

Central Compounding Center South
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Your Information. Your Rights. Our Responsibilities.

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. DATE OF NOTICE: April 14, 2003 UPDATED: May 17, 2017

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. Under applicable law, we are required to protect the privacy of your individual health information (information we refer to in this notice as "Protected Health Information"). We are also required to provide you with this Notice regarding our policies and procedures regarding your Protected Health Information and to abide by the terms of this notice, as it may be updated from time to time. We are permitted to make certain types of uses and disclosures under applicable law for treatment, payment, and healthcare operations purposes.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home, cell or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item 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. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, prescription refill requests, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at: Central Compounding Center South, Jennifer Burch, PharmD, Owner, 6224 Fayetteville Rd, #103 Durham, NC 27713 919-484-7600. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 40401, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hippa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

We may disclose to one of your family members, to a relative, to a close personal friend, or to any other person identified by you, Protected Health Information that is directly relevant to the person's involvement with your care or payment related to your care. In addition, we may use or disclose the Protected Health Information to notify, identify, or locate a member of your family, your personal representative, another person responsible for care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency, or you object to this use or disclosure, we will do in our judgment what is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person's involvement with your healthcare. We will also use our judgement and experience regarding your best interest in allowing people to pick-up filled

prescriptions, or other similar forms of Protected Health Information. We will inform you of any such uses or disclosures if they would require your signed authorization under such circumstances and give you an opportunity to object as soon as practicable.

- We will never share your information for marketing purposes or for sale of information.

Our Uses and Disclosures: How do we typically use or share your health information?

We may obtain information to dispense prescriptions and for the documentation of pertinent information in your records that may assist us in managing your medication therapy or your overall health. For treatment purposes, such use and disclosure will take place in providing, coordinating, or managing healthcare and its related services by one or more of your providers, such as when your pharmacist consults with your physician or specialist regarding your medications, treatment or condition.

For payment purposes, such use and disclosure will take place to obtain or provide reimbursement for providing pharmaceutical care services, such as when your case is reviewed to ensure that appropriate care was rendered. For reimbursement purposes, your Protected Health Information may be disclosed to one or several intermediaries employed by your plan sponsor including but not limited to insurers, pharmacy benefits managers, claims administrators and computer switching companies.

For healthcare operations purposes, such use and disclosure will take place in a number of ways, including for quality assessment and improvement; provider review and training; underwriting activities; reviews and compliance activities; and planning, development, management and administration. Your information could be used, for example, to assist in the evaluation of the quality of care you were provided.

We store some of your Protected Health Information in electronic computer files. We backup our electronic records daily and employ other precautions to safeguard the integrity of your Protected Health Information. In spite of these precautions it is possible but unlikely that a computer crash or other technological failure could cause the loss of data. In addition, reasonable safeguards are employed to protect your Protected Health Information stored on electronic media.

In addition, we may contact you to provide refill reminders, health screenings, wellness events, inoculations, vaccinations or information about treatment alternatives or other health-related benefits and services that may be of interest to you. In addition, we may disclose your health information to your plan sponsor. In addition, we may contact you for the purpose of fund raising activities.

We may use and disclose your Protected Health Information, without your authorization when the pharmacy needs to contact a physician or physician's staff and is permitted or required to do so without individual written authorization. We may use and disclose your protected health information if we are contacted by another pharmacy who states they have your request and consent to transfer pharmacy records to them.

We may use your name to reference your prescriptions and pharmaceutical care services. You may be required to sign a signature log form to acknowledge receipt of service, to acknowledge receipt of this Notice and the disclosure of Protected Health Information as outlined herein. This information may be disclosed by use to other persons who ask for you or your prescriptions by name. You may restrict or prohibit these uses and disclosures by notifying a pharmacy representative orally or in writing of your restriction or prohibition. We are not required to honor those requests. We are able to provide treatment services to you even if you object to sign the acknowledgement of the receipt of this Notice or if we decide not to honor a request regarding the information in this document. In the event of an emergency or your incapacity, we will do in our reasonable judgement what is consistent with your known preference, and what we determine to be in your best interest.

From time to time we may employ the services of business associates who may assist us in one or more tasks and who may use, change or create Protected Health Information. Business associates are required to comply with all privacy regulations on your behalf.

We may disclose Protected Health Information about you without your authorization to comply with workers compensation laws, as required by law enforcement, legal proceedings, subpoenas, court orders, public health requirements, and health oversight activities and as required by law.

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 give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time.

For more information see: www.hhs.gov/ocr/privacy/hippa/understanding/consumers/noticepp.html

Other uses and disclosures will be made only with your written authorization, and you may revoke your authorization by notifying us in writing to the address below.

In addition, you may request, and we must accommodate the request, if reasonable, to receive communications of Protected Health Information by alternative means or at alternative locations. To make this request please contact us in writing.

We reserve the right to change the terms of this Notice and to make new provisions effective for all Protected Health Information we maintain.

I acknowledge receipt of “Notice of Privacy Practices” for Central Compounding Center South Compounding Pharmacy

_____ Signature

_____ Print Name

_____ Date