



516 Monument Square
Racine, WI 53403
Phone (262) 632-0520
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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 IT CAREFULLY

SECTION A: Uses and Disclosures of Protected Health Information

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 (referred to as "PHI") 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. For treatment purposes, such uses and disclosures 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 a 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 appropriate care was rendered. For reimbursement purposes, your PHI 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; 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.

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, unless you object.

We may use and disclose your PHI, 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 consent or authorization. We may use and disclose your PHI if we are contacted by another pharmacy who states they have your request and consent to transfer pharmacy records to them.

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 PHI. Business associates are required to comply with all the privacy regulations on your behalf.

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

Other uses and disclosures will be made only with your written authorization, and you may revoke your authorization at any time by notifying us as described in Section B, except to the extent the Pharmacy has already taken action in reliance on a previously signed authorization form.

You may ask us to restrict uses and disclosures of your PHI to carry out treatment, payment, or healthcare operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, we are not required to agree to your request.

You have the right to request the following with respect to your PHI: (i) inspection and copying; (ii) amendment or correction; (iii) an accounting of the disclosures of this information by us; (We are not required to account to you for disclosures made for treatment, payment, operations, disclosures to you, disclosures to your care givers, for notifications or as otherwise excluded by law); and (iv) receipt of a paper copy of this notice upon request. The Pharmacy may require patients to make requests for access to their PHI in writing.

In addition, you may request, and we must accommodate the request, if reasonable, to receive communications of PHI by alternative means or at alternative locations. To make this request please contact us as described in Section B.

The Pharmacy may charge for supplies, labor and the postage involved in preparing PHI for your request. If you desire a price quote for this service you must request one. You have the right to withdraw your request of the PHI prior to the delivery.

We may use your name to reference your prescriptions and pharmaceutical care services. You may be required to sign a signature log form or to acknowledge receipt of service, to acknowledge receipt of this notice and the disclosure of PHI as outlined herein. We may disclose this information 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. If you request our services, we are able to provide treatment services to you, even if you object to signing the acknowledgment of the receipt of this notice or if we decide not to honor a request regarding the information in this document while noting your requests and refusals in our records. In the event of an emergency or your incapacity, we will do in our reasonable judgment what is consistent with your known preference, and what we determine to be in your best interest. We will inform you of any such uses or disclosures under such circumstances and give you an opportunity to object as soon as practicable.

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, PHI that is directly relevant to the person's involvement with your care or payment related to your care. In addition, unless you object, we may use or disclose the PHI 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 what in our judgment 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 judgment and experience regarding your best interest in allowing people to pick-up filled prescriptions, or similar forms of PHI.

We reserve the right to change the terms of this notice and to make new notice provisions effective for all PHI we maintain. You may receive a copy of this notice by contacting us as outlined in Section B or upon the receipt of pharmacy care services.

If you believe that your privacy rights have been violated, you may file a complaint with us at the location described in Section B or to the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Ave SW, Washington, DC 20201. You will not be retaliated against for filing a complaint.

Section B: Contacting Us

You may contact us for further information at:

Lakeview Pharmacy
Amy Schiveley, Privacy Officer
516 Monument Square
Racine, WI 53403
(262) 632-0520
amy@lakeviewpharmacy.com

This notice is effective 3/1/03.

Revised 12/25/02

Privacy Notice

I acknowledge that I have received a copy of Lakeview Pharmacy/Lakeview Long Term Care Pharmacy Notice of Privacy practices. This notice contains information regarding Lakeview Pharmacy/Lakeview Long Term Care Pharmacy's use and disclosure of my personal health information.

Signature _____

Date _____