

VANGUARD ADVANCED PHARMACY SYSTEMS
NOTICE OF PRIVACY PRACTICES

Privacy Notice

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

I. Our Duty to Safeguard Your Protected Health Information

We are committed to preserving the privacy and confidentiality of your health information. Copies of our privacy policies and procedures are maintained in our business office. We are required to provide you with this Privacy Notice that contains information regarding our privacy practices to explain how, when and why we may use or disclose your PHI and your rights and our obligations regarding any such uses or disclosures. Except in specified circumstances, we must use or disclose only the minimum amount of PHI necessary to accomplish the intended purpose of the use or disclosure of such information.

We reserve the right to change this notice at any time and to make the revised or changed notice effective for PHI that we already have about you as well as any information we receive in the future about you. Should we revise/change this Privacy Notice, we will promptly inform you of such changes. You also may request and obtain a copy of any new/revised Privacy Notice from the contact person identified on the last page of this notice.

Should you have questions concerning our Privacy Notice, our contact information is listed on the last page of this document.

II. How We May Use and Disclose Your Protected Health Information

We have a limited right to use and/or disclose your protected health information for purposes of treatment, payment, or for health care operations. For other uses and disclosures, you must give us your written authorization to release your protected health information unless the law permits or requires us to make the use or disclosure without your authorization.

Should it become necessary to release or give access to your protected health information to an outside party performing services on our behalf (e.g., maintaining our computers), we will require the party to have a signed agreement with us that the party will extend the same degree of privacy protection to your information as we do.

The privacy law permits us to make some uses or disclosures of your protected health information without your consent or authorization. The following describes each of the different ways that we may use or disclose your protected health information. Where appropriate, we have included examples of the different types of uses or disclosures. These include:

1. Use and Disclosures Related to Treatment

We may disclose your protected health information to those who are involved in providing medical and nursing care services and treatments to you. We may also disclose your protected health information to outside entities performing other services relating to your treatment; such as long term care facilities, hospitals, etc.

2. Use and Disclosures Related to Payment

We may use or disclose your protected health information to bill and collect payment for items or services we provided to you.

3. Use and Disclosures Related to Health Care Operations

We may use or disclose your protected health information for the performance of certain functions in monitoring and improving the quality of care and services that you and others receive. We may also disclose your protected health information for auditing, care planning, quality improvement, and learning purposes.

4. Use and Disclosures Related to Treatment Alternatives, Health-Related Benefits and Services

We may use or disclose your protected health information for purposes of contacting you to inform you of treatment alternatives or health-related benefits and services that may be of interest to you, such as a newly released medication or treatment that has a direct relationship to a treatment or medical condition.

III. Uses and Disclosures Requiring Your Written Authorization

For uses and disclosures of your protected health information beyond the above excepted purposes, we are required to have your written authorization, except as otherwise required or permitted by law. You have the right to revoke an authorization at any time to stop future uses or disclosures of your information except to the extent that we have already undertaken an action in reliance upon

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your authorization. Your revocation request must be provided to us in writing. Please contact us for purposes of revoking your authorization. Copies of the forms are available upon request.

IV. Uses or Disclosures of Information Based Upon Your Verbal Agreement

We may disclose a limited amount of your protected health information if we provide you with an advance oral or written notice and you do not object to such release or such release is not otherwise prohibited by law. However, if there is an emergency situation and you are unable to object (*e.g.*, because you were not present or you were incapacitated), disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interest. When a disclosure is made based on these or emergency situations, we will only disclose protected health information relevant to the person's involvement in your care. You will be informed and given an opportunity to object to further disclosures of such information as soon as you are able to do so.

We may disclose your protected health information to your family members and friends who are involved in your care or who help pay for your care. We may also disclose your protected health information to a disaster relief organization for the purposes of notifying your family and/or friends about your general condition, location, and/or status (*i.e.*, whether you are alive or dead). You may object to the release of this information. Our contact information is listed on the last page of this document.

V. Uses and Disclosures of Information That Do Not Require Your Consent or Authorization

State and federal laws and regulations in some instances either require or permit us to use or disclose your protected health information without your consent or authorization. The uses or disclosures that we may make without your consent or authorization are extensive. For a complete listing and use of these disclosures, please contact us. Our contact information is listed on the last page of this document.

VI. Your Rights Regarding Your Protected Health Information

You have the following rights concerning the use or disclosure of your protected health information that we create or that we may maintain about you:

1. To Request Restrictions on Uses and Disclosures of Your Protected Health Information:

You have the right to request that we limit how we use or disclose your protected health information for treatment, payment or health care operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care or services.

Should you wish a restriction placed on the use and disclosure of your protected health information, you must submit such request in writing. Such request should be submitted in writing **We are not required to agree to your restriction request.** You will be informed if we decline your request. If we accept your request, we will comply with your request not to release such information unless the information is needed to provide emergency care or treatment to you.

2. The Right to Inspect and Copy Your Health and Billing Records:

You have the right to inspect and copy your protected health information, such as your prescription and billing records. In order to inspect and/or copy your protected health information, you must submit a written request to us. If you request a copy of your prescription or billing information or other records, we may charge you a reasonable fee for the paper, labor, mailing, and/or retrieval costs involved in filing your requests. We will provide you with information concerning the cost of copying your protected health information prior to performing such service. Such requests should be submitted in writing. Our contact information for such requests is listed on the last page of this document.

We will respond within thirty (30) days of receipt of such requests. Should we deny your request to inspect and/or copy your protected health information, we will provide you with written notice of our reasons of the denial and your rights for requesting a review of the denial, if any. In the event of a review, we will select a licensed health care professional not involved in the original denial process to review your request and our reasons for denial. We will abide by the reviewer's decision concerning your inspection/copy requests. Your denial review request should be submitted in writing. Copies of these forms are available from the contact person listed on the last page of this document.

3. The Right to Amend or Correct Your Protected health information:

You have the right to request that your protected health information be amended or corrected if you have reason to believe that certain information is incomplete or incorrect. You have the right to make such requests of us for as long as we

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maintain/retain your protected health information. Your requests must be submitted to us in writing. We will respond within sixty (60) days of receiving the written request, unless an extension is necessary, in which case you will be notified, and receive a response to your request within ninety (90) days. If we approve your request, we will make such amendments/corrections and notify those with a need to know of such amendments/corrections.

We may deny your request. If your request is denied, we will provide you with a written notification of the reason(s) of such denial and your rights to have the request, the denial, and any written response (of reasonable length) you may have relative to the information and denial process appended to your protected health information. Your amendment/correction request should be submitted in writing. Our contact information for the purpose of making such a request is listed on the last page of this document.

4. The Right to Request Confidential Communications:

You have the right to request that we communicate with you about your health matters in a certain way or at a certain location. We will agree to your request as long as it is reasonable for us to do so. You may submit your requests in writing. Our contact information is listed on the last page of this document.

5. The Right to Request an Accounting of Disclosures of Protected Health Information:

You have the right to request that we provide you with a listing of certain disclosures of your protected health information that we have made over a specified period of time. This accounting will not include any information we have made for the purposes of treatment, payment, or health care operations or information released to you, your family or friends for notification purposes, disclosures made for national security purposes or to certain law enforcement officials, incidental disclosures, disclosures made as part of a limited data set (for use in research, public health, etc.), or any disclosures made pursuant to your authorization.

Your request must be submitted to us in writing and must indicate the time period for which you wish the information (e.g., May 1, 2003 through August 31, 2003). Your request may not include releases for more than six (6) years **prior** to the date of your request and may not include releases **prior** to April 14, 2003. Your request must indicate in what form (e.g., printed copy or email) you wish to receive this information. We will respond to your request with sixty (60) days of the receipt of your written request. Should additional time be needed to reply, you will be so notified. However, in no case will such extension exceed thirty (30) days. The first accounting you request during a twelve (12) month period will be free. There may be a reasonable fee for additional requests during the twelve (12) month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

You may submit your requests in writing. Our contact information is listed on the last page of this document.

VI. How to File a Complaint About Our Privacy Practices

If you have reason to believe that we have violated your privacy rights or our privacy policies and procedures, or if you disagree with a decision we made concerning access to your protected health information, you have the right to file a complaint with us or the Secretary of the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

You may submit your complaint on our *Privacy Practices Complaint* form available from our business office. Our contact information is listed on the last page of this document.

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Record of Acknowledgment / Documentation of Good Faith Effort to Obtain Acknowledgment

Resident/Patient Name: _____ Date: _____

Effective Date of This Privacy Notice

The effective date of this Privacy Notice is April 14, 2003.

Contact Information for Questions, Complaints or Requests Regarding Your Health Information

Should you have any questions concerning our privacy practices, obtaining a copy of our privacy notice, requesting restrictions on the release of your information, revoking an authorization, amending or correcting your protected health information, obtaining an accounting of our disclosures of your protected health information, requesting inspection or copying of your medical information, requesting that we communicate information about your health matters in a certain way, filing complaints, or any other concerns you may have relative to our privacy practices, please contact:

Alexander M Pytlarz, PharmD
Director of Pharmacy Systems, HIPAA Compliance Officer
905 E Manatee Ave, Bradenton, FL 34208
877-739-9974, ext. 407
941-757-0586
alexp@vanguardrx.com

If you wish, you may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. You may mail your complaint to U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201; or you may call (202) 619-0257 or 1-877-696-6775 (toll free); or you may log on to the internet address, <http://www.hhs.gov/ocr>.

Acknowledgment / Good Faith Effort to Obtain Acknowledgment (check one of the following)

I certify that I received a copy of the above-named entity's Privacy Notice and that I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that the above-named entity is committed to protecting my health information.

Date: _____ Signature: _____
Printed Name: _____

I certify that I am the authorized representative of above-identified patient, and that I have received the Privacy Notice on behalf of this individual and that the above-named entity provided me with an opportunity to review this document and ask questions to assist me in understanding the patient's privacy rights. I am satisfied with the explanations provided to me and I am confident that the above-named entity is committed to protecting health information.

Date: _____ Signature of Representative: _____
Printed Name: _____
Relationship to Individual: _____

I, _____, certify that I made a good faith effort to obtain the acknowledgment of the above-identified [resident/patient] or his/her personal representative that he/she had received a copy of the Privacy Notice of the above-identified entity, but was unable to obtain such acknowledgment for the following reason(s):

- [Resident/Patient] or personal representative refused to sign.
- [Resident/patient] or personal representative was unavailable to sign.
- Other: _____

Date: _____ Signature/Title: _____

A copy of this document must be provided to the person to whom the Privacy Notice was provided and a copy must be filed in the patient's record.