PURDUE UNIVERSITY | Department of Speech, Language, and Hearing Sciences

M.D. STEER AUDIOLOGY AND SPEECH LANGUAGE CLINICS
POLICIES, PROCEDURES, AND INFORMED CONSENT

I, _____ hereby consent to consultation, evaluation And/ or habilitation/ rehabilitation and other services as may be provided to me and/or my family by the M.D. Steer Audiology and Speech-Language Clinics. I understand that I may withdraw this consent for treatment at any time.

I understand that the M.D. Steer Audiology and Speech-Language Clinics provide services through the use of clinical teams. Each team is composed of a clinic staff member, student clinician(s) and such other consultative staff as may be indicated. All clinic staff members hold an Indiana License and a Certificate of Clinical Competence in Speech-Language Pathology and /or Audiology awarded by the American Speech-Language-Hearing Association and are directly responsible for patient care and supervision. I understand that student clinicians are supervised by other staff professionals, and in such cases, my information may be shared with the supervising professional. I further understand that the services provided may be observed and reviewed by instructors and/or students for educational and/or research purposes by visual and/or electronic means.

By signing this form, I am consenting and agreeing only to those services that the clinician working with me is qualified to provide within:

(a) The scope of that clinician's license, certification and training; or
(b) The scope of license, certification and training of clinicians directly supervising the services received by me.

The general nature of my condition; the proposed services, and the expected outcome of the proposed services, have been explained to me. I have been informed of the benefits of these services, as well as the risks and consequences associated with these services. The reasonable alternatives to these services have been explained to me.

Although we provide information on how to reach us electronically, we do not provide services via e-mail, and we discourage you from sending us any confidential information by e-mail. Please remember that e-mail is not a confidential mode of communication, and we ask that you contact us by phone.

I understand and agree to all practices noted above, and consent to the services described above.

Exceptions to the above practices are: _____.

Patient's Name: _____ Date of Birth: _____

Signed: _____ Relationship to Patient: _____
Patient or Legal Representative

_____ Signature Date: _____
Printed name if not Patient

Witness: _____

OVER

Revised 2/2020

AUTHORIZATION FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION FOR CLINICAL OR EDUCATIONAL PURPOSES

I hereby authorize M.D. Steer Audiology and Speech-Language Clinics at Purdue University, and its employees, to use and disclose my protected health information, including medical records, audiotapes and videotapes created during services provided to me for clinical or educational purposes only. I understand that this authorization is limited to the uses and disclosures described below.

Information derived from evaluation, habilitation / rehabilitation and other services provided by M.D. Steer Audiology and Speech-Language Clinics at Purdue University may be used and disclosed by clinical and other personnel for purposes of clinical review, training, classroom discussions and other educational uses. The purpose of this authorization is to permit SLHS undergraduate and graduate students to review and discuss my case with instructors and other students for educational purposes only. The information to be shared will be limited to the facts of my case, treatment and possible alternatives, habilitation/rehabilitation services video and audiotapes. I further understand that reasonable steps will be taken to protect my name, address and student or other identification number from disclosure.

I understand that clinical professors and other health care professionals reviewing my information are typically bound by ethical requirements to maintain the confidentiality of medical and treatment information. However, I understand that disclosure of the protected medical records and information, the records and information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I understand that Audiology and Speech-Language Clinics will not deny treatment or payment based upon whether I sign this authorization, and I may inspect or copy any information used or disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by mailing or delivering a written revocation to Audiology and Speech-Language Clinics, 715 Clinic Drive, West Lafayette, IN 47907. The revocation will be effective upon receipt by the University, except to the extent that the University has taken action in reliance on this authorization. I further understand that this authorization will expire five years from the Signature Date unless I specify a different expiration date or event here.

☐ **As long as needed for educational purposes.**

After the expiration date or event, this authorization will no longer be effective, and no further information will be furnished pursuant to it.

Patient's Name: _____ Date of Birth: _____

Signed: _____ Relationship to Patient: _____
Patient or Legal Representative

_____ Signature Date: _____
Printed name if not Patient

Witness: _____

☐ Patient was offered a copy of this form and declined.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received and / or read the Notice of Privacy Practices.

Patient or Legal Representative: _____
Signature

Revised 2/2020

PURDUE UNIVERSITY
AUTHORIZATION FOR USE, DISCLOSURE OR RELEASE OF
PROTECTED HEALTH INFORMATION AND MEDICAL RECORDS

I hereby request and authorize the use, disclosure and/or release by Purdue University M.D. Steer Audiology and Speech, Language Clinics and its employees, of medical records, including my social security number, or other protected health information as described below:

Patient's Name: _____ Date of Birth: _____

Patient's Address_____
(street) (city) (state) (zip)

Patient's I.D.#: _____ Phone #: _____

Please identify who is to receive the medical records or other medical information **(name and address or name and fax #):**

_____

_____

Please describe specifically what medical records or other health information may be used or released:

SPEECH AND LANGUAGE TEST RESULTS & REPORT

If this request is not made by the Patient, what is the reason for this request?
BY PATIENT OR PARENT REQUEST

Unless the "No" box is marked, this Authorization extends to such psychiatric, mental health, and drug and alcohol abuse treatment information, if any, as may be contained in said medical record including information protected by I.C. 16-39-1-9, I.C. 16-39-2-1 through 16-39-4-2 and I.C. 16-41-8-1. This release permits re-disclosure in accordance with 42 C.F.R., Part 2, which is a federal regulation governing release and use of medical information pertaining to treatment for alcohol or drug abuse. ☐ No

Unless the "No" box is marked, the Authorization also extends to information regarding communicable diseases, including human immunodeficiency virus (HIV), and AIDS related complex (ARC) and acquired immunodeficiency syndrome (AIDS), if contained in said medical record. ☐ No

I understand that upon release and disclosure of the protected medical records and information, the records and information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I understand that Purdue University will not deny treatment, payment, enrollment or eligibility for benefits based upon whether I sign this authorization. I also understand that an authorization may be necessary in order to process any request I have made for a release of medical records or other medical information. I may inspect or copy any information used or disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by mailing or delivering a written revocation to SLHS Dept., 715 Clinic Drive, West Lafayette, Indiana, 47907. The revocation will be effective upon receipt by the University, except to the extent that the University has taken action in reliance on this authorization. I further understand that, this authorization will expire as follows: (1) sixty (60) days from the Signature Date for all records except mental health records, and (2) one hundred eighty (180) days from the Signature Date for mental health records, unless I specify a different expiration date or event here:

- ■ **As long as disclosure to provider(s) named above who will receive my medical records, is necessary.**
- ☐ **As long as use or disclosure indicated above is needed for educational purposes.**
- ☐ **As long as use or disclosure indicated above is needed for promotional purposes.**

After the expiration date, this authorization will no longer be effective, and no further information will be furnished pursuant to it.

I understand that there may be a charge to cover actual costs incurred by Purdue University in preparing and delivering the information requested in this authorization, in accordance with Indiana statutes and Purdue policies.

Signed: _____ Relationship to Patient: _____
Patient or Legal Representative

_____ Date: _____
Printed name if not Patient

Witness: _____ Date: _____

☐ Patient was offered a copy of this form and declined.

Revised 2/2020

PURDUE UNIVERSITY | Department of Speech, Language, and Hearing Sciences

Designation of Individuals who are Involved in My Payment or Treatment Decisions

The Health Insurance Portability and Accountability Act (HIPAA) protects the patient's right to privacy. In order to comply with these federal privacy laws, healthcare facilities (covered entities) may provide limited information about your treatment to individuals who are involved in payment decisions unless you object to sharing this in formation.

As a covered entity, defined by HIPAA, we ask that you list the individuals you wish to authorize to receive your health information for this limited purpose. Please provide the full names of these individuals in the lines below and their relationship to you. These may include your insurance company and/or federal or state agencies such as Medicaid or Medicare. You do not need to list yourself if you are the patient.

I authorize the following individuals or entities to receive information related to my treatment in order to assist in payment decisions or make payments on my behalf.

Individual's Full Name / Insurance Company **(Please Print)**	**Relationship to Patient / Policy Holder**

The information will be presumed valid and we will rely on it until you have notified us in writing of any changes to this form**. By signing below you understand that you are financially responsible for all uninsured or uncovered expenses incurred in connection with your care.**

_____ _____

Full Patient Name (Printed) Legal Representative (printed) if applicable

_____ _____

Patient or Legal Representative (signature) Date

_____ _____

Patient Date of Birth MR#/PUID

PURDUE UNIVERSITY | Department of Speech, Language, and Hearing Sciences

M.D. Steer Speech-Language and Hearing Clinics
Demographic Survey & Emergency Contact Information

Client's Name: _____

Date of birth: _____ **Phone:** _____

Address: _____

Which category best describes you? Purdue Faculty/staff Purdue Student Community Member

Ethnicity: Hispanic or Latino Not Hispanic or Latino Prefer not to answer
(circle one)

Race: American Indian or Alaska Native Asian Black or African American Multiracial
(circle one)
Native Hawaiian or Other Pacific Islander White Prefer not to answer

Other/Additional Information: _____

Gender: Male Female Non-Binary prefer not to answer
(circle one)

Preferred Pronouns: _____ **Preferred Language:** _____

Additional languages spoken in the home: _____

Emergency Contact:

Name: _____ **Phone:** _____

Client's Physician: _____

Emergency Hospital preference: _____

Individuals authorized to pick up client (if applicable):

Name	Relationship

PURDUE UNIVERSITY | Department of Speech, Language, and Hearing Sciences

Client Name: _____

In the interest of promoting the M.D. Steer Clinic (the "Clinic") and informing the public concerning medical conditions, and the treatment and services offered by the clinic, or for medical, educational or scientific purposes, I consent to the taking and release to the public of audio or video recordings, electronic images and/or photographs (hereinafter "Recordings and Images") in connection with the services I am receiving from the professional who is responsible for my care.

I understand and agree that any such Recordings and Images shall be used for publicity, education or science; such Recordings and Images relating to my case may be published and republished, exhibited either separately or in connection with each other, in a professional journal or medical book, or used for any other purpose deemed proper in the interest of education, knowledge, research or to promote activities at the Clinic in the news media provided, however, that it is specifically understood that in any such publication or use.

I waive all rights I may have to any claims for payment or royalties in connection with any exhibition, televising or other showing of these Recordings and Images.

_____ _____

Date

Signature
(Patient, parent/guardian, or other person authorized to consent for patient)

PURDUE UNIVERSITY | Department of Speech, Language, and Hearing Sciences

PURDUE UNIVERSITY
M.D. STEER AUDIOLOGY SPEECH-LANGUAGE CLINIC
CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS
AND OTHER HEALTHCARE COMMUNICATIONS

Clients of the M.D. Steer Audiology and Speech-Language Clinic (the "Clinic") may be contacted via email and/or text messaging with reminders for upcoming appointments, to obtain feedback on recent experiences with our clinical team, and to provide general health reminders/information. Any and all such electronic communications will be made to you only if you consent to those communications under the following terms and conditions:

1. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Clinic. _____ (Patient Initials)

2. I consent to receive text messages from the Clinic at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above.

3. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

4. The **cell phone number** that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is _____.

5. The **email** that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is _____.

6. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

7. There are risks in using electronic communication for these purposes, some of which are highlighted on the back page of this form. By signing below the Clinic's client acknowledges those risks and accepts them.

I have read and understand the risks of using email and agree that email messages may include protected health information about me or the patient named below (if I am signing as the patient's representative).

Patient Signature: _____ Date: _____

Revocation: Only sign below if you do NOT want to communicate via email and/or text messages

_____ I hereby revoke my request for future communications via email and/or text messages.

_____ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email. Note: This revocation only applies to communications from this Practice.

Patient Name: _____

Patient / Patient Representative Signature: _____

Revised 2/2020

RISKS OF USING EMAIL

Email is inherently unsecure unless it is fully encrypted requiring the use of strong authentication and password protection. Most email does not meet those standards. Among the many risks of using email to communicate sensitive medical information:

- Email can be forwarded, printed, and stored in numerous paper and electronic forms and be received by many intended and unintended recipients without my knowledge or agreement.
- Emails may be sent to the wrong address by any sender or receiver.
- Email is easier to forge than handwritten or signed papers.
- Copies of email may exist even after the sender or the receiver has deleted his or her copy.
- Email service providers have a right to archive and inspect emails sent through their systems.
- Email can be intercepted, altered, forwarded, or used without detection or authorization.
- Email can spread computer viruses.
- Email delivery is not guaranteed.
- Email can be used for Phishing. Phishing is a technique of obtaining sensitive personal information from individuals by pretending to be a trusted sender.
- The use of open internet email channels is not secure or encrypted - meaning that messages between could potentially be viewed by unauthorized persons who might intercept or read those emails.
- The Clinic and its providers may not monitor my emails, or may not even receive them.
- Email is not an appropriate method for sharing urgent or emergent information.
- The Clinic will never ask for personal identifying information or other sensitive information using open email. Such information might include date of birth, mother's maiden name, social security numbers, or other personal identifying information.

PURDUE UNIVERSITY | Department of Speech, Language, and Hearing Sciences

Dear Patrons of the Purdue Audiology and Speech-Language Clinics:

The Harrison Street Parking Garage (PGH) is a 24/7 pay-by-the-hour garage. Moveable arms are installed at the garage exits, and motorists are required to pay hourly rates unless they have either a Purdue "A" parking permit or a validated parking ticket.

To validate your parking ticket during regular business hours:

- As you enter the garage, press the button on the machine to receive a PGH ticket.
- **Bring your ticket to the front office on the first floor (down the hallway to your left as you enter from the garage, room 1042). This office is open 8:00-5:00PM Monday thru Friday.**
- Keep your ticket with you. If you lose your ticket, inquire at the front desk.
- Upon exiting the garage, insert/swipe your PGH ticket into the machine. If it has been validated, you will not incur a charge. If it has not been validated, you must pay an hourly rate as listed below. The machine will accept **credit or debit card payment only**. Rates are as follows:

  0-30 minutes: $1.00

  30-60 minutes: $3.00

  $1.00 for each additional hour thereafter

*********IF YOUR TICKET DOES NOT OPEN THE GATE, AND IT IS VALIDATED, PLEASE PRESS THE CALL BUTTON AT THE GATE. **********

**Parking validation outside of business hours will be handled by staff on an as-needed basis.

Directions to Lyles-Porter Hall on Purdue University Campus

715 Clinic Drive, West Lafayette, IN 47907

From Chicago

--165 S to Exit 193

--Turn **right** onto US 231S

--Turn **left** onto US 52

--Turn **right** onto US 231

--Follow US 231 to Martin Jischke Dr.

--Turn **left** onto Martin Jischke Dr.

--Follow that road up to a Traffic circle

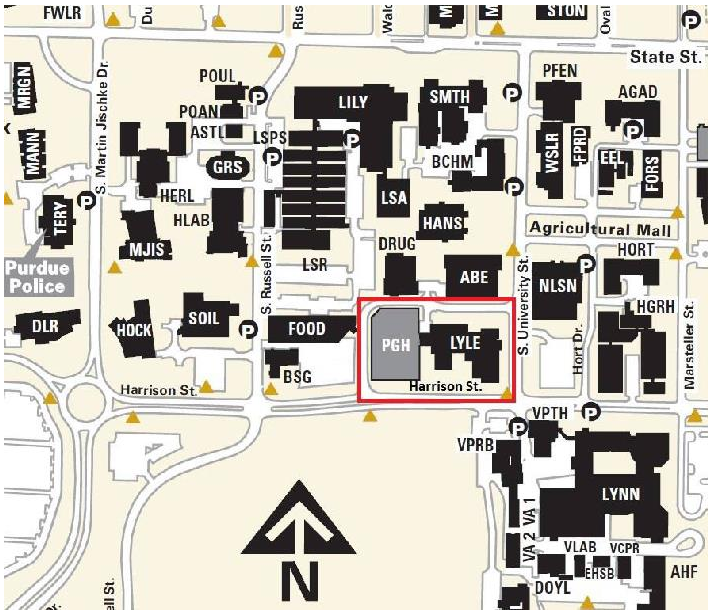
and veer off to the **right** onto Harrison St, staying

in the **left** lane.

--Go to the stop sign and go straight

--Take the next **left** onto Clinic Drive.

--Take a **right** into the Harrison Street Parking Garage.



From Indianapolis:-

---Follow I65 N

--Take exit 141 for US-52 W

--**Continue** onto US-52 W

--Turn **left** onto East 350 South/Veterans Memorial Pkwy S

--Continue **straight** to stay on East 350 South/Veterans Memorial Pkwy S

--Turn **right** onto US-231

-- Follow US 231 to Martin Jischke Dr.

-- Turn **right** onto Martin Jischke Dr.

-- Follow that road up to a Traffic circle

-- Veer off to the **right** onto Harrison St, staying in the **left** lane.

--Go to the stop sign and go straight

--Take the next **left** onto Clinic Drive.

--Take a **right** into the Harrison Street Parking Garage.

If using GPS, use Harrison Street Parking Garage. This will bring you directly to the parking garage connected to Lyles-Porter Hall.

You may park anywhere in the garage, unless otherwise designated.

Please bring your parking pass in with you so we may validate it.

If you have any questions, call us at 765-494-3789 or 765-494-4229

M.D. Steer Audiology and Speech Language Clinics ◆ Lyles-Porter Hall ◆ 715 Clinic Drive ◆ West Lafayette, IN 47907
Phone: (765) 494-3789 ◆ Fax: (765) 494-0771 ◆ www.purdue.edu/hhs/slhs

PURDUE UNIVERSITY

NOTICE OF PRIVACY PRACTICES FOR M.D. STEER AUDIOLOGY AND SPEECH-LANGUAGE CLINICS

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. If you have any questions about this Notice, please contact:

Privacy Officer
Purdue University
610 Purdue Mall
West Lafayette, IN
Telephone: (765) 496-6846
e-mail: legalcounsel@purdue.edu

WHO MUST COMPLY WITH THIS NOTICE

This Notice applies to the following departments that provide health care services to students, faculty and others including but not limited to: Purdue's M.D. Steer Audiology and Speech-Language Clinics. It also applies to the following portions of the University that provide business support to the listed health providers: Student and Receivables Business Services-Accounts Receivable, Student and Receivables Business Services-Loans, Internal Audit, Central Files, Treasury Operations, Payment Processing, Information Technology at Purdue (partial), Public Records Office, Risk Management, SLHS Business and Main Offices, SLHS Electronics and Technical Support, Technology Statewide Business Offices, Purdue Recycling, University Counsel and designees and certain other members of University administration for risk management and legal purposes. For convenience, the listed health care providers and the listed business support groups will be referred to in this Notice as "Health Care Providers." The full list of covered components at Purdue University may be found at the following web site: https://www.purdue.edu/legalcounsel/HIPAA/ This Notice does not apply to the remainder of Purdue's departments and schools.

Purdue's Health Care Providers are legally required to protect the privacy of your health information and to provide you with a notice of privacy practices. This Notice describes how the Health Care Providers may use and disclose your protected health and medical information. It also describes some rights you have regarding your health information. Health information is information about you that is received, used, or disclosed by Purdue's Health Care Providers concerning your physical or mental health, health care services provided to you, or your health insurance benefits and payments. Protected health information may contain information that identifies you including your name, address and other identifying information.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Mental health information, including psychological or psychiatric treatment records and psychotherapy notes, and information relating to communicable diseases, including HIV records, are subject to special protections under Indiana law. We will generally only release such records or information with your written authorization or with an appropriate court order. Alcohol and drug abuse treatment information is also subject to special protections under federal law. We will usually need to get your written authorization or an appropriate court order before we release this information. Except where there are special protections under Indiana law or other federal laws, we may use and disclose your health information without your authorization for the following purposes:

For treatment.
The Health Care Providers may use and disclose your health information to provide or assist with your treatment. For example, we may provide your health information to a laboratory in order to obtain a test result important for diagnosing or treating a condition you may have.

To obtain payment for health care services.
We may use and disclose your health information in order to bill and collect payment for the treatment and services provided to you. For example, we may provide limited portions of your health information to your health plan to get paid for the health care services we provide to you, unless you have paid for the health care service in full and specifically request us not to disclose information related to that service. We may also provide your health information to our business associates who assist us with billing, such as billing companies, claims processing companies, and others that process our health care claims. We will only disclose the minimum amount of information needed to obtain payment.

For health care operations.
Your health information may also be used or disclosed to improve and conduct health care operations. For example, we may use your health information in order to evaluate the quality of healthcare services that you received or to evaluate the performance of the Health Care professionals who provided health care services to you. We may also provide your health information to our auditors, attorneys, consultants, and others in order to make sure we are complying with the laws that affect us. We may also use a sign-in sheet at registration or other appropriate areas, and we may call you by name in waiting and serviceareas.

When disclosure is required by federal, state, or local law, judicial or administrative proceedings, or law enforcement.
For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot and other wounds; or when ordered in a judicial or administrative proceeding.

Response to organ and tissue donation requests and work with a medical examiner or funeral director
We may share health information about you with organ procurement organizations. We can also share information with a coroner, medical examiner, or funeral director when an individual dies.

Public health activities.
For example, we report required information about various diseases to government officials in charge of collecting that information.

Health oversight activities.
For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

Research purposes.
In certain limited circumstances, we may provide health information in order to conduct medical research. Use of this information for research is subject to either a special approval process or removal of information which may directly identify you. In most instances, we will require your written authorization prior to using or disclosing health information for research purposes.

Avoiding a serious threat of harm.
In order to avoid a serious threat to the health or safety of a person or the public, we may provide health information to law enforcement personnel or persons able to prevent or lessen such harm.

Certain government functions.
We may disclose health information of military personnel and veterans in certain situations, as well as for national security purposes or when required to assist with governmental intelligence operations.

Workers' compensation.
We disclose health information to comply with workers' compensation laws.

Appointment reminders and health-related benefits or services.
We may use health information to provide appointment reminders, or give you information about treatment alternatives, other healthcare services or benefits we offer.

Business Associates.
We will share your health information with business associates that assist our Health Care Providers. Business associates include people or companies outside of Purdue who provide services to our Health Care Providers. For example, health information may be disclosed by the clinics to a bill processing company to obtain payment for services rendered. Purdue's business associates and their subcontractors must comply with the HIPAA laws, and we have agreements with our business associates to protect the privacy and security of your health information.

Disclosures to family, friends, or others.
In very limited cases, we may provide health information to family members,

or close friends who are directly involved in your care or the payment for your health care, unless you tell us not to. For example, we may allow a friend or family member to pick up a prescription for you and, if you don't object, we may share discharge instructions with a family member or friend who accompanied you to your visit. We may also contact a family member if you have a serious injury or in other emergency circumstances. We may discuss medical information in the presence of a family member or friend if you are also present and indicate that it is okay to do so.

Communication for Marketing Purposes and Sale of Protected Health Information

In the case where we may wish to market health-related products or services to you or receive financial assistance in making the communication or in the case where costs are reimbursed to the clinic in exchange for sharing your health information, we will ask for your written authorization before using or disclosing any of your health information for these purposes.

All other uses and disclosures require your prior written authorization.

In any other situation not described above, we will ask for your written authorization before using or disclosing any of your health information. If you do sign an authorization to disclose your health information, you can later revoke that authorization in writing. This will stop any future uses and disclosures to the extent that we have not taken any action relying on the authorization.

RIGHTS YOU HAVE REGARDING YOUR HEALTH INFORMATION

The Right to Request Limits on Uses and Disclosures of Your Health Information.

You have the right to ask that Purdue's Health Care Providers limit the use and disclosure of your health information. If you or another family member or person on your behalf have paid your health care provider in full for a particular health care service or item and specifically request that we not disclose information about this health care item or service to your health plan for payment or healthcare operations purposes, we will agree to this request. We generally cannot restrict disclosure of information needed for health care treatment purposes. For other restrictions, we will consider your request but we do not have to accept it. If we do, we will put any limits in writing and abide by them except in emergency situations where the information is needed. You may not limit the uses and disclosures that we are legally required to make.

The Right to Choose How We Send Health Information to You.

You have the right to ask that we send your health information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, by fax instead of regular mail). We must agree to your request if we can easily provide it in the format you requested.

The Right to See and Get Copies of Your Health Information.

In most cases, you have the right to look at or get copies of your health information that we have, but you must make the request in writing. You can also view or obtain copies of your lab test results if they are complete and part of your medical or mental health record by viewing on the patient portal, if available, or by making the request for a copy, in writing. If we use an outside laboratory for lab testing, you can request test results directly from the lab, if the testing is complete. We will you give you the contact information for the external lab, if you request it. If we maintain an electronic copy of your medical, mental health or billing records, and you request an electronic copy of your record, we will provide you with access to the electronic information in the electronic format requested by you, if it is readily producible, or, if not, in a readable electronic format as agreed to by Purdue's Health Care Providers and you. If requested, we will transmit an electronic copy to an entity or person designated by you. If we do not have your health information but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed. If you request copies of your health information, we will charge you a reasonable fee as permitted by Indiana law. Instead of providing the health information you requested, we may provide you with a summary or explanation of the health information. We will only do this if you agree to receive information in that form and if you agree to pay the cost in advance.

The Right to Get a List of Certain Disclosures We Have Made.

You have the right to request a list of instances in which we have disclosed your health information. The list will not include uses or disclosures made for treatment, payment, and health care operation, or information given to your family or friends with your permission or in your presence without objection. It will also not include disclosures made directly to you or when you have given us a written authorization for the release of health information. The list will also not include information released for national security purposes or given to correctional institutions. To obtain this list, you must make a request in writing to the Privacy Officer listed at the top of this notice. The list we will give you will include disclosures made in the last six years unless you request a shorter time. We will provide the list to you upon request once each year at no charge.

The Right to Amend or Update Your Health Information.

If you believe that there is a mistake in your health information or that a piece of important information is missing, you have the right to request that we amend the existing information. You must provide the request and your reason for the request in writing to the Privacy Officer listed at the top of this notice. We may deny your request in writing if the health information is: 1) correct and complete; 2) not created by us; 3) not allowed to be disclosed, or 4) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file a statement of disagreement, you have the right to ask that your request and our denial be attached to all future disclosures of your health information. If we approve your request, we will make the change to your health information, tell you that we have done it, and tell others that need to know about the change to your health information.

The Right to Receive Breach Notification.

If any of Purdue's Health Care Providers or any of its Business Associates or the Business Associate's subcontractors experiences a breach of your health information (as defined by HIPAA laws) that compromises the security or privacy of your health information, you will be notified of the breach and about any steps you should take to protect yourself from potential harm resulting from thebreach.

The Right to Get This Notice by E-Mail.

You have the right to get a copy of this Notice by e-mail. Even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of this Notice.

CHANGES TO THIS NOTICE

Purdue's Health Care Providers are required to abide by the terms of this Notice of Privacy Practices. However, we may change our notice at any time. The new notice will be effective for all protected health information maintained by the covered Health Care Providers of Purdue. A revised Notice of Privacy Practices will be posted at the main entrances to our covered healthcare provider areas, may be requested from the Privacy Officer listed at the top of this notice, and may be found on our website atwww.purdue.edu/hipaa.

WHAT TO DO IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED

If you think that we may have violated your privacy rights, or you disagree with a decision we made about your health information, you may file a complaint with our Privacy Officer at the telephone number or e- mail address listed at the top of this notice. You also may send a written complaint to the Secretary of the Department of Health and Human Services. Further information about how to file a complaint is available from the Privacy Officer. We will not punish you or retaliate against you if you file a complaint about our privacy practices.

EFFECTIVE DATE OF THIS NOTICE

This notice applies to uses and disclosures of your protected health information beginning on February 1, 2020.