



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 carefully.**

Your Rights

1. You have the right to request to see or to obtain a copy of your laboratory results and any other information we have about you. You may request a copy of your laboratory results or a summary of your health information at anytime. We will provide a copy at your written request with a cost-based fee, usually within 30 days. We, however, will not discuss laboratory results with patients for any reason. For any billing issues you may contact our billing department at (818) 779-0130.
2. You have the right to request a restriction in our use or disclosure of your health information for treatment, payment or our operations. You have the right to request that we restrict disclosure of your health information to only certain individuals involved in your care or the payment of your care. If you pay for a service out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
3. You have the right to ask us to amend your health information if you believe it is incorrect or incomplete. To request an amendment it must be submitted in writing. We will respond to your request in writing within 60 days on whether we found the information to be correct or if it has been corrected.
4. You have the right to request confidential communications. You can ask us to contact you in a specific way or to send mail to a different address. We will honor all *reasonable* requests.
5. You have the right to receive a copy of this notice at anytime. A copy of this notice is also available on our website www.primexlab.com.
6. You have the right to file a complaint if you feel your rights have been violated. You may file a complaint with our practice to the Privacy Officer at the address listed below, or with the US Department of Health and Human Services Office of Civil Rights by sending a letter to 200 Independence Avenue, SW, Washington, DC 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint, but will cooperate fully to resolve any issues or possible concerns.

Your Choices

For certain health information, you can tell us your choices about what we share.

1. You have both the right and choice to tell us to share information with your family, close friends, or others involved in your care.
2. You have the right and choice to tell us to share information in a disaster relief situation.

If you are not able to tell us your preferences (i.e. if you are unconscious), we may share your information if we believe it is in your best interest. We may also share information when needed to lessen a serious and imminent threat to health or safety.

We never share your information for marketing purposes or the sale of your information unless you give us written authorization. We may contact you for fundraising efforts, but you may opt out at anytime.

Our Uses and Disclosures

We typically use or share your health information for your own treatment, to run our organization, or to bill for services. We are allowed or required to share your health information in other ways, usually ways that contribute to the public good. We may also use or disclose your information for these purposes:

- To help with public health and safety issues
- To do research
- To comply with state or federal laws, if required, including with the Department of Human and Health Services
- To respond to organ and tissue donation requests from organ procurement organizations
- To work with a medical examiner or funeral director when an individual dies
- To address workers' compensation, law enforcement, and other government requests
- To respond to lawsuits, a court or administrative order, or in response to a subpoena

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and provide a copy to you. We will not use or share your information other than as described here unless you provide us authorization. You may revoke this authorization at anytime.

We reserve the right to change the terms of this notice at any time. These changes will apply to all information we have about you. The new notice will be available upon request, in our office, or on our website.

I hereby acknowledge that I have been presented with Primex Clinical Laboratories' Notice of Privacy Practices.

Signature _____ Date _____
(For minors: Signature of parent or guardian)

Printed name of Patient _____