

Notice of Privacy Practices

Women's Health Partners and its employees, and many other healthcare professionals, work together to provide the best care to our patients. As allowed by law, patient health information is used and shared in order to provide for treatment, arrange for payment for treatment, and to conduct our healthcare operations. The purpose of this Notice is to tell you how we will use and share your health information and how you can find out more information about our privacy practices.

I. We Have a Legal Duty to Protect Your Health Information

We are required by law to maintain the privacy of our patients' health information and to provide our patients with information concerning our organizations' privacy practices. This includes your past, present or future health information (your condition, care provided to you, or payment information). We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice and to make a new Notice effective for all personal health information that we maintain. You may receive a copy of any revised Notice by contacting the Privacy Officer, Women's Health Partners, 4141 North Hampton Drive, Suite 101, Powell, Ohio 43065.

II. We May Use and Disclose (Share) Your Health Information

- For Treatment/Care.** We may use and share your health information for your treatment or care. For example:
 - Doctors, nurses, and other staff involved in your care will use information in your medical record so that we can provide you with the best care.
 - If you are being treated for a knee injury, we may share your health information with the Physical Therapy staff so they can help plan your care.
 - We may also share your health information with another health care facility or professional not associated with us but who will be providing treatment or care to you. A specific example, if you leave this healthcare facility to receive home healthcare, we may share your health information with that home health care agency so that your treatment and care plan can be prepared for you.
- For Payment of Your Treatment.** We may use and share your health information if needed for payment purposes. For example:
 - We may share information about your tests and care with your insurance company to arrange payment for services provided to you.
 - We may use your information to prepare a bill to send to you or to the person responsible for your payment.
 - We may share your health information with our business partners that help us with things like billing and claims. These businesses MUST protect the privacy of your information.
 - For payment purposes, we may share your health information with other healthcare professionals who have treated you or provided services to you, even though they may not be associated with us.
- For Healthcare Operations.** We may use and share your health information, as necessary and as permitted by law, to help improve care and operate the office (such as improving clinical care, staff evaluations, managing our business, auditing, legal services, accreditation and licensing). For example:
 - We may use and share your health information to evaluate the care the staff provides.
 - We may need to share health information with our business partners that help us with our healthcare operations. These businesses MUST protect the privacy of your information.
 - We may also share your health information with other healthcare professionals, facilities and health plans to help them improve their care and operations, but only if they also have a patient-relationship with you.
- For Appointment Reminders and Health-related Benefits or Services.** We may use health information to send appointment reminders or test results.
- Health Products and Services.** We may use your health information to let you know about our health products and services, those necessary for your care, to tell you of new products and services we offer and to give you general health and wellness information.
- For Workers' Compensation.** We may share your health information with workers' compensation agencies if needed for a benefit determination.
- When services are requested by your employer.** We may share your health information with your employer when we have provided care to you at the request of your employer. In most cases, you will get a notice that information has been sent to your employer.
- For Some Government Functions.** We may share your health information if needed:
 - If you are a veteran or in the military.
 - For national security or intelligence activities, such as protecting the President of the United States or conducting intelligence operations.

Keeping Your Personal Health Information (PHI) Private

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.

- To Avoid Harm.** We may share health information to law enforcement or safety staff in order to avoid a serious threat to the health or safety of one person or the public.
 - For Research.** We may share your health information for research when it is approved by an Institutional Review Board with special rules to ensure privacy.
 - For Purposes of Organ Donation.** We may share your health information if needed to arrange for organ or tissue donation from you or to give a transplant to you.
 - For Health Oversight Activities.** By law, we must share your health information as needed to a government agency doing audits, investigations, and civil or criminal proceedings. For example:
 - We will share information to help the government when it investigates a healthcare provider or organization.
 - For Public Health Activities.** We may share your health information for public health activities, such as reporting diseases, injuries, births, deaths, and looking into disease outbreaks. For deceased patients, by law and only if needed, we must share your health information with coroners and funeral directors.
 - For Legal Cases or Law Enforcement (at the federal, state and local level).** We may share your health information as needed:
 - To report wounds, injuries and crimes.
 - If we suspect child abuse or neglect.
 - If we believe you are a victim of abuse, neglect, or domestic violence.
 - To the Food and Drug Administration to report medicine adverse reactions, product defects, or product recalls.
 - Under court order.Ohio law requires that we obtain your permission in many instances before disclosing information about:
 - performance or results of an HIV test or diagnoses of AIDS or an AIDS-related condition,
 - drug or alcohol treatment you have received in a drug or alcohol treatment program,
 - mental health services you may have received.
- ### III. You Have the Opportunity to Object ("Opt Out") to the Following Uses and Disclosures:
- Family and Friends Helping in Your Care.** With your approval, we may share your health information with your family, friends, or other caregivers that help with your care or payment of your care. If you are not available or are incapacitated or facing a medical emergency, we may share your information if we determine that doing so is in your best interests. We may share health information to an agency that is helping in disaster relief efforts so that they may find your family or caregiver.
 - All Other Uses and Disclosures Need Your Prior Written Authorization.** In any situation not mentioned in section II or III, we will ask for your written authorization before using or sharing your health information. If you sign an authorization form, you can later cancel that authorization (in writing) to stop any future uses.
- ### V. Your Rights Regarding Your Health Information
- The Right to Access Your Own Health Information.** You have the right to copy and/or inspect most of your health information that we keep on your behalf.
 - All requests to copy and/or inspect your health information must be made in writing and signed by you or your legal representative. You may get an access request form from our Office Manager.
 - If there is a cost, we will tell you in advance. We will charge you for copying the health information, postage (if mailed) and/or for a summary or explanation of the health information.
 - The Right to Request Amendments to your Health Information.** You have the right to request amendments (changes) to your health information if you believe the information is not accurate.
 - You must make a written request and state your reason for amending your health information. Contact our Office Manager for an amendment form.
 - We are not obligated to agree to the request, but we will give each request careful consideration. If we approve your request, we will place the amendment form in your medical record, tell you that we have done it, and tell others that need to know about the change.
 - We may deny your request if the information is accurate and complete as written, or, was not created by us. If your request is denied, we will tell you, in writing, with the reason(s) for the denial. We will explain your right to file a written statement of disagreement with the denial.
 - The Right to an Accounting of Certain Disclosures of Your**

Health Information. You have the right to receive an accounting of when we shared your health information and to whom.

The list will include:

- the date and to whom (with the address, if known) health information was disclosed,
- the reason and type of health information shared.

This list will not include disclosures:

- made for treatment, payment, healthcare operations, or directly to you or to your family,
- that you have already authorized in writing,
- for national security purposes,
- for corrections or law enforcement staff, or
- occurring before April 14, 2003.

Written requests must be signed by you or your legal representative. Contact the Office Manager for an accounting request form.

- The first list in any 12-month period is free. You will be charged for each extra list you request in the same 12-month period.

- The Right to Ask For Limits on Using and Sharing Your Health Information.** You have the right to request that we limit how we use and share your health information for treatment, payment, or healthcare operations. You may not limit the uses that we are allowed to do by law.

- We are not obligated to agree to your request but we will try to abide by your request when appropriate.
- We have the right to end an agreed-to limitation if we believe that ending it is needed or that the limit will be hard to complete. You will be informed.
- You can end an agreed-to limitation by sending a written termination notice (signed by you or your legal representative) to our Office Manager.

- The Right to Choose How We Send Health Information to You.** You have the right to request that we send information on you to a different address or in a different method (e.g. via phone, fax). We must agree to your request if it is reasonable and if it can be easily done.

VI. How to Complain About Our Privacy Practices.

If you feel your privacy rights have been violated, you may file a complaint with:

- Our Privacy Officer. The complaint must be in writing and mailed to Women's Health Partners Privacy Officer, 4141 North Hampton Drive, Suite 101, Powell, Ohio 43065.

- You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. within 180 days of a violation of your rights. We will take no retaliation if you file a complaint.

For More Information About This Notice. If you have questions or need further help with this Notice, you may contact or write the Women's Health Partners Privacy Officer, 4141 North Hampton Drive, Suite 101, Powell, Ohio 43065.

As a patient you have the right to get a paper copy of this Notice of Privacy Practices, even if you have asked for a copy by e-mail or other means.

VII. Acknowledgement of Receipt of Notice.

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

VIII. Effective Date

This Notice of Privacy Practices is effective April 14, 2003.

Women's Health Partners

Women's Health Partners

Patient Name: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I hereby acknowledge that on _____ I received the Notice of Privacy Practices of this Facility which sets forth the ways in which my personal health information may be used or disclosed by this practice, and outlines my rights with respect to such information.

Patient's/Guardian Signature

Date