DOYLESTOWN WOMEN'S HEALTH CENTER, LLC

HIPPA NOTICE OF
PRIVACY PRACTICES
Effective Date: April 14, 2002

THIS NOTICE DESCRIBES HOWMEDICAL INFORMATION ABOUT YOUMAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is provided to you pursuant to the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPPA"). It is designated to tell you how we may, under federal law, use or disclose your Health Information.

I. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:

We may provide your Health Information to other health care professionals- including doctors, nurses and technicians- for purposes of providing you with care.

Our billing department may access your information- and send relevant parts- to other insurance companies to allow us to be paid for the services we render to you.

We may access or send your information to our attorneys or accountants in the even we need to information in order to address one of our own business functions.

II. We may also Use or Disclose Your Health Information Under the Following Circumstances without Obtaining Your Prior Authorization:

To Notify and/or communicate with your Family. Unless you tell us you object, we may use or disclose your Health Information in order to notify your family or to assist in notifying your family, your personal representative or another person responsible for your care about your location, your general condition, or in the event of your death. If you are unable or unavailable to agree or object, our health care professionals will use their best judgment in any communications with your family and others.

As required by Law.

For Public Health Purposes. We may use or disclose your Health Information to provide information to state or federal public health authorities, as required by law to prevent or control disease, injury or disability; to report child abuse or neglect; report domestic violence; report to the Food and Drug Administration problems with products and reactions to medications; and report disease or infection exposure.

For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

In Response to Civil Subpoenas or for Judicial and Administrative Proceedings. We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person.

To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to identify or locate a suspect, fugitive, material witness or missing person, comply with a court order or grand jury subpoena and other law enforcement purposes.

To Coroners or Funeral Directors. We may use or disclose your Health Information for purposes or communicating with coroners, medical examiners and funeral directors.

For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating with organizations involved in procuring, banking, or transplanting organs and tissues.

For Public Safety. We may use or disclose your Health Information in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

To Aid Specialized Government Functions. If necessary, we may use or disclose your Health Information for military or national security purposes.

For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

To Correctional Institutions or Law Enforcement Officials, if You are an Inmate.

III. **For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization.** If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

I. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:

Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

Change of Ownership. In the event that our Practice is sold or merged with another organization, your Health Information/record will become the property of the new owner.

II. Your Rights.

1. You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with your request.

2. You have the right to receive your Health Information through confidential means through a reasonable alternative means or at an alternative location.

3. You have the right to inspect and copy your Health Information. We may charge you a reasonable cost based fee to cover copying, postage and/or preparation of a summary.

4. You have the right to request we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.

5. You have the right to receive an accounting of disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with family; and /or for certain government functions, to name a few.

6. You have the right to a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact us using the information provided below.

III. Our Duties.

We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice.

We are also required to abide by the terms of this Notice.

We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information- even if it was created prior to the change in the Notice. If such amendment is made, we will immediately display the revised Notice at our office. We will provide you with another copy, of this Notice at any time, upon request.

IV. Complaints to the Government.

You may make complaints to the Secretary of the Department of Health and Human Services ("DHHS") if you believe your rights have been violated.

We promise not to retaliate against you for any complaint you make to the government about our privacy practices.

V. Contact Information.

You may contact us about our privacy practices by writing or calling the Privacy Officer at:

Doylestown Women's Health Center, LLC
708 Shady Retreat Rd. Suite 7
Doylestown, PA 18901
Phone: 215-340-2229
Fax: 215-340-1753

You May Contact the DHHS at:

200 Independence Avenue S.W.
Washington, D.C. 20201
Phone: 202-619-0257
Toll Free: 1-877-696-6775

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO FAMILY AND FRIENDS

I hereby authorize Doylestown Women's Health Center, LLC (the "Practice") to release my Patient Information described below to:

All of my family members
Spouse
Mother
Father
Children: _____
Other Family Members: _____
The following persons: _____
No one

I give my permission to LEAVE MESSAGES ON MACHINE (regarding test results, other results, answer questions, etc….)

Documents/Information to Be Released:

Purpose of Disclosure (explain or indicate "at the request of the individual"):

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in the Practice's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization, and my signature, and that I should send it to:

Doylestown Women's Health Center, LLC
708 Shady Retreat Rd Suite 7
Doylestown, PA 18901
Attention: [Privacy Officer]

I understand that I am not required to sign this Authorization and that the Practice may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

This Authorization expires upon [cessation of treatment; release from hospital; birth of child; conclusion of course treatment].

I hereby acknowledge receipt of a copy of this Authorization.

_____
Signature of Individual or Personal Representative

_____
Description of Personal Representative's Authority

_____
Date of Authorization

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES OR DOLYESTOWN WOMEN'S HEALTH CENTER, LLC

By signing this acknowledgment, I am acknowledging that Doylestown Women's Health Center, LLC provided to me information about its "Notice of Privacy Practices."

I was given the opportunity to ask questions about the privacy practices of Doylestown Women's Health center, LLC and my questions were answered.

I received a copy of the "Notice of Privacy Practices" of Doylestown Women's Health Center, LLC.

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Patient's Name (print) — Date

_____ _____

Witness — Date