Axelix Health Consulting, Inc.
Office of Dr. Ogunlesi
8587 East Avenue, Mentor, OH 44060-4301
Phone: (440)-867-4800

NOTICE OF PRIVACY PRACTICES OF AXELIX HEALTH CONSULTING, INC.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

AHC, Inc. will ask you to sign an acknowledgement that you have received this Notice of Privacy Practices ("Notice"). This Notice describes, in accordance with the HIPAA Privacy regulation, how Axelix Health Consulting, Inc. (AHC) may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other specific purposes that are permitted or required by law. The Notice also describes your rights and AHC's duties with respect to protected health information about you.

USES AND DISCLOSURES OF YOUR PERSONAL INFORMATION

Your Authorization – Except in cases outlined below, AHC will not use or disclose your personal information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless AHC has acted in reliance with this authorization.

Uses and Disclosure for Treatment – AHC will make uses and disclosures of your personal health information as necessary for your treatment. AHC may also release your personal health information to another health care facility or professional who is not affiliated with this practice, but who is or will be providing treatment to you. Examples of this may include releasing your personal health information to another physician's practice that will be involved with your treatment.

Uses and Disclosures for Payment – AHC will make uses and disclosures of your personal health information as necessary for payment purposes of those health professionals and facilities that have treated you or provided services to you. An example of this may include forwarding information regarding your medical treatment to your insurance company to arrange payment for services provided to you.

Family and Friends Involved in Your Care – With your permission, AHC may disclose your personal health information to designated family, friends, and others who are involved with your care or in payment of your care in order to facilitate that person's involvement in care for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and it is determined that a limited disclosure of your health information may be in your best interest, limited personal health information may be shared with such individuals without your approval.

Business Associates – AHC maintains contracts with outside persons and organizations such as professional answering services, medical transcriptionists, collection agencies, and legal services. In certain cases, it may be necessary to provide certain personal health information to one or more of these outside persons or organizations who assist with AHC health care operations. In each of these cases, business associates are required by contract to safeguard the privacy of your personal health information.

Appointment and Services – AHC may contact you to provide reminders or test results. You have the right to request and AHC will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternate means or locations. An example of this may include not leaving appointment reminders on an answering machine or voice mail at home or at work. You may request such communication in writing or at a specific phone number or address.

Confidentiality of Alcohol and Drug Abuse Patient Records – The confidentiality of alcohol and drug abuse patient records maintained by AHC is protected by federal law and regulations. Generally, AHC may not disclose any information identifying you as an alcohol or drug abuser unless you consent in writing, the disclosure is allowed by a court order or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Other Uses and Disclosures – Federal law and regulations do not protect any information about a crime committed by you either at AHC or against any person that works for or with this practice, or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child or elder abuse or neglect from being reported under State Law to appropriate State or local authorities. AHC is required by law to make certain other uses and disclosures of your personal health information without your consent or authorization.

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NOTICE OF PRIVACY PRACTICES OF AHC

- For any purpose required by law.
- For public health activities, such as required reporting of disease or injury or both and death and for required public health investigations.
- To your employer when AHC has provided treatment to you at the request of your employer to determine workplace related injuries.
- To worker's compensation agencies, if necessary, for worker's compensation benefit determination.
- To the Food and Drug Administration, if necessary, to report adverse events, product defects, or to participate in product recalls.
- To a government oversight agency conducting audits, investigations, or civil or criminal proceedings.
- If required by court or administrative ordered subpoena or discovery requests (in certain cases, you will have notice of such released information).
- To law enforcement officials as required by law to report wounds and injuries and crimes.
- If necessary, to arrange for organ or tissue donation from you or a transplant for you,
- In limited circumstances, if we suspect a serious threat to health and safety.
- For suspected child abuse or neglect or if there is suspicion that you may be a victim of abuse, neglect, or domestic violence.
- If you are a member of the military as required by armed forces services or, if necessary, for national security or intelligence activities.

RIGHTS THAT YOU HAVE:

Access to your Personal Health Information – You have the right to copy and/or inspect much of the personal health information that AHC retains on your behalf. All requests for access must be made in writing and signed by you or your representative.

Amendments to your Personal Health Information – You have the right to request in writing that personal health information that AHC maintains be amended or corrected. AHC is not obligated to make all requested amendments but will give each request careful consideration. All amendment requests must be in writing, signed by you or your representative and must state the reasons for the amendment/corrections request. All subsequent amendments will be forwarded to all those parties involved with your treatment that may not have the uncorrected information.

Accounting for Disclosures of Your Personal Health Information – You have the right to receive an accounting of certain disclosures by AHC of your personal health information after July 1st, 2010. Requests must be made in writing and signed by you or your representative. The first accounting in any one-year period is without charge and then a charge of $20 for each subsequent accounting in a one-year period will be enforced.

Restrictions on Use and Disclosure of Your Personal Health Information – You have the right to request restrictions on certain uses and disclosures of your personal health information by AHC for treatment, payment, or health care operations. This may be made in writing to AHC. AHC is not required to agree with your restriction, but will attempt to accommodate reasonable request when appropriate.

Complaints – If you believe that your privacy rights have been violated, you can file a complaint with any staff member or to the AHC Privacy Officer, Abbey Ogunlesi. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

Acknowledgement of Receipt of Notice – You will be asked to sign an acknowledgement form that you received this Notice of Privacy.

EFFECTIVE DATE – THIS NOTICE OF PRIVACY PRACTICE IS EFFECTIVE AS OF JULY 1ST, 2010

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Summary of Updated Notice of Privacy Policy

We understand that legally required paperwork is long and confusing, so we have provided this summary for you. You may request the full form at any time, and it is also available at www.axelixhc.com.

We collect personal health information such as your name, address, and social security number in the course of your treatment. We are required by law to protect this protected health information (PHI), and explain how it may be used.

When can we disclose your PHI?

- Without your consent- 1) operations, 2) for treatment purposes such as labs or x-rays, 3)to obtain payment – billing related
- As required by law- if it is a public health issue, in cases of abuse, for workers' compensation and certain other cases
- With your specific authorization- for any other instance, we cannot release your PHI without your permission.

What are your rights regarding your information?

- You can request restrictions on the use or disclosure of your PHI
- You have the right to receive confidential communications
- You have the right to inspect and copy your PHI
- You have the right to amend or change your PHI
- You have a right to receive a list of when and where your PHI was disclosed

Complaints:

You may file a complaint if your privacy rights have been violated. Please contact our privacy officer, **Abbey**, at **440-867-4800**. Please refer to the full Notice of Privacy Policy for further details.

I have read the information above, and I understand that **Axelix Health Consulting, Inc**. is required by law to provide me with this information. I also understand that I may request a full copy of the Notice of Privacy Practices at any time.

Signature: _____ Date: _____/_____/_____

First Middle Last

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AXELIX HEALTH CONSULTING, INC.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the Axelix Health Consulting Privacy Notice.

_____ _____/_____/_____
Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____
Relationship to patient

I request the following restrictions to the use of my Patient Health Information (PHI):

☐ Do not leave a message on my answering machine
☐ Home ☐ Mobile/Cell ☐ Work ☐ Other _____
(Specify)

☐ You can leave a message on
☐ Home ☐ Mobile/Cell ☐ Work

☐ Do not call my place of employment

☐ You can discuss my care with:
☐ Spouse ☐ Family Member _____ ☐ Son/Daughter ☐ Guardian
(Specify)
☐ Other _____
(Specify)

If you have any additional restrictions, list them here:

_____

_____

_____

_____

_____ _____/_____/_____ _____
Signature Patient/Personal Representative Date Witness