NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to a report of disclosures of your information, and
6. The right to a paper copy of this invoice.

We want to assure you that if your medical/protected health information is secure with us. This notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of the contact person are listed on this page:

Effective Date of this Notice	
Contact Person	John S. Weitzner, MD
Phone Number	(312) 421-2010

Uses and Disclosures: There are a number of situations where we may use or disclose to other persons or entities your confidential medical information. Certain uses and disclosures will require you to sign an Acknowledgement that you received our Notice of Privacy Practices, including treatment, payment and health care operations. Any use or disclosure of your protected health information for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures required by law or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

Use and Disclosure without Patient Acknowledgement of this Notice

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes:

Treatment:
We will use your medical information to make decisions about the provision, coordination or management of your health care, including diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your medical information with another health care provider whom we need to consult with respect to your care. We may also disclose certain information to a pharmacist for the purpose of filling a prescription for you, to a physical therapist to provide physical therapy under appropriate circumstances, or to a facility or other providers should you require surgery or

other hospital care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your medical record to obtain reimbursement from you or your health insurance plan, or another insurer for our services rendered to you. This may also include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for purposes of reimbursement. This information may also be used for billing, claims management and collection purposes together with related health care data processing through our system.

Operations: Your medical records may be used in our business planning and development operations, including improvement in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, medical review activities, and arranging for legal and auditing functions.

Use and Disclosure Without Acknowledgement or Authorization

There are certain circumstances under which we may use or disclose your medical information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law enforcement activities, judicial and administrative proceedings and in the event of death. Specifically, we are required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases and HIV / AIDS status. We are also required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law enforcement officials information that you or another person are in immediate threat of danger to your health or safety as a result of violent activity. We must also provide medical record information when ordered by a court of law to do so.

Authorization for Use or Disclosure

Except as outlined in the above sections, your medical information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to mental health treatment, drug and alcohol abuse, HIV/AIDS, or sexually transmitted disease information which may be contained in your medical records. We likewise will not disclose your medical record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

Additional Uses and Disclosures

We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Individual Rights
You have certain rights with respect to your medical record information, as follows:

1. You may request that we restrict the uses and disclosures of your medical records information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with respect to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.
2. You have the right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you will be charged a fee for the accommodation, and will be required to specify the alternative address or method of contact and how payment will be handled.

3. You have the right to inspect copy and request amendment to your medical records. Access to your medical records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding or for which your access is otherwise is restricted by law. We will charge a reasonable fee for providing a copy of your medical records, or a summary of those records, at your request, which includes the cost of copying, postage, or preparation of an explanation or summary of the information.
4. All requests for inspection, copying and/or amending information in your medical records must be made in writing and be addressed to "Privacy Officer" at our address. We will respond to your request in a timely fashion.
5. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your medical records information except for disclosures required for treatment, payment and health care operations, disclosures that require an Authorization, disclosures incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any 12-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same 12-month period.
6. You have the right to obtain a paper copy of this notice if the notice was initially provided to you electronically, and to take one home with you if you wish.
7. All requests related to your rights herein must be made in writing and addressed to "Privacy Officer" at the address noted below.

Our Duties
We have the following duties with respect to the maintenance, use and disclosure of your medical records:

1. We are required by law to maintain the privacy of the protected health information in your medical records and to provide you with this Notice of its legal duties and privacy practices with respect to that information.
2. We are required to abide by the terms of this Notice currently in effect.
3. We reserve the right to change the terms of this Notice at anytime, making the new provisions effective for all health information and medical records we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

Complaints
You may file a written complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights with respect to confidential information in your medical records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of a complaint to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints on line at the government's website:

http://www.hhs.gov/ocr/hipaa/

Contact Person
All questions concerning this Notice or requests made pursuant to it should be addressed to:

John S. Weitzner, MD
University Obstetrics & Gynecology
1725 West Harrison, Ste 838
Chicago, IL 60612

Effective Date
This Notice is effective _____ and applies to all protected health information contained in your medical records maintained by us.

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of University Obstetrics & Gynecology's **Notice of Privacy Practices**. I understand that if I have questions or complaints regarding my privacy rights, that I may contact the person listed above. I further understand that University Obstetrics & Gynecology will offer updates to the **Notice of Privacy Practices** should it be amended, modified or changed in any way.

_____
Patient or Representative Name (Please Print)

_____ _____
Patient or Representative Signature Date

○ Patient Refused to Sign ○ Patient was unable to sign because:
_____

It is the policy of our office to call you with laboratory reports. If you have not heard from us in 21 days of having the testing completed, please call our office. Please indicate all acceptable options for notification of test results:

Phone:_____ **Cell:**_____

Fax:_____**Email Address:**_____

I can best be reached at:	
Leave Recorded Message (circle one)	Yes / No
Leave Message w/ another person (circle one)	Yes / No
- If yes, indicate name(s):	
Call me at work (circle one)	Yes / No
- If yes, indicate number:	
Contact me via fax (circle one):	Yes / No
- If yes, indicate number:	

Mail: Please send all correspondence to my home address, unless otherwise indicated here:

_____

_____

_____

Referral: Did someone refer you to our office? If so, may we send that person a "thank you" (circle one)? Yes / No

_____
Patient or Representative Name (Please Print)

_____ _____
Patient or Representative Signature Date