NOTICE OF PRIVACY PRACTICES AND POLICIES

Effective July 1, 2020

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a Federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. HIPAA gives you, the patient, the right to understand and control how your personal health information (PHI) is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, I prepared this explanation of how I am to maintain the privacy of your health information and how I may disclose your personal information. Please review it carefully. This notice applies to all of the paper and electronic records of your care maintained by Paul Pawlowski MD, whether created by the doctor, office personnel, records acquired from outside resources such as other clinicians involved in your care, or laboratory/imaging reports.

WAYS IN WHICH THE PRACTICE MAY USE AND DISCLOSE YOUR INFORMATION

The following categories describe ways that I use and share your confidential information. Confidential information includes Protected Health Information ("PHI" - information that could be used to identify you). Not every use or disclosure in a category is listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

ROUTINE SITUATIONS

For Treatment: I may use information about you to provide you with medical treatment or services. Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment is when I consult with another health care provider, such as your primary care physician.

For Payment: I may use and disclose information about you so that the treatment and services you receive at the practice may be billed and payment may be collected from you, an insurance company or a third party – including a collection agency if necessary.

For Health Care Operations: I may use and share information about you for administrative functions necessary to run my practice and promote quality care. For example, I may use your information or combine it with other patient information to review the effectiveness of my treatment and services, to evaluate my performance in caring for you, or to make decisions about additional services my practice should offer. Wherever it is practical, I may remove information that identifies you. I may share information with business associates who provide services necessary to run my practice, such as transcription companies or billing services. I will contractually bind these third parties to protect your information as I would. Also, I may permit your health plan or other providers to review records that contain information about you to assist them in improving the quality of service provided to you (disclosures to health insurance can be restricted at your request if you have paid in full for my services).

Communicating with You and Others Involved in Your Care: My practice may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you are not home, I may leave minimal information on your answering machine or in a message left with the person answering the phone so that you may return my call. In certain situations, I may share information about you with a friend or family member of yours who is involved in your care or payment for your care, unless you have requested that such disclosures not occur, and I have agreed. Information disclosed will be directly relevant to such person's involvement with your care or payment related to your care. Whenever possible, this person will be identified by you as your *designated health representative*. However, in emergencies

or other situations in which you are unable to indicate your preference, I will use my best professional judgment to decide if it is necessary to share information about you with other individuals or organizations to coordinate your care or notify your family.

SPECIAL SITUATIONS

As Required by Law: I will disclose information about you when required to do so by federal, state or local law. For example, I may release information about you in response to a valid subpoena or for communicable disease reporting.

Health Oversight Activities: I may disclose information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

For Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that you have received within my practices and the records thereof, such information may be privileged under state law, and I will not release information without the written authorization of you or your legal representative, or in instance of issuance of a subpoena requiring provision of such information of which you have been properly notified and in response to which you have not opposed the subpoena within the legally specified format and time frame, or in the instance of issuance of a court order compelling me to provide PHI. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

To Avert Serious Threat to Health or Safety: I may disclose your confidential mental health information to any person without authorization if I believe reasonably that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual. These disclosures may be to law enforcement officials to respond to a violent crime, or to protect the target of a violent crime. For example, threat of harming another individual may be reported to appropriate authorities.

Worker's Compensation: If you file a worker's compensation claim, with certain exceptions, I must make available, at any stage of the proceedings, all PHI information in my possession that is relevant to that particular injury in the opinion of the California Department of Industrial Relations, to your employer, your representative, and the Department of Industrial Relations upon request.

Public Health: I may disclose information about you for public health activities, as required by law. These activities generally include, but are not limited to, the following:

- To prevent or control disease, injury or disability;
- To report child abuse or neglect;
- To report adult and domestic abuse;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To disclose your health information to coroners in connection with their investigations of deaths;
- 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 notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

Law Enforcement: I may release information about you if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;

• If you are suspected to be a victim of a crime, generally with your permission;
• About a death we believe may be the result of criminal conduct;
• About criminal conduct at a healthcare facility; and,
• In emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

DISCLOSURES THAT REQUIRE AUTHORIZATION

Psychotherapy notes are handled separately under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and have additional protections. Specifically, the regulations state that in most instances a practice must obtain an authorization for any use or disclosure of psychotherapy notes. No authorization is needed to carry out treatment, payment, or health care operations and the uses listed under "Routine Situations." Additionally, in the following circumstances your psychotherapy notes may be used or disclosed without your authorization: (1) to defend my practice if you sue me or bring some other legal proceeding, (2) if the law requires me to disclose the information to you or the Secretary of HHS or for some other reason, (3) in response to health oversight activities concerning your doctor, (4) to avert a serious threat to health or safety, or (5) to the coroner or medical examiner after you die. All other circumstances require a valid authorization from you.

Confidential information may be released for payment and health care operations only to health plans and their agents and business associates of the practice. The definition of health plan does not include life insurance companies, automobile insurance companies or workers' compensation carriers. These are not covered under HIPAA, and if you would like information submitted to one of these companies, an authorization will be required, unless I am otherwise required by state or federal law. I will not sell your health information or release any PHI for marketing or fundraising without your prior written authorization.

YOUR RIGHTS AS A PATIENT

In addition to provisions by the practice to protect your confidential information, you are entitled to six specific rights as a patient.

You have the right to request restrictions on certain uses and disclosures: You have the right to request a restriction or limitation on the use and sharing of information about you for treatment, payment, administrative functions, or with individuals involved in your care. To request restrictions, you must make your request in writing. In your request, you must tell me 1) what information you want to limit; 2) whether you want to limit use or disclosure or both; and 3) to whom you want it to apply. I am not required to agree to your request. If I agree, I will comply with your request unless the information is needed to provide you with emergency treatment. If you have paid for services "out of pocket", in full and in advance, and you request that I not disclose PHI related solely to those services to a health plan, I will accommodate your request, except where I am required by law to make a disclosure, or if you rescind your request in writing.

You have the right to receive confidential communications: You have the right request that my staff or I communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or at a post office box. To request confidential communications, you must make your request in writing. Your request must specify how or where you wish to be contacted. I will not ask you the reason for your request. I will seek to accommodate all reasonable requests.

You have the right to inspect and obtain copies: You have the right to review and obtain copies of information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes, information compiled in reasonable anticipation of a legal action or proceeding;

and confidential information related to certain laboratory tests under CLIA. To inspect and copy information that may be used to make decisions about you, you must submit your request in writing. You may be charged a fee for the costs of copying, mailing or other supplies associated with your request. In the following circumstances I may deny your request to inspect and copy information.

• I have determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of you or another person;

• The information makes reference to another person (unless the other person is a health care provider) and I have determined, in the exercise of professional judgment that the access requested is reasonably likely to cause substantial harm to the other person; or

• The request for access is made by your representative and I have determined, in the exercise of professional judgment, that the provision of access to your personal representative is reasonably likely to cause substantial harm to you or another person.

If you are denied access, you may request a review of the denial: The review will be completed by a qualified individual other than myself. I will comply with the outcome of the review.

You have the right to amend confidential information: If you feel that the information I have about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as the information is kept by or for my practice. To request an amendment, your request and a reason that supports your request must be made in writing and submitted to me. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask me to amend information that:

• Was not created by my practice, unless the person or entity that created the information is no longer available to make the amendment. In such instances I would consider the request;

• Is not part of the Information kept by or for my practice;

• Is not part of the information which you would be permitted to inspect and copy; or

• Is accurate and complete.

You have the right to receive an accounting of disclosures of confidential information: You may ask to receive an accounting of certain disclosures made about you that were not related to the routine uses listed above. To request this list or accounting of disclosures, you must submit your request in writing to me. Your request must state a time period that may not be longer than six years and indicate in what form you want the list (for example on paper or in an electronic file). The first list you request will be free. For additional lists, I may charge you the costs of providing the list. I will notify you of the estimated cost involved and you may choose to withdraw or modify your requests because any costs are incurred. Disclosures do not have to be made when those disclosures are:

• To carry out treatment, payment and health care operations;

• As a result of a signed authorization;

• For the practice's directory or to persons involved in your care;

• For national security or intelligence purposes; or

• To correctional institutions or law enforcement officials

You will be notified, as required by law, in the case of a breach of your unsecured protected health information.

You have the right to obtain a paper copy of this Notice upon request: Even if you have requested an electronic copy, I will provide you with a paper copy of this Notice at your request.

MY PRACTICE'S DUTIES

In addition to your rights as a patient, my practice has duties to protect your confidential information and inform

you of changes to protection measures. I am required by law to maintain the privacy of confidential information and provide you with notice of my legal duties and privacy practices with respect to such information. I am required to abide by the terms of this Notice currently in effect.

CHANGES TO THIS NOTICE

I reserve the right to revise or change provisions on this notice. I will make the new Notice provisions effective for all confidential information I maintain. I will promptly revise and distribute my Notice whenever there is a change to the uses or disclosures, your rights, and my duties, or other privacy practices stated in this Notice. I will post a note indicating that there are changes to the Notice throughout my practice for six months from the effective date of the change. A copy of the current Notice will be available throughout my practice and on my website. The Notice will contain the effective date on the top of first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be submitted or verified in writing. You have specific rights under the Privacy Rule. You will not be penalized for filing a complaint.

OTHER USES OF INFORMATION

Other uses and disclosures of information not covered by this notice or the laws that apply to my practice will be made only with your written permission. If you provide my practice specific permission to use or disclose information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, I will no longer use or disclose information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures I have already made with your permission, and that I am required to retain my records of the care that I provided to you.

PRIVACY AND SECURITY OFFICER

I am the privacy and security officer for my practice. You may contact me with questions, complaints, or comments, at (323) 366-5352 or by mail to Paul Pawlowski MD, 3756 W Avenue 40, Suite K #181, Los Angeles, CA, 90065.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I am required to provide you with a copy of this Notice and document your receipt. Please fill out an Acknowledgement of Receipt of Notice of Privacy after receiving this Notice. (See next page.)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In order to comply with HIPAA standards each practice must obtain a signed acknowledgement that each direct treatment patient has received its Notice of Privacy Practices or must document a good faith effort to provide the Notice and receive a written acknowledgement of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or health care operations.

By signing below, I acknowledge that I have received and reviewed a copy of the Notice of Privacy Practices and Policies from Paul Pawlowski MD,

_____ _____

Patient signature (electronic signatures not accepted) Date

_____

Patient's name (printed)