HIPAA – 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.

Flourish Integrative Pharmacy works with you to provide quality prescriptions. This Notice of Privacy Practices ("notice") describes:

- How we may use and disclose your medical information
- Your rights to access and amend your medical information

We are required by law to:

- Maintain the privacy of your medical information
- Provide you with notice of our legal duties and privacy practices with respect to your medical information
- Abide by the terms of this notice

Permitted Uses and Disclosures of your Medical Information

As permitted by your health plan or prescription benefit plan, we may use and disclose your medical information for the following purposes only:

Treatment

We may use and disclose your medical information to healthcare professionals to provide, coordinate and manage the delivery of medical items or services. For example, our pharmacist may disclose medical information about you to your physician in order to coordinate the prescribing and delivery of your medications. We will fill and send to you orders that you send to Flourish Integrative Pharmacy.

Payment

We may use and disclose medical information about you to manage your account and process your claims for medications you have received. For example, we may provide you with claim forms containing your information for you to submit to your health plan or employer for payment.

Healthcare Operations

We may use and disclose your medical information to carry on our own business planning and healthcare operations. We need to do this so we can provide you with pharmacy benefits and ensure you receive the highest-quality services. For example, we may use and disclose medical information about you to:

- Assess the use or effectiveness of certain medications
- Develop and monitor medical protocols
- Give you helpful medication reminders and health-management services.

At your request, we may send you information about health conditions, medications or promotions. At your request or the request of your health plan, we may send you information or contact you about programs designed to improve your health.

Care Coordination and Treatment Reminders

We may use or disclose your medical information to contact you about treatment options or alternatives that may be of interest to you. For example, we may call you to remind you of expired prescriptions, the availability of alternative medications or to inform you of other medications that may benefit your health.

Individuals Involved in Your Care or Payment for Your Care

We may disclose medical information about you to someone who assists in or pays for your care. Unless you write to us and specifically tell us not to, we may disclose your medical information to someone who has your permission to act on your behalf. We will require this person to provide adequate proof that he or she has your permission.

Business Associates

We may arrange to provide some services through contracts with business associates. On occasion, we may disclose your medical information to business associates acting on our behalf. If any medical information is disclosed, we will protect your information from further use and disclosure using confidentiality agreements.

Research

Under certain circumstances, we may use and disclose medical information about you for research purposes. Before we use or disclose medical information about you, we will either remove information that personally identifies you or gain approval through a special approval process designed to protect the privacy of your medical information. In some circumstances, we may use your medical information to generate aggregate data (summarized data that does not identify you) to study outcomes, costs and provider profiles and to suggest benefit designs for your employer or health plan. These studies generate aggregate data that we may sell or disclose to other companies or organizations. Aggregate data does not personally identify you.

Abuse, Neglect or Domestic Violence

We may disclose your medical information to a social service, protective agency or other government authority if we believe you are a victim of abuse, neglect or domestic violence. We will inform you of our disclosure unless informing you will place you at risk of serious harm.

Public Health

We may disclose your medical information to a public health department, including the U.S. Food and Drug Administration, when required by law for the reporting or tracking of illnesses, injuries or dangerous preparations.

Health Oversight

We may disclose medical information to a health oversight agency performing activities authorized by law, such as investigations and audits. These agencies include governmental agencies (state and federal) that oversee the healthcare system, government benefit programs and organizations subject to government regulation and civil rights laws.

To Avert Serious Threat to Health or Safety

We may disclose your medical information to prevent or lessen an imminent threat to the health or safety of another person or the public. Such disclosure will only be made to someone in a position to prevent or lessen the threat.

Judicial Proceedings

We may disclose your medical information in the course of any judicial proceeding in response to a court order, subpoena or other lawful process, but only after we have been assured that efforts have been made to notify you of the request.

Law Enforcement

We may disclose your medical information, as required by law, in response to a subpoena, warrant, summons or, in some circumstances, to report crime.

Coroners and Medical Examiners

We may disclose your medical information to a coroner or a medical examiner for the purpose of determining cause of death or other duties authorized by law.

Organ, Eye and Tissue Donation

We may disclose your medical information to organizations involved in organ transplantation to facilitate donation and transplantation.

Workers Compensation

We may disclose your medical information in order to comply with workers compensation laws and other similar programs.

Specialized Government Functions, Military and Veterans

We may disclose your medical information to authorized federal officials to perform intelligence, counter-intelligence, medical suitability determinations, Presidential protection activities and other national security activities authorized by law. If you are a member of the U.S. armed forces or of a foreign military force, we may disclose your medical information as required by military command authorities or law. If you are an inmate in a correctional institution or under the custody of a law enforcement official, we may disclose your medical information to those parties if disclosure is necessary for 1) the

provision of your healthcare; 2) maintaining the health or safety of yourself or other inmates; or 3) ensuring the safety and security of the correctional institution or its agents.

As Otherwise Required By Law

We will disclose medical information about you when required to do so by law. If federal, state or local law within your jurisdiction offers you additional protections against improper use or disclosure of medical information, we will follow such laws to the extent they apply.

Other Uses and Disclosures

Other uses and disclosures of your medical information not listed in this notice will be made only with your written authorization. You may revoke this authorization at any time unless we have taken action in reliance upon it.

Your Rights With Respect to Your Medical Information

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy

Subject to some restrictions, you may inspect and copy medical information that may be used to make decisions about you. To do so, submit a written request to Flourish Integrative Pharmacy at the address listed below.

Right to Amend

If you believe medical information about you is incorrect or incomplete, you may ask us to amend the information. Such request must be made in writing and submitted to Flourish Integrative Pharmacy at the address listed below. In addition, you must provide a reason supporting your request to amend.

Right to an Accounting of Disclosures

You have the right to request an accounting of disclosures of your medical information. This accounting identifies the disclosures we have made of your medical information other than for treatment, payment or healthcare operations. You must submit your request in writing to Flourish Integrative Pharmacy at the address listed below. The provision of an accounting of disclosures is subject to certain restrictions.

Right to be Notified

You have the right to be notified following a breach of unsecured PHI if your PHI is affected. This notification will be made by mail unless we do not have a correct mailing address for you, then we may use our web site, media stories or ads to inform you.

Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information we use and disclose about you for treatment, payment or healthcare operations. You also may request that your medical information not be disclosed to family members or friends who may be involved in your care or paying for your care. Your request must 1) be in writing; 2) state the restrictions you are requesting; and 3) state to whom the restriction applies. We are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment.

Right to Request Disclosures to your Insurance Plan.

You have the right to request that we do not disclose information to your insurance plan about services provided however you must pay for the services in full. If you do not pay for the services within 30 days of first statement date, the restriction is void and we may bill your insurance.

Confidential Communications

You may ask that we communicate with you in a particular way and in a particular place to protect the confidentiality of your medical information. Your request must be submitted in writing to Flourish Integrative Pharmacy at the address listed below and you must state an alternate method or location you would like us to use to communicate your medical information to you.

Right to a Paper Copy of This Notice

You have the right to request a paper copy of this notice at any time. For information about how to obtain a copy of this notice and answers to frequently asked questions, please call **(405) 751-3333.** Even if we have agreed to provide this notice electronically, you are still entitled to a paper copy.

Right to File a Complaint

If you believe we have violated your privacy rights you may file a written complaint to Flourish Integrative Pharmacy at the address listed below. You may also file a complaint with the **Secretary of the Department of Health and Human Services**. You will not be penalized for filing a complaint.

Written complaints and written requests for a copy of your medical information, amendment to your medical information, an accounting of disclosures, restrictions on your medical information or for confidential communications may be mailed to:

Flourish Integrative Pharmacy
14720 N Pennsylvania Ave
Oklahoma City, OK 73134

Please include your name, address. We reserve the right to revise this notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future.

Acknowledgement of Notice of Privacy Practices

The purpose of the form below is to verify that you received this Notice of Privacy Practices. You are not required to sign or return this form. Your pharmacy services will continue even if you do not return this form.

If you choose to return this form, please complete the information below and mail this page of the notice to the following address:

Flourish Integrative Pharmacy
14720 N Pennsylvania Ave.
Oklahoma City, OK 73134

All members of your family who are on your prescription benefits plan may also sign this form acknowledging that they read the notice. Please share this notice with your family members.

Signature: _____

Date: _____