Cincinnati Hematology-Oncology, Inc.
Notice of Privacy Practices-Overview

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.

EFFECTIVE: April 14, 2003

The following is a summary of Cincinnati Hematology-Oncology, Inc.'s (CHO) Notice of Privacy Practices:

Uses and Disclosures

- CHO will use and disclose your Protected Health Information only for the purposes of treatment, payment, and healthcare operations or as required by law. None of these uses and disclosures require your written authorization.
- Other uses and disclosures of your Protected Health Information will be made only with your written authorization and you may revoke such authorization at any time in writing.

Appointments and Services

- CHO may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- CHO may also contact you regarding your treatment and payment.

Your Rights

- You have the right to request restrictions on certain uses and disclosures of your Protected Health Information.
- You have the right to receive confidential communications.
- You have the right to inspect and obtain a copy of your Protected Health Information.
- You have the right to amend your Protected Health Information.
- You have the right to an accounting of disclosures of your Protected Health Information.
- You have the right to obtain a printed copy of the Notice of Privacy Practices.

Medical Practice's Duties

- CHO is required by law to maintain the privacy of confidential information and provide individuals with notice of its legal duties and privacy practices with respect to such information.
- The practice is required to abide by the terms of the Notice currently in effect.
- The practice reserves the right to change the terms of its Notice and to make the new Notice provisions effective as of that date detailed in the then current policy for all confidential information that it maintains.

Complaints

You may complain to the practice and to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Contact: Privacy Officer, Corporate Office, 2727 Madison Rd., Suite 400, Cincinnati, Ohio, 45209. Phone: (513) 321-4333.

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EFFECTIVE: April 14, 2003

Uses and Disclosures

1. Except as otherwise provided, or with your signed consent, this office will use and disclose your Protected Health Information for the purposes of treatment, payment, and health care operations. This may include disclosures to another health care provider who, at the request of your physician, becomes involved in your treatment, such as a lab technician, pharmacist or another physician. We may also disclose your Protected Health Information to your health plan in order to receive payment. When necessary, this practice may use or disclose your Protected Health Information to Business Associates that assist us with our health care operations, such as auditing, accreditation, and legal services. These Business Associates are required to properly safeguard the privacy of your Protected Health Information.

2. The following are other purposes for which the practice is permitted or required to use or disclose confidential information without your written authorization:
    - (a) Uses and disclosures for public health activities;
    - (b) Reporting victims of abuse, neglect, or domestic violence;
    - (c) Disclosures for health oversight activities;
    - (d) Disclosures for judicial and administrative proceedings;
    - (e) Disclosures for law enforcement purposes;
    - (f) Uses and disclosures about decedents;
    - (g) Uses and disclosures for cadaveric organ, eye, or tissue donation purposes;
    - (h) Uses and disclosures for research purposes under limited circumstances;
    - (i) Disclosures to avert a serious threat to health or safety; and
    - (j) Uses and disclosures for specialized government functions.

3. Other uses and disclosures of your Protected Health Information will be made only with your written authorization and you may revoke such authorization at any time in writing.

Appointments and Services

1. This practice may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Unless you request restrictions on these notifications we will do so without your written authorization.
2. CHO may also contact you regarding your treatment and payment. Unless you request restrictions on these notifications we will do so without your written authorization.

Your Rights

1. ***The right to request restrictions on certain uses and disclosures***. You have the right to request restrictions on some of our uses and disclosures of your Protected Health Information. These restrictions must be made in writing and signed by you or your Personal Representative with an

appropriate legal Power of Attorney on file. This office is not required to agree to your restrictions. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the Privacy Officer*,* Corporate Office, 2727 Madison Rd., Suite 400, Cincinnati, Ohio, 45209. (513) 321-4333. You may obtain a Request for Restrictions on Uses and Disclosures of Protected Health Information Form from the Privacy Officer. This will be maintained in the patient file and in the HIPAA Compliance Manual in the Privacy Officer's office.

2. ***The right to receive confidential communications.*** You have the right to request, and we will accommodate your reasonable requests, to receive communications regarding your health information from us by alternative means or at alternative locations. For example, if you wish to receive communication at your work place instead of your home, we will contact you at work or if you only wish to receive written communication instead of telephone communication, we will not call you. You may obtain a Request for Confidential Communication Form from the Privacy Officer*,* Corporate Office, 2727 Madison Rd., Suite 400, Cincinnati, Ohio, 45209. (513) 321-4333. This will be maintained in the patient file and in the HIPAA Compliance Manual in the Privacy Officer's office.

3. ***The right to inspect and obtain a copy of your Protected Health Information.*** You have the right to inspect and obtain a copy of your Protected Health Information maintained by this office. All requests for access must be made in writing and signed by you or your Personal Representative with an appropriate legal Power of Attorney on file. An upfront fee of $1.00/page for the first 10 pages, $.50/page for pages 11-50, and $.20/page for pages 51 and higher must be received via credit card payment before we will provide you access to the copies. There will also be a charge for postage at the foregoing rates if you request a mailed copy. The fee for a summary of the requested information is $200/hour. You may request an estimate of the summary charge. We will inform you of the actual fee for the summary and you must agree to and pay the fee via credit card payment before we will start the summary process. You may obtain a Request to Inspect and Copy Protected Health Information Form from the Privacy Officer, Corporate Office, 2727 Madison Rd., Suite 400, Cincinnati, Ohio, 45209. (513) 321-4333. In certain circumstances you may not be permitted access to your Protected Health Information (e.g., psychotherapy notes, information compiled for legal action, or information subject to prohibition by law). Depending on the circumstances, you may request a review of the decision to deny access. For questions about access to health information, please contact the Privacy Officer, Corporate Office, 2727 Madison Rd., Suite 400, Cincinnati, Ohio, 45209. (513) 321-4333.

4. ***The right to amend Protected Health Information.*** You have the right to request your Protected Health Information maintained by this office be amended or corrected. You may obtain a Request to Amend Protected Health Information Form from the Privacy Officer, Corporate Office, 2727 Madison Rd., Suite 400, Cincinnati, Ohio, 45209. (513) 321-4333. All amendment requests must be in writing, signed by you or your Personal Representative with an appropriate legal Power of Attorney on file, and must state the reasons for the amendment. If we make your amendment, we may also notify others who work with us and have copies of the un-amended record if we believe that such notification is necessary. We will send those individuals a copy of your written Request to Amend Protected Health Information Form and the actual amendment. In certain cases, we may deny your request for amendment. If we deny your request, you may submit a statement of disagreement to us and we may prepare a rebuttal that if prepared will be provided to you. These materials may be disclosed with your Protected Health Information in the

future. For questions about amendments to your health information, please contact the Privacy Officer, Corporate Office, 2727 Madison Rd., Suite 400, Cincinnati, Ohio, 45209. (513) 321-4333.

5. ***The right to receive an accounting of disclosures of Protected Health Information.*** You have the right to receive an accounting of certain disclosures of your Protected Health Information made by us after April 14, 2003. You have the right to request an Accounting of Disclosures of your Protected Health Information for up to six years, however you may not request an Accounting of Disclosures occurring before April 14, 2003. Requests must be made in writing and signed by you or your Personal Representative with an appropriate legal Power of Attorney on file. The first accounting in any 12-month period is free. For each subsequent accounting you request within the same 12-month period you will be charged a fee as followed: $1.00/page for the first 10 pages, $.50/page for pages 11-50, $.20/page for pages 51 and higher to be paid via credit card payment prior to receipt of copies. The right to receive this information is subject to certain exceptions, restrictions, and limitations. You may obtain a Request for an Accounting of Disclosure Form from the Privacy Officer, Corporate Office, 2727 Madison Rd., Suite 400, Cincinnati, Ohio, 45209. (513) 321-4333.

6. ***The right to obtain a printed copy of the Notice of Privacy Practices.*** You have the right to obtain a printed copy of the Notice of Privacy Practices at any time upon request. To request a printed copy of the Notice, please contact the Privacy Officer, Corporate Office, 2727 Madison Rd., Suite 400, Cincinnati, Ohio, 45209. (513) 321-4333.

Medical Practice's Duties

1. Cincinnati Hematology-Oncology, Inc. is required by law to maintain the privacy of confidential information and provide patients with notice of its legal duties and privacy practices with respect to such information.
2. The practice is required to abide by the terms of the Notice currently in effect; and
3. The practice reserves the right to change the terms of its Notice at any time, effective upon such change and to make the new Notice provisions effective for all confidential information that it maintains. Upon revision, the Notice will be posted in the waiting room, on the web site and will be available upon request.

Complaints

You may complain to Cincinnati Hematology-Oncology, Inc. and to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. A complaint must be in writing, either on paper or electronically, and must name the practice that is the subject of the complaint and describe the acts or omissions believed to be in violation of your rights. A complaint must be filed within 180 days of when you knew or should have known that the act or omission complained of occurred, unless this time limit is waived by the Secretary for good cause shown. You will not be retaliated against for filing a complaint. You may retain a Privacy Violation Complaint Form from the Privacy Officer. You may also choose to submit an anonymous complaint in our comment box located in the waiting room.

Contact: Privacy Officer, Corporate Office, 2727 Madison Rd., Suite 400, Cincinnati, Ohio, 45209. Phone: (513) 321-4333.

Acknowledgement of Notice of Privacy Practices

This Practice will make a good faith effort to obtain individuals' written acknowledgement that they received the Notice of Privacy Practices. Please sign below to acknowledge receipt of this Notice. You will receive a copy of this acknowledgement for your records.

I acknowledge receipt of Cincinnati Hematology-Oncology, Inc.'s Notice of Privacy Practices.

Name:____

Telephone Number:____

Address:____

Date of Birth #:________________________ **Social Security #:**___________________

We may only disclose your Protected Health Information to a person(s) you designate to be directly involved in your health care. Please indicate the full names of the person(s) whom we may disclose your Protected Health Information regarding your current care.

Patient Only:______**Spouse:**_____________________ **Other(s):**_________________________

Full Name   Full Name(s)

No restrictions:_______   _________________________

Full Name(s)

Signature____ **Date:**_________________

If this acknowledgement is authorized for the individual patient by a Personal Representative (with an appropriate legal Power of Attorney on file) complete the following:

Personal Representative's Name:____

Personal Representative's Signature:____

Relationship to the Patient:______________________________ **Date:**_________________

YOU HAVE A RIGHT TO A COPY OF THIS ACKNOWLEDGEMENT

For Office Use Only: Patient Refuses to Sign Acknowledgement

I certify that the above patient received Cincinnati Hematology-Oncology, Inc.'s Notice of Privacy Practices and refused to sign this acknowledgement form.

Comments:____

____

Employee Signature:_________________________________Date:____________________

Witness Signature:__________________________________Date:____________________

**This acknowledgement must be kept in the patient's chart.