Pure Pharmacy
12425 Old Meridian Street, Suite B3
Carmel, IN 46032

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.

Your Rights You have the right to:

- **Get a copy of your paper or electronic medical record:** You can ask to see or get an electronic or paper copy of your medical record and other health information. We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- **Correct your paper or electronic medical record:** You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we will tell you why in writing within 60 days.
- **Request confidential communication:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- **Ask us to limit the information we 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 have shared your information:** You can ask for a list (accounting) of the times we have 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, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will 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 paper copy of this privacy notice:** You can ask for a paper copy of this notice at any time. 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 action.
- **File a complaint if you believe your privacy rights have been violated:** You can complain if you feel we have violated your rights by contacting us as provided in this notice. 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, let us know. In the following circumstances, you have both the right and the choice to tell us to the way that we use and share information as we:

- share information with your family, close friends, or others involved in your care;
- share information in a disaster relief situation;
- include your information in a hospital directory.

If you are not able to tell us your preference, for example you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the following circumstances, we never share your information unless you give us written permission:

- marketing purposes; or
- sell your information.

In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures We may use and share your information without your written authorization as we:

- **Treat you:** We can use your health information and share it with other professionals who are treating you.
- **Run our organization:** We can use and share your health information to run our organization, improve your care, and contact you when necessary.
- **Bill for your services:** We can use and share your health information to bill and get payment from health plans or other entities.
- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety.
- **Do research:** We can use your information for health research, subject to applicable requirements.
- **Comply with the law:** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy laws.
- **Respond to organ and tissue donation requests:** We can share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Address workers' compensation, law enforcement, and other government requests:** We can use or share information about you: for workers' compensation claims; for law enforcement purposes or with a law enforcement official; with health oversight agencies for activities authorized by law; for special government functions such as military, national security, and presidential protective services.
- **Respond to lawsuits and legal actions:** We can share heal information about you in response to a court or administrative order or in response to a subpoena.

Our Responsibilities

We are committed to maintaining 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 which has been provided to you. We will not 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. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all the information we have about you. The new notice will be available upon request, in our office, and on our website.

Contact Us

Privacy Manager
(317) 740-1856

Or via mail at:
Pure Pharmacy
12425 Old Meridian, STE B-3
Carmel, IN 46032

Washington Residents

Pure Pharmacy
12425 Old Meridian Street, Suite B3
Carmel, IN 46032

This notice is supplemented by our Washington Consumer Health Data Notice, available here. Our Washington Consumer Health Data Notice includes important additional information about the use of your consumer health data.

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Notice of Privacy Practices Acknowledgment Form

I acknowledge that I have received the Notice of Privacy Practices ("Notice") from Pure Pharmacy ("Pure") and that I have been provided an opportunity to review it. I understand that:

I have certain rights to privacy regarding my protected health information.

- Pure can and will use my health information for purposes of my treatment, payment for treatment, and health care operations.
- The Notice explains in more detail how Pure may use and share my protected health information for other purposes.
- I have the rights regarding my protected health information listed in the Notice.
- Pure has the right to change the Notice from time to time and I can obtain a current copy of the Notice by contacting the person listed in the Notice.

Name: _____ Date:_____

Signature: _____ Date of Birth:_____

Relationship to Participant: _____

FOR OFFICE USE ONLY:

Good Faith Effort to Obtain Acknowledgment Form

Name of Participant: _____ Date of Birth: _____

I attempted to obtain the participant's (or the representative of the participant) signature on the **Notice of Privacy Practices Acknowledgment Form**, but was unable to do so, as documented below:

Reason: _____

Name: _____ Date: _____

Signature: _____