INDIANA PROFESSIONALS RECOVERY PROGRAM

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 review it carefully. The privacy of your medical information is important to us.

If you have any questions about this notice,
please contact our Compliance Line at 888-883-8433

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect August 1, 2015, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Who Will Follow This Notice

This notice describes our practices and those participants listed below in our organized health care arrangement. As such, we may share your medical information and the medical information of others we service with each other as needed for treatment, payment or health care operations relating to our organized health care arrangement.

This notice does not imply any joint venture or any other special association or legal relationship between the hospital and its medical staff. This notice is an administrative tool permitted by federal law allowing the hospital and medical staff to tell you about common privacy practices.

If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We will also use our professional judgment and our experience with common practice to allow a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of medical information.

By Law or Special Circumstances:
We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:
• as required by law;
• for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, to employers, the IN Nurses Association, and any other government agency as required by law regarding work-related illness or injury;
• to report adult abuse, neglect, or domestic violence;
• to nursing oversight agencies;
• in response to court and administrative orders and other lawful processes;
• to law enforcement officials after receiving subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
• to coroners, medical examiners, and funeral directors;
• to organ procurement organizations;
• to avert a serious threat to health or safety;
• in connection with certain research activities;
• to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
• to correctional institutions regarding inmates; and
• as authorized by state worker's compensation laws.

Restriction:
You have the right to request that we place certain restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions except in limited circumstances described below, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions must be in writing. You may obtain a form to request additional restrictions on the use or disclosure of your medical information on by using the contact information listed at the end of this notice. We will not be bound to the restrictions unless our agreement is signed by you and the appropriate hospital representative. We will grant a request for restriction of disclosure of your protected health information to your health insurer if three conditions are met: (1) the reason we would disclose to the insurer is for payment or health care operations, (2) the disclosure is not required by Jaw, and (3) you or another person has paid us in full for the health care item or service.

Confidential Communication:
You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations. For example, you might request that we contact you at work or by mail. You must make your request in writing. You may obtain a form to request alternative communications by using the contact information listed at the end of this notice. We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment.

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. Your request must be in writing, and it must explain why the information should be amended. You may obtain a form to request an amendment by using the contact information listed at the end of this notice. We may deny your request if we did not create the information you want amended and the individual who provided the information remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be attached to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice:
If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice obtain this notice in written form.

Along with IPRP, the following participate in our organized health care arrangement:
• Members of our medical staff and their employees or workforce who provide services or support to the physician at the center.
• Our employed physicians and their office staff.

Uses and Disclosures of Medical Information

We use and disclose medical information about you for treatment, payment, and health care operations.

For example:

Treatment: We may use or disclose your medical information to a physician or other health care provider in order to provide treatment to you.

These uses are necessary to make sure that all our patients receive quality care.

Some examples are:
- We may remove information that identifies you from the medical information so others may use it for studies in health care delivery without learning who the patients are; and
- We may disclose your medical information to another provider who has a relationship with you and is subject to the same Privacy rules, for their health care operation purposes.

On Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

Use and Disclosure of Certain Types of Medical Information. For certain types of medical information we may be required to protect your privacy in ways more strict than we have discussed in this notice. We must abide by the following rules for our use or disclosure of certain types of your medical information:

Alcohol and Drug Abuse Information.
We may not disclose your medical information that contains alcohol and drug abuse information except to you, your personal representative or pursuant to an authorization or as may otherwise be allowed by law.

Your Rights Regarding Medical Information about You

Right to Inspect and Copy: You have the right to look at or get copies of your medical information, with limited exceptions. You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a fee for copying and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

We may deny your request to inspect and copy in very limited circumstances as allowed by law. If you are denied access to your medical information, you may request that the denial be reviewed. Another Licensed health care professional chosen by the hospital 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.

Disclosure Accounting:
You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities, for six (6) years from the date of your request. You must make a request in writing to request a listing of disclosures. You may obtain a form to request the accounting by using the contact information at the end of this notice. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the: information listed at the end of this notice for a full explanation of our fee structure.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to

your medical information or in response to a request you made to amend or restrict the use or disclosure of · your medical information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services at the following address:

United States Department of Health & Human Services
Office of Civil Rights
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Room 509 HHH Building
Washington, D.C. 20201

For additional information:

Telephone: (888) 883-8433
You may write to us at:
Compliance and Regulation Officer
IPRP
805 Marsh Street
Valparaiso, IN 46385

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Fax: (219) 929-5514

You may also call the Compliance Line at:
1-888-883-8433

THIS NOTICE IS YOUR COPY TO RETAIN FOR ANY FUTURE QUESTIONS OR CONCERNS REGARDING THE USE OF YOUR PROTECTED HEALTH INFORMATION.

Please sign the Acknowledgement to signify your receipt and understanding of this document for our records.

Thank you.

PATIENT SIGNATURE_____

WITNESS_____

COPY GOES TO CLIENT AND ORIGINAL STAYS ON FILE.