NHFC
4 Columbus Circle, 4th Fl.
New York, NY 10019
T: 212.517.7676
F: 212.489.6294

PLEASE EMAIL THIS FORM TO FRONTDESK@NHFC.COM

HIPAA Notice of Privacy Practices

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

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

Uses and Disclosures of Protected Health Information

Your protected health information 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 purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. As another example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Use required by law: We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when, required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.

Under Section 164.508 (c)(1), (2) and (4), a covered entity may use to disclose protected health information for treatment, payment, or heath care operations, may disclose protected health information for treatment activities of a health care provider, and may disclose protected health information to another covered entity for health care operations activities of the entity that receives the information, if each entity has or had a relationship with the individual who is the subject of the protected health information is being requested.

Under Section 164.502 (a)(1)(ii), a covered entity is permitted to use or disclose health information for treatment, payment, or health care operations, without patient consent. Treatment includes consultation between health care providers regarding a patient and referral of a patient by one provider or another. Covered entities include health care providers (such as affiliate doctors, affiliate clinics, and affiliate hospitals) and health insurance companies.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: (The following is a statement of your rights with respect to your protected health information.)

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You have the right to inspect and copy your protected health information. 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 protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your case or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to see another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You may have the right to have your physician amend your protected health information. 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 the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

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

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature Below is only an acknowledgment that you have received this Notice of our Privacy Practices:

Print Name of Female Patient or Legal Representative* 患者全名拼寫或法人代表	Signature of Female Patient or Legal Representative* 患者簽字或法人代表	Date 日期
Print Name of Partner** or Legal Representative* 配偶或伴侶全名拼寫	Signature of Partner** or Legal Representative* 配偶或伴侶簽字	Date 日期

* For patients who may not be capable of providing informed consent, the signature of a legal representative is required. For a valid HIPAA authorization, the "legal representative" must have authority under state law to make health care decisions for the patient.

** Not required for single female patient using donor's sperm.

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HIPAA Consent Form

This consent form allows New Hope Fertility Center to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclose to carry out treatment, payment or health care operations.

New Hope Fertility Center has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures, including releasing protected health information to covered entities. No consent is necessary for our office to transfer your medical records to any health care provider referred by you. Covered entities include health care providers (such as affiliate doctors, affiliate clinics, and affiliate hospitals) and health insurance companies.

It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices upon my visit to the office.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations. I understand that while New Hope Fertility Center is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

I understand that New Hope Fertility Center may refuse services if I refuse to sign this consent.

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that the office may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information.

I understand that New Hope Fertility Center may refuse services if I revoke this consent.

Print Name of Female Patient or Legal Representative* 患者全名拼寫或法人代表	Signature of Female Patient or Legal Representative* 患者簽字或法人代表	Date 日期

Print Name of Partner** or Legal Representative* 配偶或伴侶全名拼寫	Signature of Partner** or Legal Representative* 配偶或伴侶簽字	Date 日期

* For patients who may not be capable of providing informed consent, the signature of a legal representative is required.
For a valid HIPAA authorization, the "legal representative" must have authority under state law to make health care decisions for the patient.

** Not required for single female patient using donor's sperm.