PITTSBURGH INFECTIOUS DISEASES, LTD.

101 DRAKE ROAD, SUITE C
PITTSBURGH, PA 15241
412-347-0057
412-347-0062 FAX

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Dear_____:

Welcome to our practice! We hope the enclosed information will be of some help to you and assist us in your care. We respect your time and would like to make your visit to our office efficient as possible. An appointment has been scheduled for you with Dr. _____ in our office on _____, _____ at _____.

MEDICAL INFORMATION: In order for our physicians to perform a comprehensive examination, we request that you bring any previous medical records (i.e., notes from prior treating physicians or facility), laboratory results, and radiology studies (i.e., chest x-ray, CT scan, bone scan, MRI, etc) pertaining to the condition for which you will be seen.

MEDICAL INSURANCE: Please complete the enclosed Health History and Patient Registration forms. As a courtesy, we will file a claim with your insurance carrier based upon the information provided. We request, however, that you also bring any insurance cards and applicable co-payments at the time of your visit to ensure accurate and prompt submission of charges incurred. Regardless of insurance, payment remains your personal responsibility.

FINANCIAL POLICY: Payment is expected at the time services are rendered. Several payment options are available to you and will be discussed by the receptionist at the conclusion of your visit.

NOTICE OF PRIVACY PRACTICES. Enclosed is a *Notice of Privacy Practices* for Pittsburgh Infectious Diseases, Ltd. Please review this information and sign the Acknowledgment of Privacy Notice form that is also enclosed. Please return this form to us at the time of your appointment.

CANCELLATION: Our appointments are made on a limited basis. Please notify us as early as possible if you are unable to keep this appointment. A charge of $25.00 will be assessed to those individuals who miss a scheduled appointment and have not provided at least 24 hours' notice.

As you arrive for your appointment, please park in the parking lot located in the front of the building. Enter via the main entrance and take the steps/elevator to the second floor, Suite C. If needed, handicap parking spaces are available and are located on your right in the front far corner of the building; this will allow you to enter the building via the walkway and avoid the front steps. (Note: There is no access to our office from the rear entrance to the building).

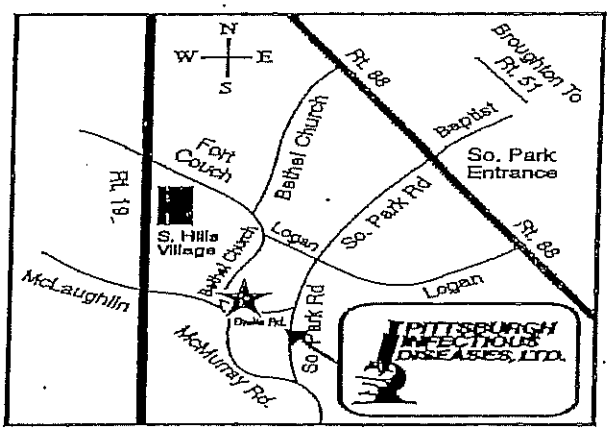
If you should have any questions regarding the above or if we may be of further assistance, please do not hesitate to contact our office. We look forward to meeting you!

Sincerely,

Appointment Secretary

Enclosures

(OVER)



Pittsburgh Infectious Diseases, Ltd.

We are located at 101 Drake Road in Upper St. Clair – 412/347-0057

From Route 19-South/Washington Road. Turn LEFT onto Fort Couch Road and continue past South Hills Village (on right) and continue to the traffic light at the intersection of Bethel Church Road. Continue straight ahead at this traffic light–Fort Couch Road becomes Bethel Church Road. Continue approximately one mile to Drake Road. Turn LEFT onto Drake Road and make an immediate LEFT turn into our parking lot–St. Clair Commons Center.

From Route 19-North/Washington Road. Turn RIGHT at the Orange Belt sign just as you approach Upper St. Clair High School. At the stop sign at the bottom of the exit ramp, turn LEFT onto McMurray Road and continue to the first traffic light, get into the left lane (Sunoco). Turn LEFT onto Bethel Church Road and make an immediate RIGHT turn onto Drake Road and an immediate LEFT turn into our parking lot–St. Clair Commons Center.

From Route 88/Library Road. Turn onto Bethel Church Road and continue several miles to the traffic light at the intersection with Fort Couch Road. At this traffic light, turn LEFT remaining on Bethel Church Road. Continue approximately one mile to Drake Road. Turn LEFT onto Drake Road and then make an immediate LEFT turn into our parking lot–St. Clair Commons Center.

From McLaughlin Run Road or McMurray Road. Continue to Bethel Church Road (Sunoco), turn onto Bethel Church Road and make an immediate RIGHT turn onto Drake Road and then an immediate LEFT turn into our parking lot–St. Clair Commons Center.

From South Park Road continue to Drake Road (Ruthfred Shops). Turn onto Drake Road–we are located in the St. Clair Commons Center, which will be on your right, at 101 Drake Road at the intersection with Bethel Church Road.

From Interstate 79 take the Bridgeville Exit (Exit 54). Stay in the center lane on the exit ramp and at the light turn RIGHT, staying in the center lane. At the traffic light, turn LEFT onto Washington Avenue and stay in the RIGHT lane. At the traffic light, turn RIGHT onto Chartiers Street and continue to the stop sign. At the stop sign, continue across Bank Street/Mayview Road to Lesnett Road. Continue on Lesnett Road to the traffic light (winding road–watch for deer). At traffic light, turn RIGHT onto McLaughlin Run Road (watch speed limit). McLaughlin Run Road becomes McMurray Road at the traffic light by Upper St. Clair High School/USC Township Administration Building. Continue straight ahead, on McMurray Road, to first traffic light past the high school, get into the LEFT lane. Turn LEFT at the traffic light onto Bethel Church Road (Sunoco), make an immediate RIGHT turn onto Drake Road, and turn LEFT into our parking lot–St. Clair Commons Center.

Pittsburgh Infectious Diseases, Ltd ▪ 101 Drake Road - Suite C, Pittsburgh, PA 15241 ▪ 412/347-0057

PATIENT REGISTRATION

Welcome to our office. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Patient Name	Today's Date	Date of Birth	Sex	Age
Parent if Patient is a Minor				
Patient's Social Security Number	Pennsylvania Driver's License No.			
Home Address	City	State	Zip	
Mailing Address if Different	City	State	Zip	
Home Telephone Number	Work Telephone Number			
Occupation	Employer's Name			
Employer's Address	City	State	Zip	
Spouse Name	Employer			
Other Physician's Name				
Whom May We Thank for Referring You to Our Practice?				
NOTIFY IN CASE OF EMERGENCY				
Name	Relationship			
Address	City	State	Zip	
Home Telephone	Work Telephone			
Nearest Relative (not living with you)				
Home Telephone	Work Telephone			
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES				
Name	Telephone			
Address	City	State	Zip	
Insurance Company	Claim Address			
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#.		
Insurance ID No.:				
Secondary Insurance	Claim Address			
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#		
Were You Injured on the Job? YES NO	Have you Informed Your Employer? YES NO			
Date of Original Injury:				
Worker's Compensation Carrier Name	Address	City	State	Zip

Please Read Our Financial Policy Statement and Agreement on Reverse

FINANCIAL POLICY - Pittsburgh Infectious Diseases, Ltd.

Patient Name: _____ **Date of Birth:** _____

BASIC POLICY Payment for service is due in full at the time service is provided in our office.
FOR PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.
MEDICARE PATIENTS We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time service is provided.
WELFARE PATIENTS All welfare patients must provide a current, valid recipient I.D. card.
NONCOVERED SERVICES Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.
PERSONAL INJURY CASES This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.
WORKER'S COMPENSATION If your injury is work-related, we will need the case number and carrier name prior to your visits in order to bill the worker's compensation insurance company.
MISSED APPOINTMENTS In fairness to other patients and the doctor, we require at least 24 hours' notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice.

Please check one: I have paid my insurance deductible for the calendar year _____ ☐ Yes ☐ No ☐ Don't know

MEDICARE PATIENTS: SIGNATURE ON FILE I request payment of authorized Medicare benefits be made on my behalf to Pittsburgh Infectious Diseases, Ltd. for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to CMS (Centers for Medicare and Medicaid Services) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Name (Please Print):	**PROVIDER**
Patient's Signature:	
Patient's Medicare No.: Date:	

ASSIGNMENT OF INSURANCE BENEFITS Patients with insurances please read and sign below.
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Pittsburgh Infectious Diseases, Ltd. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date: _____

I have read, understood, and agreed to the above financial policy for payment of professional fees.
The patient is ultimately responsible for all professional fees.

Signature: _____ Date: _____

HEALTH HISTORY
(Confidential)

Name_____ Today's Date_____

Age_____ Birthdate_____ Date of last physical examination_____

What is your reason for visit?_____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononeucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking.	**ALLERGIES** To medications or substances
Pharmacy Name_____ Phone_____	

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates._____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ Signature

_____ Date

Pittsburgh Infectious Diseases, Ltd.

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

PLEASE CIRCLE YOUR RESPONSES TO THE FOLLOWING:

May we leave messages concerning your appointments with a co-worker, receptionist or secretary that regularly answers your calls? Yes No N/A

May we leave messages on a voice mail at work? Yes No N/A

May we leave messages on a voice mail at home? Yes No N/A

May we discuss your appointments/treatment with your spouse? Yes No N/A

If you are over the age of 18, still living at home, may we discuss your appointments/treatment with your parents or guardian? Yes No N/A

May we discuss your appointments/treatments with your adult children? Yes No N/A

I authorize the following persons to have access to information regarding my treatment/condition:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Health care entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for treatment, payment and healthcare operations (TPO) may be permitted without prior consent in an emergency.

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

FOR INTERNAL USE:

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom, Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized.
(2) Type key: T = Treatment Records; P = Payment Information; O = Healthcare Operations
(3) Enter how disclosure was made: F = Fax; P = Phone; E = Email; M = Mail; O = Other

Pittsburgh Infectious Diseases, Ltd.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Notice of Privacy Practices. Pittsburgh Infectious Diseases, Ltd. has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information, how you can access your protected health information, and other rights concerning your protected health information.

I acknowledge that I received or was offered a copy of the Pittsburgh Infectious Diseases, Ltd. Notice of Privacy Practices.

_____

Print Name of Patient

_____ _____

Signature of Patient/Personal Representative Date

_____ _____

Name of Personal Representative Relationship to Patient

GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

(For office use only when efforts to obtain acknowledgment of receipt of notice are unsuccessful)

- ❑ Individual refused copy of NPP
- ❑ Individual accepted copy of NPP; refused to sign Acknowledgement of Receipt
- ❑ Communication barriers prohibited obtaining acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other _____

_____ _____

Signature of Staff Member Date

_____

Print Name of Staff Member

NOTICE OF PRIVACY PRACTICES – PITTSBURGH INFECTIOUS DISEASES, LTD.

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.

About this Notice

Pittsburgh Infectious Diseases, Ltd. is required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights, and we have certain legal obligations, regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" (PHI) is information that individually identifies you and that we create or obtain from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information.

We may use and disclose your Protected Health Information in the following circumstances.

For Treatment. We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

For Payment. We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

For Health Care Operations. We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical students, medical technicians, and other authorized personnel for educational and learning purposes.

Appointment Reminders, Treatment Alternatives, and/or Health-Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health-related benefits and services that may be of interest to you.

Minors. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Research. We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

As Required by Law. We will disclose PHI about you when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

Business Associates. We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.

Organ and Tissue Donation. If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation, such as an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may disclose PHI as required by military command authorities. We also may disclose PHI to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration (FDA) for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Abuse, Neglect, or Domestic Violence. We may disclose PHI to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. For example, these oversight activities include audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves in the event of a lawsuit.

Law Enforcement. We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.

Military Activity and National Security. If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your PHI to authorized officials so they may carry out their legal duties under the law.

Coroners, Medical Examiners, and Funeral Directors. We may disclose PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Requires Us to Give You an Opportunity to Object and Opt Out

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that

person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures of Protected Health Information for marketing purposes; and
3. Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Special Protections for HIV Information, Alcohol and Substance Abuse Information, Mental Health Information and Genetic Information

The confidentiality of alcohol and drug abuse treatment records, HIV-related information, and mental health records maintained by us is specifically protected by state and/or Federal law and regulations. Generally, we may not disclose such information unless you consent in writing, the disclosure is allowed by a court order, or in limited and regulated other circumstances.

Your Rights Regarding your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

Right to Inspect and Copy. You have the right to inspect and copy PHI that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to a Summary or Explanation. We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.

Right to an Electronic Copy of Electronic Medical Records. If your PHI is maintained in an electronic format (know as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecure Protected Health Information.

Right to Request Amendments. If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long

as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the end of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right to an Accounting of Disclosures. You have the right to ask for an "accounting of disclosure," which is a list of the disclosures we made of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or payment for your care, like a family member or friend. To request a restriction on who may have access to your PHI, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.

Out-of-Pocket Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the end of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your PHI, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes to this Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website (www.pittsburghid.com).

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed below. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, address it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

If you have any questions about this notice or if you need more information, please contact our privacy officer.

Contact Information:

Privacy Officer
Pittsburgh Infectious Diseases, Ltd.
St. Clair Commons Center
Suite C – Second Floor
101 Drake Road
Pittsburgh, PA 15241
Telephone: (412) 347-0057
Fax: (412) 347-0062

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