<u>**NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMATION**</u>

For ALLERGY ASSOCIATES, INC.

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.

Federal regulations developed under the Health Insurance Portability and Accountability Act (HIPAA) require that the practice provide you with this Notice Regarding Privacy of Personal Health Information. The Notice describes (1) how the practice may use and disclose your protected health information, (2) your rights to access and control your protected health information in certain circumstances, and (3) the practices' duties and contact information.

I. Protected Health Information

"Protected health information" is health information created or received by your health care provider that contains information that may be used to identify you, such as demographic data. It includes written or oral health information that relates to your past, present, or future physical or mental health; the provision of health care to you; and your past, present, or future payment for health care.

II. The Use and Disclosure of Protected Health Information in Treatment, Payment and Health Care Options

Your protected health information may be used and disclosed by the practice in the course of providing treatment, obtaining payment for treatment, and conducting health care operations. Any disclosures may be made in writing, electronically, by facsimile, or orally. The practice may also use or disclose your protected health information in other circumstances if you authorize the use or disclosure, or if state law or the HIPAA privacy regulations authorize the use or disclosure.

Treatment. The practice may use and disclose your protected health information in the course of providing or managing your health care as well as any related services. For the purpose of treatment, the practice may coordinate your health care with a third party. For example, the practice may disclose your protected health information to a pharmacy to fulfill a prescription for asthma medication, to an X-ray facility to order an X-ray, or to another physician who is administering your allergy shots which we prepared. In addition, the practice may disclose protected health information to other physicians or health care providers for treatment activities of those other providers,

Payment. When needed, the practice will use or disclose your protected health information to obtain payment for its services. Such uses or disclosures may include disclosures to your health insurer to get approval for a recommended treatment or to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. When obtaining payment for your health care, the practice may also disclose your protected health information to your insurance company to demonstrate the medical necessity of the care or for utilization review when required to do so by your insurance company. Finally, the practice may also disclose your protected health information to another provider where that provider is involved in your care and requires the information to obtain payment.

Operations. The practice may use or disclose your protected health information when needed for the practice's health care operations for the purposes of management or administration of the practice and of offering quality health care services. Health care operations may include: (1) quality evaluations and improvement activities; (2) employee review activities and training programs; (3)

accreditation, certification, licensing, or credentialing activities; (4) reviews and audits such as compliance reviews, medical reviews, legal services, and maintaining compliance programs; and (5) business management and general administrative activities. For instance, the practice may use, as needed, protected health information of patients to review their treatment course when making quality assessments regarding allergy care or treatment. In addition, the practice may disclose your protected health information to another provider or health plan for their health care operations.

Other Uses and Disclosures. As part of treatment, payment, and healthcare operations, the practice may also use or disclose your protected health information to: (1) remind you of an appointment including the leaving of appointment reminder information on your telephone answering machine; (2) inform you of potential treatment alternatives or options; or (3) inform you of health-related benefits or services that may be of interest to you.

III. Additional Uses and Disclosures Permitted Without Authorization or an Opportunity to Object

In addition to treatment, payment, and health care operations, the practice may use or disclose your protected health information without your permission or authorization in certain circumstances, including:

When Legally Required.
When There are Risks to Public Health.
To Report Abuse, Neglect, or Domestic Violence.
To Conduct Health Oversight Activities.
For Judicial and Administrative Proceedings.
For Law Enforcement Purposes.
To Coroners, Funeral Directors, and for Organ Donation.
To Prevent or Diminish a Serious and Imminent Threat to Health or Safety.
For Specified Government Functions.
For Worker's Compensation.

IV. Uses and Disclosures Permitted With an Opportunity to Object

Subject to your objection, the practice may disclose your protected health information (1) to a family member or close personal friend if the disclosure is information directly relevant to the person's involvement in your care or payment related to your care; or (2) when attempting to locate or notify family members or others involved in your care to inform them of your location, condition or death. The practice will inform you orally or in writing of such uses and disclosures of your protected health information as well as provide you with an opportunity to object in advance. Your agreement or objection to the uses and disclosures can be oral or in writing. if you do not object to these disclosures, the practice is able to infer from the circumstances that you do not object, or the practice determines, in its professional judgment, that it is in your best interests for the practice to disclose information that is directly relevant to the person's involvement with your care, then the practice may disclose your protected health information. If you are incapacitated or in an emergency situation, the practice may exercise its professional judgment to determine if the disclosure is in your best interests and, if such a determination is made, may only disclose information directly relevant to your health care.

V. Uses and Disclosures Authorized by You

Other than the circumstances described above, the practice will not disclose your health information unless you provide written authorization. You may revoke your authorization in writing at any time except to the extent that the practice has taken action in reliance upon the authorization.

VI. Your Rights

You have certain rights regarding your protected health information under the HIPAA privacy regulations. These rights include:

The right to inspect and copy your protected health information.
The right to request a restriction on uses and disclosures of your protected health information.
The right to request to receive confidential communications from the practice by alternative means or at an alternative location.

The right to request an amendment of your protected health information.
The right to request an accounting of certain disclosures.
The right to obtain a paper copy of this Notice.

VII. The Practice's Duties

The practice is required to ensure the privacy of your health information and to provide you with this Notice of your rights and the practice's duties and procedures regarding your privacy. The practice must abide by the terms of this Notice, as may be amended periodically. The practice reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that the practice collects and maintains. If the practice alters its Notice, the practice will provide a copy of the revised Notice through regular mail or in-person contact.

VIII. Complaints

If you believe that your privacy rights have been violated, you have the right to relate complaints to the practice and to the Secretary of the Department of Health and Human Services. You may provide complaints to the practice verbally or in writing. Such complaints should be directed to the practice's Privacy Officer. The practice encourages you to relate any concerns you may have regarding the privacy of your information and you will not be retaliated against in any way for filing a complaint.

IX. Contact Person

The practice's contact person regarding the practice's duties and your rights under the HIPAA regulations is the Privacy Officer. The Privacy Officer can provide information regarding issues related to this Notice by request. Complaints to the practice should be directed to the Privacy Officer at the following address:

ALLERGY ASSOCIATES, INC.
1570 Woodlake Drive
Chesterfield MO 63017
Attn: Privacy Officer

The Privacy Officer can be contacted by telephone at 314-878-0996.

X. Effective Date This Notice is effective on April 14, 2003.

Allergy Associates, Inc.

Rand E. Dankner, M.D
Jacqueline L. Reiss, M.D.

HIPPA AUTHORIZATION FORM TO RELEASE INFORMATION

(PERMISSION FROM PATIENT/PATIENT'S LEGAL GUARDIAN TO SHARE PERSONAL MEDICAL INFORMATION.)

Patient Name: ______________________________ D.O.B.: ____________________

Street Address: ______________________________

City, State, Zip: ______________________________

I ____________________, hereby authorize Allergy Associates, Inc., to release any and all medical
(Patient Name) information and test results that pertain me, to the following individual(s) and or Physicians:

Name: ________________________ Relationship to Pt: ________________________

Name: ________________________ Relationship to Pt: ________________________

Name: ________________________ Relationship to Pt: ________________________

I authorize Allergy Associates Inc., to contact the individual(s) listed above to convey any pertinent information to me, in the event that I am unable to be reached by the facility.

I understand that I may revoke/cancel this authorization by notifying Allergy Associates inc., in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is to be released.

I acknowledge that I have received a copy of ALLERGY ASSOCIATES, INC.'s notice regarding privacy of personal health information.

______________________________ ____________________
Signature of Patient Date:

OR

Signature of parent or legal guardian or
personal representative of patient's estate

Date:

Chesterfield Office
1570 Woodlake Drive
Chesterfield, MO 63017
Phone: (314) 878-0996
Fax: (314) 878-6283

St. Peters Office
4601 Executive Centre Parkway Suite 100
St. Peters, MO 63376
Phone: (636) 928-3344
Fax: (636) 928-5851