NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. YOUR HEALTH INFORMATION PRIVACY IS IMPORTANT TO US.

We are required by the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") to maintain the privacy of your health information, as well as give you this notice regarding our privacty practices, legal duties, and your rights concerning your health information. This Notice takes effect August 1st, 2008, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information, or for additional copies of this Notice, please contact us using the information listed.

Use and Disclosures of Health Information

Your health information may be used or disclosed by Elliot M. Hirsch, MD, Inc. including physicians and office staff that are involved in your care and treatment, including electronic disclosures. It is the responsibility of Elliot M. Hirsch, MD, Inc. to ensure that all uses or disclosures are made in accordance with HIPAA and as further detailed below.

Required Disclosures: Elliot M. Hirsch, MD, Inc. is required to disclose protected health information to you directly when requested in accordance with your rights described below or the Department of Health and Human Services when investigating or determining compliance with HIPAA.

The Physicians and Staff of Elliot M. Hirsch, MD, Inc. may disclose and use your protected health information for treatment, payment, and healthcare operations as described below.

Treatment: We will use and disclose your 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, consultation between physicians relating to your care, or your referral for health care to another physician.

Payment: We will use and disclose your protected health information as needed to obtain payment for services we provide to you. This may include obtaining reimbursement information for the health care services you are receiving, confirming coverage or co-pay amounts under your health plan, billing and collecting from you, an insurance company, or a third party for your health care services, or obtaining precertification or preauthorization for specific health care services.

Health Care Operations: We may use and disclose your health information to support the business operations of the practice. Healthcare operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities, cost-management analysis. We may also call you by name in the waiting room when your physician is ready to see you.
Email communication: Most standard email providers such as Gmail, Hotmail, etc. do not provide a secured or encrypted means of communication. As a result, there is risk that any protected health information contained in an email may be disclosed to, or intercepted by, unauthorized third parties. Additionally, email messages accessible through personal computers, laptops, or phones have inherent privacy risks especially when the email account is provided by an employer, when the account is not password protected, or the account is shared. Use of more secure communications, such as phone, fax or mail is preferred and always an available alternative. When you include protected health information in unsecured email communications, you are accepting responsibility for any unauthorized access or disclosure to protected health information contained within the message. We are not responsible for unauthorized access of protected health information while in transmission and will not be responsible for safeguarding

information once it is delivered. We will use the minimum necessary amount of protected health information when communicating with you.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your explicit written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such
as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you 30¢ for each page, $14.50 per hour for staff time to locate and copy your health

information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before August 1, 2014. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. You may also file a complaint with or contact the Department of Health and Human Services, Office for Civil Rights at: Office of Civil Rights, DHHS, Region IX by mail at 90 7th Street, Suite 4-100, San Francisco, California 94103, by telephone at (415) 437-8310 or (415) 437-8311 (TDD), or by facsimile at (415) 437-8329. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Elliot M. Hirsch, M.D.
Telephone: 818-825-8131 Fax: 818-616-1044
E-mail: drelliothirsch@gmail.com
Address: 13351 Riverside Dr., #573, Sherman Oaks, CA 91423

This Form is for patient educational purposes only, in accordance with federal regulations put forth in the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Please retain for your records

NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGEMENT

I acknowledge and agree that I have been provided a copy of the Notice of Privacy Practices for Elliot Hirsch, M.D., Inc. that describes how my protected health information must be protected, as well as my rights to access and control such information. I acknowledge and agree that I have reviewed the Notice of Privacy Practices in its entirety and been given the opportunity to ask any questions regarding the use or disclosure of my protected health information and my associated rights. I acknowledge and agree that I have had all my questions answered to my satisfaction.

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE)________________________ **DATE** ________________

PRINTED NAME ____

PERSONAL REPRESENTATIVE'S AUTHORITY (IF APPLICABLE)____

DISCLOSURE AUTHORIZATION FORM: FAMILY & FRIENDS

As described in the Notice of Privacy Practices, any disclosure of your protected health information can only be made with your written authorization. It is our practice not to disclose any information to a person, regardless of their relationship with you, unless you have specifically authorized them to receive such information.

AUTHORIZATION

I authorize the physicians and staff of Elliot M. Hirsch, MD, Inc. to disclose my protected health information to those individuals listed below:

Name: Relationship

____
____
____

The information that can be disclosed to the above named individuals includes: (check one)

[ ] All PHI

[ ] Only information relating to (*specify such as appointments, payment, etc.*):________________________

[ ] Only information pertaining to the time period from:_________________ to_____________________

[ ] Other (*specify*):

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) ____________________**DATE** _________________

PRINTED NAME ____

PERSONAL REPRESENTATIVE'S AUTHORITY (*IF APPLICABLE*) _____________________________________

This authorization will be in full force and effect for two years from the date of signature unless indicated.