Pacific In Vitro Fertilization Institute

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Pacific In Vitro Fertilization Institute's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of this Notice and will explain below any restrictions I request regarding my medical information.

*I request the following restriction(s): _____

Patient: _____ _____ _____
(Print) (Sign) (Date)

_____ (Optional) I authorize release of information including the diagnosis, records and financial information
(initial) rendered to me. This information may be released to (e.g. spouse, parent, etc.):

Person: _____ Relationship: _____
(If Applicable)

This *Release of Information* will remain in effect until terminated by me in writing.

_____ I am aware that Pacific In Vitro may be contacting me at my primary phone number through a text
(initial) messaging system for appointment reminders (standard message and date rates may apply).

☐ Check this box to opt out of text message reminders by Pacific In Vitro

It is understood that all electronic communication is not encrypted and secure. Electronic communication containing clinical information should be limited in use. However, there are certain circumstances where electronic communication is required by me.

Electronic communications should never be used in cases of an emergency or urgent request for information.

I consent to electronic communication (if required) with Pacific In Vitro Fertilization Institute. I understand that I may revise or withdraw my consent at any time in writing, and that I have the right to receive a copy of this authorization form.

I also understand that Pacific In Vitro Fertilization Institute does have a secure email service which can be accessed through https://web1.zixmail.net/s/login?b=pacificinvitro

_____ _____ _____
Patient Name Patient Signature Date

Internal Use Only

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time):_____

By (name and title): _____

PACIFIC IN VITRO FERTILIZATION INSTITUTE
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your "protected health information". PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health, the heath care you have received, or payment for your health care.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any new revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

You will be asked to sign a consent form after reviewing this notice. Once you have consented to the use and disclosure of your PHI for treatment, payment, and health care operations by signing the consent form, we will use or disclose your protected health information as described. Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purposes of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills. We will not use or disclose your health information without your authorization, except as described in this notice.

Following are examples of the types of uses and disclosures of your protected health care information that we are permitted to make once you have signed our consent form.

TREATMENT: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we may instruct you to have laboratory tests, and we may use the results to diagnose your condition. In addition, we may disclose your PHI to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

PAYMENT: We may use and disclose your health information to others for the purpose of obtaining payment for treatment and services that you receive. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. Disclosures to your protected health information may also be made to billing services or collection agencies.

HEALTH CARE OPERATIONS: We may use or disclose, as needed, your PHI in order to improve the quality and effectiveness of the healthcare and reproductive medicine services we provide, as well as to support the business activities of our practice. For example, your health information may be disclosed to members of our staff for the purpose of evaluating the performance of our staff, assessing the quality of care and outcomes in your case and similar cases, training of medical students, and for learning how to improve our facilities, health care, and other services.

In addition, we use a sign-in form at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to see you. We may use or disclose your PHI as necessary, to contact you to provide you with appointment reminders.

BUSINESS ASSOCIATES: There are some services provided at Pacific In Vitro Fertilization Institute through contact with business associates. For example: We will share your PHI with third party "business associates" that perform various activities (i.e., billing, transcription services) for the practice, including certain laboratory tests and the services of anesthesiologists and psychologists. When these services are used, we may disclose your PHI to our business associate so they can perform the job we have asked them to do. Your health information is protected through our agreement with our business associates to appropriately safeguard your information. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We will collect health information on you and your partner. For example: Although health information in your medical records belongs to you, it will contain some information pertaining to your partner. This is because the treatment of infertility may focus on the couple rather than the individual.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT

We may use or disclose your PHI in the following situations without your authorization or providing you with the opportunity to agree or object. These situations include:

REQUIRED BY LAW: We may use or disclose your PHI to the extent that the use or disclosure is required by law or in response to a valid subpoena, discovery request or other lawful process. The use or disclosure is will be made in compliance with the law and your health information will be released to an appropriate public health authority or attorney and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such disclosures.

PUBLIC HEALTH: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury, or disability.

COMMUNICABLE DISEASES: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

HEALTH OVERSIGHT: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

ABUSE OR NEGLECT: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

FOOD AND DRUG ADMINISTRATION: We may disclose your PHI to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products, to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required.

CENTERS FOR DISEASE CONTROL: Data from your ART procedure will also be provided to the Centers for Disease Control and Prevention (CDC). The 1992 Fertility Clinic Success Rate and Certification Act requires that CDC collect data on all assisted reproductive technology cycles performed in the United States annually and report success rates using these data. Because sensitive information will be collected on you, CDC applied for and received an "assurance of

confidentiality" for this project under the provisions of the Public Health Service Act, Section 308(d). This means that any information that CDC has that identifies you will not be disclosed to anyone else without your consent.

LEGAL PROCEEDINGS: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extend such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

LAW ENFORCEMENT: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and is likely that a crime has occurred.

CRIMINAL ACTIVITY: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

MILITARY AND NATIONAL SECURITY: When appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department off Veteran's Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

WORKER'S COMPENESATION: We may disclose your protected health information as authorized to comply with worker's compensation laws and other similar legally established programs.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT REQUIRE YOU THE OPPORTUNITY TO AGREE OR OBJECT

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether this disclosure is in your best interest.

OTHERS INVOLVED IN YOUR HEALTH CARE OR PAYMENT FOR YOUR CARE: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosure to family or other individuals involved in your health care.

2. YOUR RIGHTS

- You have the right to inspect and copy your protected health information. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be review. In some circumstances, you may have the right to have this decision reviewed.
- You have the right to request restrictions on our use and disclosure of your PHI for treatment, payment, or health care operations. If we agree to any restriction, then we cannot violate that restriction except in the case of emergency treatment. Your request must state the specific restriction requested and to whom you want the restriction to apply. Please note that your physician is not required to agree to a restriction that you may request.
- You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact.
- You may have the right to request in writing that we amend your PHI. Your request must contain the reasons to support the requested amendment. We will act upon request withing sixty (60) days after we receive your request. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- You have a right to receive an accounting of all our disclosures of your PHI in the six years prior to the date of your request, except for disclosures: (a) to carry out treatment, payment, and health care operation; (b) to you; (c) for persons involved in your care; (d) for national security or intelligence purposes; (e) to correctional institutions or law enforcement officials; (f) pursuant to any written authorization that you give to us or; (g) that occurred prior to April 14, 2003.
- You have the right to obtain a paper copy of this notice from us upon request.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our privacy officer, Thomas Kosasa, at (808) 946-2226, for further information about the complaint process.

This notice is effective as of April 14, 2003.