

NOTICE OF PRIVACY PRACTICES

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. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT OUR PRIVACY OFFICE AT THE PHONE NUMBER AT THE BOTTOM OF THIS NOTICE. THIS NOTICE IS EFFECTIVE AS OF APRIL 1ST 2007.

Who will follow this notice?

CCB-MCB LLC. (hereinafter "Manhattan Cryobank"), provides health care to our patients in partnership with other professionals and health care organizations. The information privacy practices in this notice will be followed by all employees, medical staff or other professionals at our location.

Our pledge to you:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by our facility and providers described above. We are required by law to:

- Keep medical information about you private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

What is "PROTECTED HEALTH INFORMATION" (PHI)?

Protected health information ("PHI") is demographic and individually identifiable health information that will or may identify the patient and relates to the patient's past, present or future physical or mental health or condition and related health care services.

Uses and Disclosure of Protected Health Information

Manhattan Cryobank uses and discloses your protected health information for treatment, payment and health care operations. The following are examples of when our office may use or disclose your PHI without your consent or authorization:

- **Treatment:** Manhattan Cryobank may disclose your PHI to physicians, nurses, and other health care personnel/professionals who provide you with health care services or are involved in your care. For example, we can provide your physician with your laboratory test results.
- **Payment:** Manhattan Cryobank may use and disclose your PHI in order to bill and collect payment for the services you may receive from us. For example, we may disclose your diagnosis or other information about your health to your insurance provider to obtain payment for the services we provide. We may use the emergency contact information you provided to contact you if the address of record is no longer accurate.
- **Health Care Operations:** Manhattan Cryobank may use and disclose your PHI to operate our business. For example, your PHI may be reviewed as part of our quality improvement program. We may also contact you regarding appointments or other health related services.

Other Uses and Disclosure of PHI:

Manhattan Cryobank may also use or disclose your PHI without your consent or authorization, in compliance with guidelines outlined by law, for the following purposes:

- **Disclosure required by law, judicial/administrative proceeding, or legal enforcement:** Manhattan Cryobank will disclose PHI when a law requires that we report information to government agencies, or law enforcement personnel in response to a medical emergency.
- **Public Health:** Manhattan Cryobank must report certain PHI about various diseases, such as infectious disease reports.
- **Health Oversight:** Manhattan Cryobank is required to provide PHI to assist the government when it conducts an audit, investigation, or inspection of a health care provider or organization.
- **Government Functions:** In certain situations, Manhattan Cryobank may disclose PHI of military personnel and veterans. Additionally, we may disclose PHI for national security purposes, such as conduction national intelligence operations.

Other Uses and Disclosure of PHI:

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Right to Access and or Amend Your Records:

- Unless prohibited by State or Federal Law, you have the right to inspect or obtain a copy of your medical information, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.
- If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. You may submit a written statement of disagreement with a decision by us not to amend a record.

Right to Accounting of Disclosure:

You have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain disclosures we have made of your PHI. You must submit your request in writing to Manhattan Cryobank.

Right to Request Restrictions:

You may request, in writing, that we restrict certain uses or disclosure of your PHI. We will consider your request and work to accommodate it when possible, but we are not legally required to accept it. We will inform you of our decision on your request.



369 LEXINGTON AVENUE, #401, NEW YORK, NY 10017
TEL: 212.396.2796 ♦ FAX: 212.396.2797
EMAIL: INFO@MANHATTANCRYOBANK.COM
WEBSITE: WWW.MANHATTANCRYOBANK.COM

Requests for Confidential Communications:

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

Communications Via E-Mail:

In order to communicate information needed to treat you, obtain payment for services, or conduct our business operations, our staff may communicate information about you via email.

Right to request a paper copy of this Notice:

You may receive a paper copy of this Notice from us upon request, even if you have agreed to receive this notice electronically.

Changes to this Notice:

We reserve the right to revise or amend this notice. Any revision or amendment to this notice will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in our waiting area. You can receive a copy of the current notice at any time. The effective date is listed at the top of this form. Copies of the current notice will be available each time you come to our facility for treatment. You will be asked to acknowledge in writing your receipt of this notice.

Complaints:

- If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Office. You may file a complaint by contacting Dieter Walter, privacy officer with Manhattan Cryobank at 212.396.2796.
- If you are not satisfied with our response, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Privacy Office Contact Information

Company: Manhattan Cryobank
 Privacy Officer: Dieter Walter
 Address: 369 Lexington Avenue, #401, New York, NY 10017
 Telephone: 212.396.2796
 Fax: 212.396.2797 / 646.219.6569
 Web site: www.manhattancryobank.com
 Email: info@manhattancryobank.com

I hereby attest that I have read and understand the above information provided to me.

Signature – Patient

Date

Printed Name – Patient

<u>For Office Use Only</u>	
_____ Signature – Manhattan Cryobank Representative	_____ Date