OB/GYN ASSOCIATES OF LANCASTER, INC.

Obstetrics and Gynecology

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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 GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Privacy Officer at 740-653-5088.

Effective date of this Notice: April 14, 2003

OUR PLEDGE REGARDING MEDICAL INFORMATION:
We understand that medical information about you and your health is personal. We are committed to protecting the privacy of medical information about you. We create a record of the care and services you receive in the practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated or used by the practice, whether made by practice's personnel or another doctor. Other doctors may have different policies or notices regarding the use and disclosure of your medical information created or used in that doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. The medical information that we have about you is called protected health information. We also describe your rights and certain obligations we have regarding the use and disclosure of your protected health information. We are required by law to:

- Make sure that protected health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to protected health information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.
The following categories describe different ways that we use and disclose protected health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. In this notice, the word "use" means to review, consult, read, update, and study your protected health information so that we can provide health care to you to assure that we are caring for you in the best way that we can and to perform other activities permitted or required by law. The word "disclose" in this notice means that we are providing your protected health care information to someone outside of our practice so that he or she can provide care for you, understand your health condition in order to explain it to you, learn more about your particular health condition, so that we can get paid for providing health care to you and other activities permitted by law. Following is a discussion of these activities.

- **For Treatment**. We may use protected health information about you to provide you with medical treatment or services in our office. We may disclose medical information about you to other doctors, nurses, technicians, medical students, or hospital personnel who are involved in taking care of you at the hospital or in other doctor's offices. We also may disclose protected health information about you to people outside our office who may be involved in your medical care, such as family members, laboratory technicians, or health professionals outside of our practice, that are part of your care.
- **For Payment**. We may use and/or disclose protected health information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. We may send you a statement for our services that contains our return address on the envelope. We may also tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment.
- **For Health Care Operations**. We may use and/or disclose protected health information about you for the business purposes of our practice. These purposes are activities such as training medical students and residents, assuring quality care for all of our patients, review, credentialing and evaluation of the doctors, nurses and assistants who provide care to you. We may also share your protected health information with others who assist us in record keeping, such as the transcriptionists who type some of our records and the billing clerks who prepare and submit the bills for payment.
- **Appointments and Reminders**. We may use and/or disclose protected health information to contact you or as a reminder that you have an appointment, to keep track of who is waiting in the office to be seen and who you are waiting to see, and to call your name in the waiting room.
- **Marketing and Fund-Raising**. We may use and/or disclose protected health information for marketing or fund-raising purposes, such as to tell you about alternative health care services or treatment options that may be of interest to you or to contact you as part of a fund-raising effort.
- **Emergencies**. We may use and/or disclose protected health information about you for emergency treatment. This could occur in a situation where you have come into our office and are unable to provide consent because of the condition of your health and the need for immediate treatment. If this happens we will attempt to obtain your permission for this use or disclosure as soon as possible after the emergency treatment.
- **Health-Related Benefits and Services**. We may use and/or disclose protected health information to tell you about health-related benefits or new products or services that may be of interest to you. For instance, we may learn of a new medication that may be helpful to you and we may send you information about this new medication in the mail with our return address on the envelope.
- **Individuals Involved in Your Care or Payment for Your Care**. We may disclose protected health information about you to a friend or family member who is involved in your medical care. We may also disclose protected health information to someone who helps pay for your care.
- **For Communication Purposes**. We may use and/or disclose your protected health information to a third party if we have significant difficulty communicating with you. For instance, if you have difficulty speaking and/or understanding English or you are deaf or hearing impaired, we may wish to have a sign or foreign language interpreter available to assist us in communicating with you. We will attempt to obtain your consent for treatment prior to using another person to assist us in communicating with you and if that is not possible we will obtain your consent as soon after providing treatment as possible.
- **Business Associates**. We may disclose protected health information to employees in other businesses who assist us in your health care treatment. For instance, we may use a copy service when it is necessary to copy your medical record to send to another physician or health care facility. When we use business associates to assist us in providing service to you, we require that they agree to safeguard your protected health information before we allow them to be our business associates and before we disclose any protected health information to them.
- **Correctional Institution**. We may disclose protected health information about you to individuals in correctional facilities so that you can receive appropriate health care if you were to go to jail.

- **As Required By Law**. We may disclose protected health information about you when required to do so by federal, state or local law. If a law requires that we disclose protected health information about you, we will do so only to the extent required by the law. Federal law permits and/or requires us to disclose your protected health information to agencies that do health care oversight, public health activities, workers compensation, food and drug administration, and similar legally regulated activities. For instance, state law requires and we do report instances of communicable diseases, such as venereal disease, to the Health Department. Another example is if a drug or a other product prescribed for you has been recalled by the Food and Drug Administration (the "FDA") and the FDA requires us to, we will disclose your name and other identifying information to them.
- **Lawsuits, Disputes and Subpoenas**. If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a court or administrative order. We may also disclose protected health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement**. We may disclose information if asked to do so by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About a death we believe may be the result of criminal conduct;
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding protected health information we maintain about you:

- **Right to Inspect and Copy**. You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to the address listed on the first page no later than one (1) week before you would like to inspect your protected health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend**. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the practice. To request an amendment, your request must be made in writing and submitted to the address listed on the first page. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the protected health information kept by or for the practice;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

  If we deny your request for the amendment, we must let you know in writing. You have the right to disagree with our denial of your requested amendment.
- **Right to an Accounting of Disclosures**. You have the right to request that we provide you with an "accounting of disclosures," in compliance with 45 CFR 164.528 This is a list of certain disclosures we made of your protected health information that were **not** related to treatment, payment, health care operations, or any of the other routine uses or disclosures described in this Notice, were not required by law, and for which you did not sign an authorization. To request this list or accounting of disclosures, you just submit your request in writing to the address listed on the first page. Your request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within any twelve (12) month period will be free. For additional lists, we may charge you for the costs of providing the list. 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.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the protected health information we use or disclose about you 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, like a family member or friend. For example, you could ask that we not use or disclose information to your spouse about a surgery you had. ***We are not required to agree to your request***. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to the address listed on the first page. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.
- **Right to Request Alternative Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential alternative communications, you must make your request in writing to the address listed on the first page. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the office at the number listed on the first page.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for protected health information we already have about you as well as any information we create or receive in the future.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the practice and with the Secretary of the United States Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer at 740-653-5088. To file a complaint with the Secretary of the United States Department of Health and Human Services, send a letter to: Secretary, United States Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201 or an email to: HHS.Mail@hhs.gov. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose protected health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

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PATIENT ACKNOWLEDGEMENT FORM

NOTICE OF PRIVACY PRACTICES

Patient Name: ______________________________

Date: ______________________________

________ I have received a copy of OB/GYN Associates of Lancaster's Notice of Privacy Practices

________ I was offered a copy of OB/GYN Associates of Lancaster's Notice of Privacy Practices, and declined it.

Patient Signature: ______________________________

A good faith effort was made to provide a copy of OB/GYN Associates of Lancaster's Notice of Privacy Practices to this patient and to obtain her acknowledgement of the same. Patient _____ACCEPTED ____ DECLINED the Notice and refused to sign this acknowledgement.

OB/GYN Associates of Lancaster representative:

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Signature: ______________________________ Date________