PATIENT INFORMATION

PRIMARY CARE DOCTOR: ______________________ PCP # ______________ FAX # ______________

PATIENT NAME: ______________________ **BIRTHDATE:** ______________ AGE: ________

SOCIAL SECURITY # ______________________ MARITAL STATUS: ( ) S ( ) M ( ) W ( ) D

HOME TELEPHONE # ______________ **CELLULAR #** ______________ RELIGION: ______________

STREET ADDRESS: ______________________ **APT. #** ________

CITY: ______________________ **STATE**: ______________ **ZIP:** ______________

DRIVER'S LICENSE: ______________________ DRIVER'S LICENSE STATE: ________

EMPLOYER/SCHOOL: ______________________ TITLE: ______________ PHONE # ______________

STREET ADDRESS: ______________________ CITY: ______________ STATE: ______ ZIP: ________

SPOUSE NAME: ______________________ BIRTHDATE: ______________

STREET ADDRESS IF DIFFERENT FROM ABOVE: ______________________

TRANSLATOR NEEDED ( ) YES ( ) NO PRIMARY LANGUAGE SPOKEN: ______________ REFERRED BY: ______________

****

SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY, OTHER THAN SOMEONE LIVING WITH YOU:

NAME: ______________________ PHONE # ______________ RELATIONSHIP: ______________

ADDRESS: ______________________ CITY : ______________ STATE: ________ ZIP: ________

****

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

MOTHER'S NAME: ______________________ FATHER'S NAME: ______________________

EMPLOYED BY: ______________________ EMPLOYED BY: ______________________

PHONE # ______________________ PHONE # ______________________

****

PRIMARY INSURANCE INFORMATION:

INSURANCE CO. ______________________

ADDRESS: ______________________

CITY/STATE/ZIP: ______________________

PHONE # ______________________

I.D. # ______________ GRP # ________

INSURED'S NAME OR # ______________________

IS THIS AN EMPLOYER PLAN ( ) YES ( ) NO

INSURED'S SOCIAL SEC. # ______________ DOB: ________

RELATIONSHIP TO INSURED: SELF HUSBAND WIFE CHILD OTHER

SECONDARY INSURANCE INRORMATION:

INSURANCE CO. ______________________

ADDRESS: ______________________

CITY/STATE/ZIP: ______________________

PHONE # ______________________

I.D. # ______________ GRP # ________

INSURED'S NAME OR # ______________________

IS THIS AN EMPLOYER'S PLAN ( ) YES ( ) NO

INSURED'S SOCIAL SEC. # ______________ DOB: ________

RELATIONSHIP TO INSURED: SELF HUSBAND WIFE CHILD OTHER

GUARANTEE OF PAYMENT

I fully understand that I am directly responsible for payment to the physician in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered. unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in the event if becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim.

ASSIGNMENT OF INSURANCE BENEFITS

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any payment of any benefits to the physicians in this office for medical or surgical treatment received by me. In these circumstances**, I understand that I am financially responsible for any charges not covered by insurance.** I permit a copy of the authorization to be used in place of the original.

SIGNATURE (Patient's parent if minor): ______________________ **DATE:** ______________

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION*

I, ____(Patient name), *authorize* Femlife Healthcare for Women, LLC to *release* or *discuss* information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named person(s)*

1) ____________________________________ Relationship: ___________________

2) ____________________________________ Relationship: ___________________

3) ____________________________________ Relationship: ___________________

****

* PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL **NOT BE GIVEN** ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.

* YOU ARE **NOT REQUIRED** TO LIST ANY NAME IF YOU DO NOT SO CHOOSE.

****

Please list any *additional* phone numbers where you would like us to contact you for:

- Results – Lab, X-ray, Ultrasounds, Mammograms, etc.
- Reminder notices
- Changes on scheduled appointments

1. ____

2. ____

Patient Signature: ____

ADVANCE DIRECTIVE

Do you have an Advance Directive / Living Will? ( ) YES ( ) NO
If **yes**, please provide us with a copy for our records.

If **no**, please let us know if you require information.

I was referred to Femlife Healthcare for Women By:

☐ Friend ☐ Relative ☐ Physician ☐ Insurance
☐ Reputation of LLC's Physician(s) ☐ Existing Patient ☐ Other

Carlos R. Sarduy, MD **Pablo E. Uribasterra, MD** **Monica Daniel, MD**
Yara Delgado-Spasic, MD **Francoise Veneroni, MD**

PATIENT'S RESPONSIBILITY FOR PAYMENT

Patient's Name:____________________________________ S.S. #:_______________________ Accnt #____________

I am a member of ____ health insurance plan. My plan may or will only provide payment for *certain* covered medical services. I have requested that Femlife Healthcare for Women, LLC provide medical services which my health insurance plan *may* not pay for (Deductible, Members Portion, Out-of-Pocket, Termination of Coverage, etc.). *I agree that I am financially responsible for these services.*

Agreement: I understand that Femlife Healthcare for Women, LLC standard procedure is to bill patients for any non-covered or denied services. If I do not pay for these services within 90 days from the date of service, I agree and permit FHW, LLC to charge the credit card below for the outstanding amount. This credit card agreement will remain active for one (1) year from the signed date.

Credit Card #: ____ Exp.Date: ________/________/________

( ) VISA ( ) MasterCard

____ ____________________________

Signature Date

RESPONSABILIDAD DE PAGO DEL PACIENTE

Nombre del Paciente:____________________________________ S.S.#: ___________________ Accnt # __________

Soy participante del plan de seguro medico____. Este plan cubre parte o puede no cubrir el pago de *varios* servicios medico (Deducibles, Responsabilidades que provenga de su cuvertura medica o Terminacion de cobertura, etc.). He solicitado que el grupo medico FemLife Healthcare for Women, LLC, me provea servicios medicos por los cuales pueden no estar o no estan cubiertos por mi plan de seguro medico. Personalmente deseo los servicios medicos. *Estoy de acuerdo que soy responsable economicamente por mis servicios medicos.*

Acuerdo: Entiendo que el procedimiento establecido por Femlife Healthcare for Women, LLC es de cobrarle al paciente por cualquier servicio que haya sido negado o no pagado por mi seguro medico. Si yo no pago por estos servicios entre los 90 dias del dia del servicio, autorizo y estoy de acuerdo con que FHW, LLC me cobre a la tarjeta de credito notada aqui por el balance pendiente. Este acuerdo de la tarjeta de credito se mantendra activa durante un (1) ano del dia firmado.

Credit Card # ____ Exp. Date: ________/_________/_________

( ) VISA ( ) MasterCard

____ ____________________________

Firma Fecha

17901 NW 5th Street, Suite 202 • Pembroke Pines, FL 33029
Phone: 954-447-1994 • femlifemd.com • Fax: 954-447-1766

Carlos R. Sarduy, MD Pablo E. Uribasterra, MD Monica Daniel, MD
Yara Delgado-Spasic, MD Francoise Veneroni, MD

NICA INFORMATION

I have been furnished information by FemLife Healthcare for Women, LLC prepared by the Florida Birth-Related Neurological Injury Compensation Association, and have been advised that Dr. Carlos Sarduy, Dr. Pablo Uribasterra, Dr. Monica Daniel, Dr. Yara Delgado-Spasic and Francoise Veneroni, MD are participating physicians in the program, where in certain limited compensation is available in the event certain neuro-logical injury may occur during labor, delivery or resuscitation. For specifics on the program, I understand I can contact the Florida Birth-Related Neurological Injury Compensation Association (NICA), 1435 Piedmont Drive East, Suite 101, Tallahassee, FL 32312. 1-800-398-2129. I further acknowledge that I have received a copy of the brochure prepared by NICA.

DATED this _________ day of _______________________________ ,200_____.

____
Signature

____
Name of Patient

____
Social Security

Attest:

____
Witness

____
Date

SEE SECTION 766.316, FLORIDA STATUES

17901 NW 5th Street, Suite 202 • Pembroke Pines, FL 33029
Phone: 954-447-1994 • femlifemd.com • Fax: 954-447-1766

ANTEPARTUM RECORDS

Name: ____ SS # _____________________ Date: _____/_____/_____

1. **HIGH RISK SCREENING:** Please fill out this information as fully and accurately as possible in order to provide better prenatal care for you.

A. EMPLOYMENT, HOME AND LIFESTYLE (Please place a check mark **ONLY** next to those statements which are true for you)

____ You travel more than 45 minutes to your job.
____ Your job is physically very demanding.
____ You care for more than one pre-school child at home.
____ You are without someone to help you during your pregnancy.
____ You often go without enough rest.
____ You have a relationship which is seriously strained.
____ You are exposed to radiation or chemicals at work or at home.
____ You own a cat at home.
____ You have poor eating habits, a special diet, or practice vegetarianism.
____ You eat fewer than three meals daily or you occasionally do not eat for over 24 hours.
____ You occasionally eat laundry starch, clay or dirt.
____ You smoke cigarettes _________ amount per day __________ years of use.
____ You drink more than two alcoholic drinks in a day.
____ You use any drugs not prescribed by a doctor.
____ You have used addictive or street drugs.

B. PAST HEALTH HISTORY (Please check those conditions that are true for your health history)

____ Diabetes ("sugar" diabetes)
____ Varicosities/Phlebitis
____ Epilepsy (seizure or spells)
____ Hepatitis/Liver Problems
____ Abnormal Pap Smear
____ High Blood Pressure
____ Rheumatic Fever
____ Asthma
____ Blood Transfusion
____ STD's, Herpes, HPV
____ Mitral Valve Prolapse
____ Heart Problems
____ Thyroid Problems
____ Major Accidents
____ DES Exposure

____ You have infertility problems or have used infertility drugs.
____ You were using birth control pills at conception.
____ You have had surgery on the ovaries, uterus, tuble or cervix (Fibroids, cysts, tumor, etc.)

____ You have two or more abortions.
____ You have three or more pregnancies.
____ A child weighed more than 9 lbs. at birth
____ A child born dead (stillborn).
____ Twins or triplets delivered.
____ Child with birth defects.
____ Placenta Previa previous pregnancy.
____ You have blood clotting problems.
____ You have three or more miscarriages.
____ Fewer than 12 months since last birth.
____ A child weighed less than 5 lbs. at birth.
____ A child died before one month of life.
____ One or more cesarean sections.
____ Child born premature/early labor.
____ Unusual shape/size of uterus.
____ You weigh less than 100 lbs./over 200 lbs

____ You have any surgeries or hospitalizations during this last year (please specify): ______________
____
____

____ Your family has any of these medical conditions:
Diabetes: ____ High Blood Pressure: ____ Heart Disease: ____ Any type of Cancer: ____

ANTEPARTUM RECORDS

Name: ____ SS # _____________________ Date: _____/_____/_____

C. GENETIC INFORMATION: (Please check those conditions that are true for either yourself, baby's father or anyone in either family)

____	You are 35 years old or older	____	Down Syndrome
____	Spina Bifida or Anencephaly	____	Mental Retardation
____	Tay-Sachs (Jewish background)	____	Thalassemia (Mediterranean background)
____	Sickle Cell trait or disease	____	Hemophilia
____	Cystic Fibrosis	____	Muscular Dystrophy

____ Other inherited genetic or chromosomal disorders: ____
____

I have read all of the above and I have answered the questions to the best of my ability.
I have not intentionally withheld any pertinent medical information.

PATIENT'S SIGNATURE: ____ **DATE:** _____/_____/_____

##

Physician's Comment: ____

____

____

2. WOMAN'S HEALTH REVIEW: (Information to be filled by Medical Staff)

Birthdate: _______/_______/_______ Age: _______ Female: W B L A, Status: M S D W SE, Weight: ________

Occupation: ____ Education: __________________________________

TOTAL PREGNANCIES: G: __________ PARA: ______________

DATE	WEEKS	LABOR/HRS	BIRTH/WT	DELIVERY	HOSPITAL	COMMENTS/COMPLICATIONS
________	_______	__________	_________	________	___________	___________________________
________	_______	__________	_________	________	___________	___________________________
________	_______	__________	_________	________	___________	___________________________
________	_______	__________	_________	________	___________	___________________________

3. WOMAN'S HEALTH EXAM: (Information to be filled by Medical Staff)

N	ABN		N	ABN	
_____	_____	Heent	_____	_____	Vulva _______________________________
_____	_____	Fundi	_____	_____	Vagina _______________________________
_____	_____	Teeth	_____	_____	Cervix _______________________________
_____	_____	Thyroid	_____	_____	Uterus _______________________________
_____	_____	Breast	_____	_____	Adnexa _______________________________
_____	_____	Lungs	_____	_____	Rectum _______________________________
_____	_____	Heart	_____	_____	Diagonal Conjugate _____________________
_____	_____	Abdomen	_____	_____	Spines _______________________________
_____	_____	Extremities	_____	_____	Sacrum _______________________________
_____	_____	Skin/L.Nodes	_____	_____	Arch _______________________________

DATE: ________/________/________ **EXAM BY M.D. :** ____

Carlos R. Sarduy, MD Pablo E. Uribasterra, MD Monica Daniel, MD
Yara Delgado-Spasic, MD Francoise Veneroni, MD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices for Femlife Healthcare for Women, LLC. The Notice of Privacy Practices is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996.

Effective Date of Notice: April 14, 2003

Patient: ______________________________________ Date: ___________________

Or

Patient's Representative: _______________________ Date: ___________________

Relationship to Patient: ________________________

FOR USE BY FEMLIFE STAFF ONLY:

_____ Patient refused to sign

_____ Patient unable to sign

____
Femlife Employee's Initials

____
Today's Date

17901 NW 5th Street, Suite 202 • Pembroke Pines, FL 33029
Phone: 954-447-1994 • femlifemd.com • Fax: 954-447-1766

EFFECTIVE APRIL 14, 2003

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 about this notice, please contact our office at Femlife Healthcare For Women, 17901 NW 5 Street, Suite # 202, Pembroke Pines, FL 33029.

PURPOSE OF THIS NOTICE

This notice describes the ways in which we may use and disclose medical information about you. This notice also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

OUR LEGAL REQUIREMENTS

We are required by law to:

1) • Make sure that medical information that identifies you is kept private;

2) • Give you this notice of our legal duties and privacy practices with respect to medical information about you;

3) • Follow the terms of the notice that currently is in effect;

4) • Change the notice only in accordance with federal rules; and

5) • Provide our internal complaint process for privacy issues to you.

WHO WILL FOLLOW OUR PRIVACY PRACTICES

This notice describes the practices of Femlife Healthcare for Women and that of:

1) • All Femlife employees, staff and other Femlife personnel.

2) • Femlife affiliated entities and subsidiaries (all of which are collectively referred to as “Femlife”).

All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or health care operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services that we provide to you. We need this record to provide you with medical care and to comply with certain legal requirements. This notice applies to all of the records of your care we generate. This notice also applies to other health information about you, such as information collected with your authorization during research studies that do not involve treatment. Your personal doctor and other entities providing products or services to you may have different policies or notices regarding their use and disclosure of your medical information.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you:

1) • **Right to Inspect and Copy**. You have the right to inspect and copy medical information about you or your care. Usually, this includes medical and billing records.

To inspect and copy medical information about you or your care, you must submit your request in writing to our office Femlife Healthcare For Women, 17901 NW 5 Street, Suite # 202, Pembroke Pines, FL. 33029. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

1) • **Right to Amend**. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us.

To request an amendment, your request must be made in writing and submitted to our office Femlife Healthcare For Women, 17901 NW 5 Street, Suite # 202, Pembroke Pines, FL 33029. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

1) • Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

2) • Is not part of the medical information kept by or for us;

3) • Is not part of the information which you would be permitted to inspect and copy; or

4) • Is accurate and complete.

5) • Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This accounting is a list of the disclosures we made of medical information about you, except disclosures made for treatment, payment and Sheridan's health care operations.

To request this list or accounting of disclosures, you must submit your request in writing to the office of Femlife Healthcare For Women, 17901 NW 5 Street, Suite # 202, Pembroke Pines, FL 33029. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

1) • Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose 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. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to our office Femlife Healthcare For Women, 17901 NW 5 Street, Suite # 202, Pembroke Pines, FL 33029. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

1) • Right to 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. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to our office Femlife Healthcare For Women, 17901 NW 5 Street, Suite # 202, Pembroke Pines, FL 33029. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

1) • Right to a Paper Copy of This Notice. You have the right to a 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.

To obtain a paper copy of this notice, contact our office Femlife Healthcare For Women, 17901 NW 5 Street, Suite # 202, Pembroke Pines, FL 33029.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we are permitted to use and disclose medical information as a health care provider, although certain of these categories may not apply to our business and we may not actually use or disclose your medical information for such purposes. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose information will fall within one of the categories.

1) • For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to physicians, nurses and their office personnel, medical technicians, labs, hospitals and other facilities and their staff. For example, your health care provider may disclose your medical information for treatment purposes when referring you to another health care provider. We also may disclose medical information about you to people who may be involved in your medical care after you have received our products and services, such as social workers or home health agencies.

2) • For Payment. We may use and disclose medical information about you so that the treatment and services we provide you may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about products and services we provided to you so your health plan will pay us or reimburse you for the products and services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

3) • For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to run our company and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new

treatments are effective. We may also disclose information to our compliance department, attorneys, auditors, business planners and managers, health care educators and trainers, peer review committees and general administrators for review and learning purposes and in order to assist in the defense of any claim, lawsuit, proceeding or investigation. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

4) • Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or services.

5) • Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

6) • Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

7) • Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your location and condition and that you are receiving products and services from us. In addition, we may disclose medical information about you to any entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

8) • Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one product or service to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave our premises. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care.

9) • As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

10) • To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

1) • Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

2) • Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

3) • Public Health Activities. We may disclose medical information about you for public health activities. These activities generally include the following:

   4) • to prevent or control disease, injury or disability;

   5) • to report births and deaths;

   6) • to report child abuse or neglect;

   7) • to report reactions

   8) • to notify people of recalls of products they may be using;

   9) • to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

   10) • to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

11) **• Health Oversight Activities**. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

12) • **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in

response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

13) **• Law Enforcement**. We may release medical information if asked to do so by a law enforcement official:

14) • In response to a court order, subpoena, warrant, summons or similar process;

15) • To identify or locate a suspect, fugitive, material witness, or missing person;

16) • About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;

17) • About a death we believe may be the result of criminal conduct;

18) • About criminal conduct occurring on our premises; and

19) • In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

20) **• Coroners, Medical Examiners and Funeral Directors**. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral directors as necessary to carry out their duties.

21) **• National Security and Intelligence Activities**. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

22) **• Protective Services for the President and Others**. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

23) **• Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

24) • **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

25) • **Sale of Business Assets.** We reserve the right to transfer medical information about you to a third party in conjunction with the sale of our company or certain assets belonging to our company.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in your physician's office (or at the facility where you are being treated). The notice will contain on the first page, in the top right-hand corner, the effective date. If we do change this notice, we will re-post a copy of the current notice, but we not redistribute this notice to you.

EFFECTIVE APRIL 14, 2003

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our office Femlife Healthcare for Women or at 954-447-1994. 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 disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

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