HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. IT ALSO SHOWS AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND RETAIN FOR YOUR RECORDS.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We, are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint

For more information about HIPAA or to file a complaint, contact:

The U.S. Department of Health and Human Services
Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 Tel. (202) 619-02570

109 Valley Rd. Montclair, NJ 07042
www.wombkeepers.com
Fax: 973-655-9665 Phone: 973-655-9662 staff@wombkeepers.com

PATIENT DISCLOSURE INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request that confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual home.

I wish to be contacted in the following manner (check all that apply)

[ ] Home Phone:_____ [ ] Okay to leave message
[ ] Cell Phone: _____ [ ] Okay to leave message
[ ] Other Phone:_____ [ ] Okay to leave message

I authorize Wombkeepers Obstetrics and Gynecology to release my protected health information to the following individual:

Name:_____ Relationship:_____

HIPAA ACKNOWLEDGEMENT

With my consent, Wombkeepers may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO), as further detailed in the Notice of Privacy Practices.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Wombkeepers reserves the right to revise its Notice of Privacy Practices at anytime and patients may request to receive any revisions in person or in writing.

With my consent, Wombkeepers may call my home or other designated location and leave a message, on voice mail or in person, in reference to any items that assist in my care or as necessary for payment. Wombkeepers may also mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With my consent, Wombkeepers may E-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Wombkeepers restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Wombkeepers use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing this document I acknowledge that I have read and/or received a copy of the Wombkeepers Obstetrics and Gynecology HIPAA Notice of Privacy Practices. I have also read the contents of this form. I consent to the use and disclosure of my protected health information by Wombkeepers in order to carry out treatment, healthcare procedures and payment. I have had the opportunity to ask questions and all my questions have been answered.

Printed Name:	Signature:	Date:
Witnessed by:	Signature:	Date:

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