



NOTICE OF PRIVACY PRACTICES  
EFFECTIVE DATE OF NOTICE: August 10, 2012

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.

If you have any questions about this Notice, please contact our Privacy Officer listed below.

### 1. Introduction

Your privacy is important to us. If you have any questions about this notice, please let us know. This Notice of Privacy Practices (this "Notice") describes how we may use and disclose your protected health information ("PHI") to carry out treatment, payment, and/or health care operations and for other purposes that are permitted or required by law. It also describes your rights concerning your PHI. PHI is information about you, including information that may identify who you are or where you live, that relates to your past, present, or future physical or mental health or condition, related health care services, and payment for such services.

To promote continuity and consistency of care, we have an integrated electronic medical record. This means information created in the course of our caring for you will reside in the integrated record and may be available to others involved with your care.

### 2. Who Will Follow This Notice

This Notice describes the privacy practices of our practice, as follows:

- All departments and units;
- Any health care professional authorized to enter information into your medical or billing records at our practice;
- All employees, medical staff members, allied health professionals, and other authorized workforce who may need access to your information;
- All residents, postgraduate fellows, medical students, and students of other health care professions or educational programs at our practice.

### 3. Our Legal Duty

We are required by law to:

- Keep records of the care that we provided to you;
- Keep your PHI private;
- Notify you, under certain circumstances, of breaches affecting your PHI;
- Abide by the terms of the Notice that is currently in effect; and
- Give you this Notice of our duties and privacy practices with respect to your PHI.

We may change our Notice at any time. We reserve the right to revise or amend this Notice. Any revision or amendment to this Notice will apply to all of your records that any of our providers have created or maintained in the past and for any of your records that we may create or maintain in the future. We will visibly post a copy of our current Notice in our offices. You may request a copy of the Notice. The Notice also will be posted on our website.

### 4. We May Use and Disclose Medical Information about You

The following categories describe different ways we may use and disclose PHI. Not every use or disclosure in a category will be listed.

**a. Treatment:** We may use and disclose your PHI to provide you with medical treatment or services. For example, we may disclose your PHI to doctors, nurses, and other health care personnel or providers to coordinate the different things you need, such as prescriptions, lab work, and any medical testing or procedures.

We may not disclose to an insurer for the purposes of accident and health or sickness insurance coverage you or your family's genetic information or request for genetic services, request or require collection of or disclosure of an individual's or a family member's genetic information, or disclose an individual or family member's genetic information without the written consent of the person affected, the person's legal guardian, or a person with power of attorney for health care for the person affected.

**b. Payment:** We may use and disclose your PHI to bill and collect payment for your health care services. We may disclose your PHI to other health care providers and organizations involved in your care to assist in their billing and collection efforts. This may include, for example, disclosures to your health insurance plan about services we recommend for you so your plan can determine eligibility, coverage, or medical necessity or for utilization review activities. We also may disclose your PHI to third parties for collection of payment.

**c. Healthcare Operations:** We may use your PHI or share it with others in the course of operating our practice. For example, we may use your information to evaluate: the performance of our staff in caring for you; the quality of our services; and effectiveness of various treatments. This includes combining information we have with information from other health care providers to compare our services and outcomes so we can see where we can make improvements in our care and services. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are. We also may call you by name in the waiting areas. We also may disclose your PHI to third parties who perform various activities on our behalf, such as data analysis and risk management.

In addition, we may disclose your PHI for payment activities and certain business operations of another health care provider or health plan as long as they have or had a relationship with you; the information disclosed pertains to that relationship; and the information is used for one of the following health care operations: quality assessment and improvement; case management and care coordination.

**d. Education and Training:** We may disclose information to doctors, nurses, technicians, training doctors, medical students, postgraduate fellows and other hospital personnel for review and learning purposes. These same classes of individuals and other health care professional students may participate in examinations or procedures and in your care as part of our educational programs that we participate with.

**e. Appointment Reminders:** We may use and disclose your PHI to contact you as a reminder that you have an appointment or to provide you information regarding your medical care.

**f. Treatment Alternatives:** We may use and disclose PHI to tell you about possible treatment options or alternatives.

**g. Health Related Benefits and Services:** We may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

**h. Research:** We may use and disclose PHI about you for research purposes under certain limited circumstances. We must obtain a written authorization to use and disclose PHI about you for research purposes, except in situations where a research project meets specific, detailed criteria established by the HIPAA Privacy Rule to ensure the privacy of PHI. We may also allow a researcher and/or their designee, to review PHI on our site to prepare for a research project, or to look for persons who may be able to participate in a research project. We will not allow the PHI reviewed by the researcher for this reason to leave our facility.

**i. Reproductive Services:** Should you undergo In vitro fertilization (IVF) at our facility, data from your ART procedure will be provided to the Society for Assisted Technology (SART) and the Centers for Disease Control and Prevention (CDC). The 1992 Fertility Clinic Success Rate and Certification Act requires that CSC collect data on all assisted reproductive technology cycles performed in the United States annually and to report success rates using this data. Since sensitive information is collected about you, CSC 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 CSC

has that identifies you will not be disclosed to anyone else without your consent.

## **5. You Will Have the Opportunity to Agree or Object to These Uses and Disclosures**

Provided you do not object, we may disclose your PHI in the following situations after we discuss it with you. If, however, you are not able to object, we may disclose your PHI if it is consistent with your known prior expressed wishes and is determined to be in your best interests. As soon as you are able, we will give you the opportunity to object to any further disclosures.

•**Individuals Involved in Your Care or Payment for Your Care and Notification:** Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify information that directly relates to that person's involvement in your health care. We also may give information to someone who helps pay for your care. We may share PHI with these people to notify them about your location and general condition.

## **6. We May Make the Following Uses and Disclosures Without Your Authorization**

•**When Required By Law:** We will use and disclose your PHI when we are required to do so by federal, state, or local law.

•**To Avert a Serious Threat to Health or Safety:** We may use and disclose your PHI to prevent a serious threat to your health and safety or the health and safety of others.

•**For Organ and Tissue Donation:** We will disclose your PHI to a designated organ donor program as required or permitted by law.

•**For Specific Government Functions:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law, as well as to others so they may provide protection to the President and other authorized persons or foreign heads of state. If you are a member of the armed forces, we may release your information as required to your military command authorities.

•**For Legal Proceedings:** We may disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone involved in a dispute, but only after efforts have been made to tell you about the request or to obtain an order protecting the PHI requested.

•**For Law Enforcement:** We may use or disclose your PHI for law enforcement purposes, such as legal processes, limited information requests for identification and location purposes, information pertaining to victims of a crime, suspicion that death has occurred as a result of criminal conduct, a crime occurring on our premises, and certain medical emergencies (not on the premises).

•**For Health Oversight:** We may disclose PHI about you to a state or federal health oversight agency that is authorized by law to oversee our operations. These activities are necessary for the government to monitor our health care system, government programs, and compliance with civil rights laws.

•**To Coroners, Medical Examiners, and Funeral Directors:** We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We also may release PHI to funeral directors as necessary for them to carry out their duties.

•**For Workers' Compensation:** We may disclose your PHI as permitted by workers' compensation laws and other similar programs.

•**For Business Associates:** We may share your PHI with other parties called "business associates" who help us with providing services to you. We are required to sign contracts with these business associates that require them to protect PHI.

•**For Public Health:** We will disclose PHI to public health authorities for public health activities, investigations, or interventions as required by law. Public health activities generally include:

- Reporting births and deaths, birth defects, children at risk, and child abuse or neglect;
- Preventing or controlling disease, injury, or disability;
- Notifying people of recalls of medical products they may be using;
- Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- Reporting reactions to medications or problems with products; and
- Notifying the appropriate government authority if we believe a patient has been the victim of abuse, domestic violence, or neglect.

•**Regarding Inmates or Individuals in Custody:** If you are in legal custody, we may disclose your PHI to a correctional institution or law enforcement official. PHI may be disclosed to provide you health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

## **7. Other Uses and Disclosures of Your PHI**

Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, we will stop any use or disclosure of PHI previously permitted by your written authorization. We are unable to “take back” any disclosures we have already made with your permission. If the authorization was obtained as a condition of obtaining health insurance coverage, the insurer may contest a claim under the policy if you wish to revoke this authorization. Certain information, such as HIV/AIDS and substance abuse information, is subject to additional protections.

With the use of an EHR (Electronic Health Record), like that used in our office, the accounting of disclosures of your PHI for a period of 3 years prior includes treatment, payment, and HCO (Health Care Operations). In addition, you have the right to an accounting of disclosures from our business associates.

## **8. Your Rights Regarding Your PHI**

**a. You have the right to request restrictions on how we use and disclose your PHI for treatment, payment, or health care operations.** We, however, are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, your request must be in writing to our Privacy Officer and must describe:

- The information you wish restricted;
- Whether you are requesting to limit our use, disclosures, or both; and
- To whom you want the limitation to apply.

We must comply with the requested restriction under certain circumstances (for payment or health care operations) when the provider has been paid out of pocket in full.

**b. You have the right to request confidential communications from us** by alternative means or at an alternative location. We will accommodate reasonable requests. We may ask you for information as to how payment will be handled or to specify an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please notify our Privacy Officer.

**c. You have the right to inspect and obtain a paper or electronic copy of your PHI** that our facilities use to make decisions about you for as long as we maintain the PHI. There are a few exceptions. If we deny your request to inspect your PHI, we will give you reasons in writing for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed. You may direct that the copy be transmitted directly to an entity or person designated by you, provided that any such designation is clear, conspicuous, and specific with complete name and mailing address or other identifying information. Please contact our Privacy Officer if you have questions about access to your health information.

**d. You have the right to request an amendment** if you feel the PHI we have about you is incorrect or incomplete. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with us. We may prepare a rebuttal and will provide you with a copy of such rebuttal. Please contact our Privacy Officer if you have questions about the process.

**e. You have the right to find out what disclosures we have made about you** to whom, and why. This applies to disclosures made for reasons other than treatment, payment, or our health care operations. It also excludes disclosures we made to you or as authorized by you, for a facility directory, to family members or friends involved in your care, for notification purposes, or as required by law. The right to receive this information is subject to certain exceptions, restrictions, and

limitations. Please contact our Privacy Officer for further information.

**f. You have the right to a paper copy of this Notice.** You are entitled to receive a paper copy of our Notice even if you have agreed to accept this Notice electronically. You may ask us to give you a copy of this Notice at any time. To obtain a paper copy of this Notice, contact our Privacy Officer.

**g. You have the right to file a complaint.** If you believe your privacy rights regarding your PHI may have been violated, you may file a complaint with any of our facilities or the Secretary of the Department of Health and Human Services. We will not retaliate or take action against you for filing a complaint.

For additional information or to submit a complaint, please contact our Privacy Officer:

Privacy Officer  
1401 South Beretania Street, Suite 250  
Honolulu, HI 96814  
808-545-2800

**h. Acknowledgement of receipt of this notice.** We will request that you sign a separate form acknowledging that you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign a form stating that the good faith effort to obtain a written acknowledgement was conducted, but that it was not obtained, and will include the reason why. This acknowledgement of receipt of this notice or the statement indicating that the written acknowledgement was not obtained and the reason why, will be filed with your records.

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

I have been presented with a copy of Advanced Reproductive Medicine & Gynecology of Hawaii, Inc. and Fertility Institute of Hawaii'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 the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

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Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Name: \_\_\_\_\_

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Signature of patient, parent, or representative Relationship

\_\_\_\_\_  
Date

**Internal Use Only:**

If a patient or the patient's representative refuses to sign the Acknowledgement of Receipt of Notice, please document the date and time the notice was resented to the patient and sign below.

Presented on (Date and Time):  
\_\_\_\_\_

By: (Name and Title):  
\_\_\_\_\_