Notice of Privacy Practices

The Life Extension Center, LLC

Effective Date: August 1, 2008

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians, or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign in sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to

agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

8. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and Georgia law.

11. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

19. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

20. Fundraising. We may use or disclose your demographic information and the dates that you received treatment in order to contact you for fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by Georgia law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and will offer you a copy at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: **Department of Health and Human Services, Office of Civil Rights**

You will not be penalized for filing a complaint.

Complaints submitted to the DHHS Office for Civil Rights should be directed to:

Office for Civil Rights/U.S. Department of Health & Human Services
61 Forsyth Street, SW. - Suite 3B70/Atlanta, GA 30323
(404) 562-7886; (404) 331-2867 (TDD)
(404) 562-7881 FAX

The Physicians and Staff of the Life Extension Center Want You to Know How We Will Protect Your Private Health Information.

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. The Health Insurance Portability and Accountability Act ("HIPAA") covers physicians and all other health care providers, health insurance companies and their claims processing staffs.

The HIPAA rules require that our practice provide all of our patients with the attached Notice of Privacy Practices on their first visit to us. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of our Notice to review. You are entitled to a personal copy of the Notice at any time to review and keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer.

Thank you for your cooperation.

I acknowledge that I have received a copy of the practice's Notice of Privacy Practices and have been given an opportunity to ask questions.

Patient Name:_____
(Please Print)

Signature of Patient or Personal Representative:

_____ **Date:** _____

If Personal Representative, give relationship to patient:

_____

The Life Extension Center, LLC

Notice of Privacy Practices Acknowledgments Tracking Information

Name of Patient: _____

Address: _____

_____

For Office Use Only:

Date received:	Processed by:
Practice Follow-up: ☐ Yes ☐ No	Date of Practice Follow-up:

Complete the following only if the Patient refuses to sign the Acknowledgment:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____

The Life Extension Center, LLC

Special Note on Authorizations Related to Marketing

HIPAA established special requirements for marketing activities. The patient's authorization must be obtained for all marketing activities except:

1. face-to-face communication by the physician or other employee of the physician practice; or
2. promotional gifts of nominal value provided to the patient by the physician practice.

In addition, the authorization must indicate whether the physician practice receives direct or indirect remuneration from a third party in connection with the marketing activities.

Thus, to the extent the authorization concerns marketing activities, the following should be added to the form:

> **Marketing**
> This authorization authorizes marketing activities for which this medical practice ☐ will ☐ will not receive direct or indirect compensation.

"Marketing" is defined by HIPAA to include all communications that encourage the purchase or use of a product or service except communications for:

1. treatment;
2. case management or care coordination of the individual, or direct or to recommended alternative treatments, therapies, health care providers or settings of care; or
3. certain other health plan communications concerning benefits.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME_____
LAST **FIRST** **MI**

DATE OF BIRTH: ____/____/____ **SS#:** ____-____-____ **MEDICAL RECORD #**_____

_____
ADDRESS **CITY** **STATE** **ZIP**

DAY PHONE:_____

EVENING PHONE:_____

☐ I authorize The Life Extension Center, LLC to use or disclose my protected health information as indicated below to:

_____
Name of entity to receive this information

_____
ADDRESS **CITY** **STATE** **ZIP**

_____
PHONE NUMBER **FAX NUMBER**

☐ I authorize_____
Name of entity to release this information

To release my protected health information to The Life Extension Center, LLC as indicated below.

INFORMATION TO BE RELEASED:

- ☐ From & To Dates _____
- ☐ History and physical exam
- ☐ Office notes
- ☐ X-ray reports
- ☐ Lab reports
- ☐ Hospital records (Op note, Discharge summary)
- ☐ Medication records
- ☐ Other: _____

PURPOSE OF DISCLOSURE:

- ☐ Changing physicians
- ☐ Continuing care
- ☐ At patient request
- ☐ Second opinion
- ☐ Legal
- ☐ Insurance/Workers' Compensation
- ☐ School
- ☐ Other: _____

I understand that this authorization will expire:_____
Expiration Date or Defined Event

I understand that I may revoke this authorization at any time by notifying The Life Extension Center, LLC in writing. This authorization will cease to be effective on the date notified except to the extent that the practice has acted in trust upon this authorization.

_____ _____
Signature of Patient or Legal Guardian **Date**

Effective Date:

The Life Extension Center, LLC
Authorization Tracking Information

Name of Patient: _____
Address: _____

_____

For Office Use Only:

Date received:	Processed by:
Review Date:	Response Date:
Patient Follow-up: ☐ Yes ☐ No	Date of Patient Follow-up:
Practice Follow-up: ☐ Yes ☐ No	Date of Practice Follow-up:

Reviewer's Comments:

_____

_____

_____

_____

Action Taken:

_____

_____

_____

_____

CONSENT FOR DISCLOSURE TO FAMILY MEMBER
AND/OR PERSONAL REPRESENTATIVE

PATIENT NAME/ID #_____

ADDRESS_____ **ADDRESS**_____
ADDRESS _____ **ADDRESS**_____
CITY, STATE ZIP_____ **CITY/STATE/ZIP**_____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for The Life Extension Center, LLC and Doctor _____ and his/her staff to disclose my personal medical information to the following individual(s):

Name: _____ Relationship to Patient :_____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient : _____

Conditions for Disclosure (Check the item(s) that apply):

☐ The practice may disclose my personal health information to the individual(s) above **only** in my presence.
☐ The practice may disclose my medical information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile or e-mail or regular mail.
☐ Other Conditions of Disclosure: _____
_____

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: _____
Date of Signature: _____

Witnessed by: _____ Title/Position:_____
Print Name of Witness:_____ Date: _____

The Life Extension Center, LLC
REQUEST FOR ACCESS TO MEDICAL INFORMATION

Our practice is using this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Notice of Privacy Practices provided to our patients includes information about how we collect and use the protected health information of our patients. Our Notice also contains a section on Patient Rights that describes our patient's rights under the current privacy law. These laws confirm that patients have the right to access, inspect, and copy the protected health care information used to make decisions about them.

The Practice is required by law to keep the original patient record. This form is to request access to your records, however, please keep in mind that any questions you may have about medical records created by another practice or health care provider must be directed to that provider. In providing access to these records:

1. We will only include information used to make decisions about the patient;
2. We may limit access to information generated only by this The Life Extension Center;
3. Under some circumstances, such as increased risk of harm or injury, the practice may withhold the requested information;
4. We may also provide a summary of the requested information, if you are agreeable. This may be preferred when there is a large volume of chart pages or to provide a layman's description of complex medical data.

Our Privacy Officer will evaluate your request and notify you of our decision within fifteen (15) days of this request. If the request is approved, we will provide the information within thirty (30) days. In some circumstances, an extension of an additional thirty (30) days may be necessary, for example, if patient is not an active patient or if the chart is many years old.

If you wish to have a personal copy, reasonable costs will be charged for the request to cover our administrative costs, as well as the cost of postage or other delivery, when applicable. We will provide you with an estimated cost for this Request upon approval of the Request and give you the option of withdrawing or amending this request.

Patient Name:_____ Date of Birth:_____
(Please Print)

Health Care Information requested. Please provide dates, diagnosis, treatment, or any other indications of the specific information you desire:_____

_____

_____

_____

Is a summary of the information acceptable? Yes_____ No _____

Do you wish to:

- ☐ Arrange an appointment to inspect the requested information?
- ☐ Receive a copy of the information?

If you would like a personal copy, what are your instructions regarding delivery?

- ☐ I will pick the up the copies
- ☐ Please mail the copies to me at the following address:_____

_____

This Request was signed by: _____
Printed Name – Patient or Representative

Signature:_____ Date:_____

Relationship to Patient (if other than patient):_____

The Life Extension Center, LLC
Request for Amendment of or Addition to Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that health information that pertains to you be amended if you believe that it is incorrect or incomplete. We will review your request and either grant your request or explain the reason why it will not be granted. In the event that your request is not granted, you have the right to submit a statement of disagreement that will accompany the information in question for all future disclosures. Alternatively, you may request that we append to your medical record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

I, _____ (*print name*) believe that the following health information pertaining to me is incorrect or incomplete (please copy below or attach the challenged entry and identify its location in the medical record):

_____

_____

_____

_____

I believe that the information described above is incomplete or incorrect for the following reasons:

_____

_____

_____

_____

Please choose <u>one</u> of the following:

ADDENDUM REQUEST:

☐ I, _____ (*print name*) hereby request that the attached statement of no more than 250 words be made a part of any medical record (*attach statement*). I understand that you will attach this to my record and include it with each future disclosure of the contested portion of my medical record.

AMENDMENT REQUEST:

☐ I, _____ (*print name*) hereby request that you amend the health information identified above as follows:

_____

_____

Additionally, I request that the following people be notified of the correction:

Name	Address
_____	_____
_____	_____
_____	_____
_____	_____

We must tell you within sixty (60) days if we will make the change you requested, or that we need more time (up to 30 more days) to decide. We do not have to make your requested changes if (1) they do not involve your medical records, billing records or other records that we use to make decisions about you; or (2) they involve records you have no right to access; or (3) we did not create the information (unless the person or entity that created the information is unable to act on your request; or (4) the information is already accurate and complete.

If we agree to change your information, we will send the change as you have requested, above. We will also send the change to any other persons that we know received the information before it was amended, unless you instruct us not to.

Optional: Do not send the change to anyone other than those I have specified. _____
Initial

Signed:_____ Date: _____

Print Name:_____Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____