

This notice applies to all records generated by your physician, office medical or billing personnel, or Business Associates.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your health information and provide a description of our privacy practices. We will abide by the terms of this notice and notify you if we cannot agree to a requested restriction.

USE AND RELEASE OF MEDICAL INFORMATION

We may use and release your medical information (clinical and billing) for:

- Payment, Treatment, Healthcare Operations
- Business Associates
- Appointment Reminders
- Treatment Alternative Education
- Health-related Benefits or Services
- As required by law to State/Federal Agencies
- Family or friends involved in your care
- Entities assisting in Disaster Relief

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the healthcare provider, you have the *Right to:*

- Access Information
- Request Amendments
- An Accounting of Disclosures
- Request Privacy Restrictions
- Request Alternate Communication
- File Complaints
- Obtain a Detailed Copy of this Notice

Please refer all requests to our Privacy Official.



Access:

You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but there are limited circumstances in which we can deny your request. These denials must be provided to you in writing, and you may request a second review in writing.

Amend:

If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend, or add to the information. You have the right to request an amendment for as long as the information is kept by or for the physician.

We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial in writing.

AN ACCOUNTING OF DISCLOSURES:

You have the right to request an accounting of disclosures of medical information about you. This does not include disclosures for treatment, payment, operations, or to you or your authorized representative.

Request Restrictions:

You have the right to request a restriction or limitation on the medical information we use or release about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we release about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request, but will do so if the request is reasonable.

Request Confidential Communications:

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. We reserve the right to contact you by other means and at other locations if you fail to respond to communications from us.



▶ A PAPER COPY OF THIS NOTICE:

You have the right to a detailed paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

▶ COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us by contacting the Privacy Official or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

▶ OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or release medical information about you, you may withdraw that permission, in writing, at any time.

▶ CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the practice and include the effective date. We can provide additional copies of the notice when you check in for future appointments, at your request.

If you have any questions about this notice, would like to request a form or have any complaints, please contact:

Privacy Official:

Nancy Rohr

Phone Number:

303.584.8221

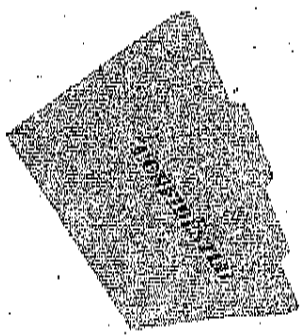


Prepared by HCA Management Services, LP

Minimally Invasive Gynecology
Center of Denver

**NOTICE OF
PRIVACY PRACTICES**

Effective Date: April 14, 2003



This notice describes how medical information about you may be used and released and how you can get access to this information.

PLEASE REVIEW IT CAREFULLY

HeathONE Clinic Services

Practice Name
Mountain Vista Women's Care

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Mountain Vista Women's Care may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Mountain Vista Women's Care will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Mountain Vista Women's Care

I acknowledge that I have been given the Notice of Privacy Practices by Mountain Vista Women's Care

I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient (or Responsible Party) Signature

Date

Original - Practice

HIM.PRI.001, HIM.PRI.007

Revision Date: May 22, 2003