91766-2007. Your request must state the time period to be covered, which may not be longer than six years and may not include dates before **April 14, 2003**. You are entitled to one disclosure accounting in any 12-month period at no charge. If you request any additional accountings less than 12 months later, we may charge a fee.

RIGHT TO REQUEST LIMITS ON USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. However, by law, we do not have to agree to your request. Because we strongly believe that this information is needed to appropriately manage the care of our patients, we rarely grant such a request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Western University of Health Sciences Patient Care Center, 795 E. Second St., Pomona, CA 91766-2007. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

RIGHT TO CHOOSE HOW WE SEND MEDICAL INFORMATION TO YOU You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only phone you at work or use a P.O. Box when we send mail to you. To request confidential communications, you must make your request in writing, specify how or where you wish to be contacted, and submit it to the Western University of Health Sciences Patient Care Center, 795 E. Second St, Pomona, CA 91766-2007. When we can reasonably and lawfully agree to your request, we will.

RIGHT TO A PAPER COPY OF THIS NOTICE You have the right to a paper copy of this Notice upon request. This can be done in one of three ways: ask for a copy at the registration area of the Center; write to Western University of Health Sciences Patient Care Center, 795 E. Second St., Pomona, CA 91766-2007; or call at (909) 706-3900. You may also obtain a copy of this Notice of Privacy Practices on our website at: <http://www.westernuhealth.com>.

CHANGES TO THIS NOTICE We may change this Notice and our privacy practices at any time, as long as the change is consistent with state and federal law. Any revised Notice will apply both to the medical information we already have about you at the time of the change, and any medical information created or received after the change takes effect. We will post a copy of our current Notice in the Center and on our website at: <http://www.westernuhealth.com>. The effective date of the Notice will be on the first page, in the top right-hand corner.

QUESTIONS If you have any questions about this Notice, please contact the Western University of Health Sciences Patient Care Center, 795 E. Second St., Pomona, CA 91766-2007. The Office for Civil Rights has established a toll-free “privacy line” to enable the public to ask questions related to the privacy regulations. The privacy line can be reached at 1(866) 627-7748 or you can call 1(415) 437-8310

COMPLAINTS If you believe your privacy rights have been violated, you may file a complaint with any of the following:

- You can write the Western University of Health Sciences Patient Care Center, 795 E. Second St., Pomona, CA 91766-2007, or call (909) 469-8616.
- You may file a written complaint with the secretary of the Department of Health & Human Services. Instructions on how to file a complaint can be found on the Office for Civil Rights website at: <http://www.hhs.gov/ocr/privacyhowtofile.htm>
- You can call the Federal Office for Civil Rights in San Francisco at 1(415) 437-8310.

We will not take retaliatory action against you if you file a complaint about our privacy practices.

This Patient Rights document incorporates the requirements of the Joint Commission on Accreditation of Healthcare Organizations; Title 22, California Code of Regulations, Section 70707; Health and Safety Code Sections 1262.6, 1288.4, and 124960; and 42 C.F.R. Section 482.13 (Medicare Conditions of Participation).