HIPAA 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.

This notice explains how Metropolitan Family Care INC. (MFC) uses and discloses (shares) your health information. It also explains your
health information rights.
You will receive this Notice of Privacy Practices on your first service encounter with MFC. You will be asked to acknowledge receipt of
this notice.

OUR LEGAL OBLIGATIONS

We have a legal obligation to:
1. Maintain the privacy of your Protected Health Information. Protected Health Information ("health information") is health
information that individually identifies you.
2. Inform you about our legal duties and privacy practices related to your past, present and future health information.
3. Follow the terms of this notice as currently in effect.

HOW WE MAY USE AND DISCLOSE (SHARE) YOUR HEALTH INFORMATION

The following describes the ways we may use and disclose ("share") your health information. All other uses and disclosures will require
your written authorization or the written authorization of your legal health care representative.

Treatment/Care

We may use and share your health information to provide, coordinate and manage your health care and any related services.
This includes the coordination or management of your health care with outside providers. For example, if you are or become
home bound, we may share your health information with the home care agency providing your care and services.

Payment of Your Treatment/Care

We may use and share your health information for payment of health care provided by us or another provider. For example,
your health information may be disclosed to your health plan for determination of coverage or payment of a bill.

Health Care Operations

We may use and share your health information to support MFC operational and business activities. For example, your health
information may be used and shared to conduct quality assessment and review activities. We may also contact you to remind
you of an appointment.
We may share your health information for functions and services provided by our Business Associates. For example, we may
share your health information with a company to perform billing services on our behalf. Business Associates and their
subcontractors are obligated by law to protect the privacy of your health information.

Individuals Involved in Your Care or Payment for Your Care

When appropriate, we may share your health information with a person who is involved in providing or paying for your care,
such as a family member, close friend or legal health care representative. You may opt out of this disclosure as outlined in this
notice.

As Required by Law

We will share your health information when required to do so by international, federal, state or local law; statutes;

regulations;
court orders.

To Avert a Serious Threat to Health or Safety

Your health information may be shared to prevent a serious threat to your health and safety or the health and safety of the
public or another person. Disclosures will be made only to someone who may be able to help prevent or lessen the threat
(including the target of the threat).

Organ, Eye or Tissue Donation

We may share your health information with organizations involved in procuring, banking or transplanting organs, eyes or
tissue.

Essential Government Functions

Your health information may be shared with authorized federal officials for: 1.) conducting intelligence, counter intelligence
and national security activities; 2.) providing protective services to the President of the United States; 3.) making medical
determinations for U.S. State Department employees; 4.) determining eligibility for or conducting enrollment in certain
government benefit programs; and 5.) military purposes (for example, if you are a member of the armed forces, we may
release your health information as required by military command authorities).

Law Enforcement (Federal, State, Local)

Your health information may be shared with a law enforcement official if the information is: 1.) required by law; 2.) to identify
or locate a suspect, fugitive, material witness, or missing person; 3.) to report the victim or suspected victim of a crime or death
resulting from criminal activity (this includes suspected abuse, neglect or domestic violence; 4.) to report the commission and
nature of a crime, location of crime or crime victims, and the perpetrator of a crime (this includes crimes occurring on MFC
premises).

We may share your health information if you are an inmate of correctional facility.

Health Oversight Activities

We must share your health information with government agencies for legally authorized activities such as audits,
investigations, and civil or criminal proceedings.

Public Health Activities

We may share your health information for public health activities such as: 1.) the prevention or control of disease, injury or
disability; 2.) to report births and deaths; 3.) to report adverse reactions to medications or problems with products; 4.) to notify
people of recalls of products they may be using; 5.) to notify a person who may have been exposed to a disease or who may be
at risk for contracting or spreading a disease or condition; 6.) to provide proof of immunization to a school where proof is
required for student admission (a verbal discussion with or an e-mail from the parent or legal guardian suffices as authorization
to share immunization information).

Additional State and Federal Requirements

Some state and federal laws provide additional privacy protection of your health information. These include:

Sensitive Information. Some types of health information are particularly sensitive, and the law, with limited exceptions, may

require that we obtain your written permission or in some instances, a court order, to use or disclose that information.
Sensitive health information includes information dealing with genetics, HIV/AIDS, mental health, sexual assault and alcohol
and substance abuse.
Information Used in Certain Disciplinary Proceedings. State law may require your written permission if certain health
information is to be used in various review and disciplinary proceedings by state health oversight boards.
Information Used in Certain Litigation Proceedings. State law may require your written permission for us to discloseinformation in certain legal proceedings. Disclosures to Certain Registries. Some laws require your written permission if we disclose your health information to certainstate-sponsored registries.

Worker's Compensation

Your health information may be shared with Worker's Compensation or similar programs as necessary to provide benefits for
work related injuries or illness.

Decedents

Upon your death, we may share your health information with: 1.) a person who was involved in providing or paying for your
care, such as a family member, close friend or legal health care representative; 2.) a coroner or medical examiner as necessary
to identify a deceased person or determine the cause of death; 3.) a funeral director as necessary to perform their duties.
Health information is not subject to privacy protection 50 years following the date of your death.

Research

Under no certain circumstances will we use or disclose health information about you for research purposes.

Marketing

Your health information will not be shared for marketing purposes.

Change of Ownership

In the event MFC is sold or merged with another organization, your health information will become the property of the new owner although you will maintain the same rights with respect your health information.

Data Breach Notification

We may use or share your health information to provide legally required notices of an unauthorized breach (access) of your
unsecured health information.
In the event of a breach of your unsecured health information, you will be notified by MFC. You may also be notified by one of
our Business Associates or their subcontractors.

Psychotherapy Notes

MFC does not create or maintain psychotherapy notes.

Sale of Protected Health Information

Your health information will not be sold without written authorization from you or your legal health care representative.

YOUR OPPORTUNITY TO OPT OUT OF CERTAIN USES AND DISCLOSURES

You may Opt Out of the following uses and disclosure of your health information.

Individuals Involved in your Care or Payment for Your Care

Unless you Opt Out, we may share your health information with a person who is involved in providing or paying for your care
such as a family member, close friend or legal health care representative.

Disaster Relief

We may share your personal health information with disaster relief organizations to coordinate your care or notify

your family
and friends of your location or condition in a disaster. You will be provided with an opportunity to object to such a disclosure
whenever it is feasible to do so.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The Right to Access Your Own Health Information

With certain exceptions outlined by privacy regulations, you have the right to review and copy your health information and
billing records.

To review or obtain a copy of your health information, you or your legal health care representative must submit a written
request. The request form is available at your physician's office and on our website at metropolitanfc.com. Send your request
form to: Metropolitan Family Care Inc. 3341 East Livingston Avenue Suite # D Columbus, Ohio 43227

We have up to 30 days from the time of your written request to make your health information available to you. We may charge
you a reasonable fee based on our costs to copy and mail your health information. You may ask for the cost in advance of the
information being prepared.

In very limited circumstances, we may deny your request. If we deny your request, you will receive written notification of the
denial. You have the right to appeal the denial by submitting a written appeal request to: MFC Compliance Officer, 3341 E. Livingston Avenue , Suite D,Columbus, Ohio 43227. Your appeal request will then be reviewed by a licensed health care professional
not directly involved in your care or in the denial of your request for access to your health information. You will be notified in
writing regarding the outcome of that appeal.

The Right to Amend Your Health Information

If you believe your health information is incorrect or incomplete, you have the right to request that we amend (change) the
information as long as the information was created by us.

To request an amendment of your health information, you or your legal health care representative must submit a written
amendment form stating the reason(s) for amending your health information. The amendment request form is available at
your physician's office and on our website at metropolitanfc.com. . Send your amendment request form to: MFC Compliance
Officer, 3341 E. Livingston Avenue , Suite D,Columbus, Ohio 43227. We will respond within 60 days.

If your request is approved, we will place the amendment request form in your health record and correct your health
information to reflect the approved amendment.

We may deny your request if the existing health information is correct and complete, was not created by us, or is not available
for inspection. If your request is denied, we will notify you in writing and include the reason(s) for the denial. We will explain
your right to file a written statement of disagreement with the denial.

The Right to an Electronic Copy of Electronic Medical Records

If your health information is maintained in an electronic record (known as an electronic medical record or electronic health
record), you have the right to request that an electronic copy of your record be given to you or transmitted to another
individual or entity. We will make every effort to provide access to your health information in the form or format you request.

We may charge you a reasonable fee based on our costs for the labor associated with preparing and transmitting the electronic
health information.

The Right to an Accounting of Certain Disclosures of Your Health Information

You have the right to request a list of certain disclosures of your health information. The list will not include disclosures made:
1.) for purposes of treatment, payment, or health care operations; 2.) to you, your caregivers or your legal health care
representative; 3.) for which you or your legal health care representative provided a written authorization; 4.) for national
security or intelligence purposes; 5.) to correctional institutions or law enforcement officials; 6.) for purposes of research or
public health when direct patient identifiers are not used; 7.) as required by law; 8.) to a health oversight agency in certain
circumstances; 9.) before April 14, 2008.

By law, the maximum period the list must cover is 6 years immediately preceding the written request for an accounting of
certain disclosures.

The first accounting of certain disclosures in a 12 month period will be provided at no charge. For any additional accounting of
disclosures, you may be charged a reasonable fee based on our costs for the labor associated with preparing the accounting of
disclosures.

To request an accounting of disclosures of your health information, you or your legal health care representative must submit a
written request. The form to request for an accounting of disclosures is available at your physician's office and on our website
at metropolitanfc.com. Send your account request form to: MFC Compliance Officer, 3341 E. Livingston Avenue , Suite D,Columbus, Ohio 43227.

The Right to Request Restrictions of Your Health Information

You have the right to request a restriction or limitation on how we use or disclose your health information. However, you may
not restrict or limit the uses that are required by law.

You have the right to restrict disclosure of your health information to your health plan when you have paid out of pocket and in
full for the health care item or service unless the disclosure is required by law.

To request a restriction of your health information, you or your legal health care representative must submit a written request.
The form to request a restriction of your health information is available at your physician's office and on our website at
metropolitanfc.com. Send your restriction request form to: MFC Compliance Officer, 3341 E. Livingston Avenue , Suite D,Columbus, Ohio 43227.

The Right to Choose How We Share Your Health Information with You

You have the right to request, in writing, that we communicate your health information in a certain way or at a certain location.
For example, you may request that we only contact you by mail or at work.

We will accommodate reasonable and feasible requests.

The Right to a Paper Copy of this Notice

You have the right to a paper copy of this notice, and may request a paper copy of this notice at any time, even if you agreed to
receive this notice electronically. You may obtain a copy of this notice from your physician's office and on our website at
metropolitanfc.com.

REVISIONS TO THIS NOTICE OF PRIVACY PRACTICES

We reserve the right to make revisions to the terms of this notice as required by law. Revised notices will be available at your
physician's office and on our website at metropolitanfc.com.

IF YOU HAVE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you feel your privacy rights have been violated or you disagree with a decision we made about your health information rights, you
may call the MFC Compliance line at 614-237-1067, or send a written
complaint to: MFC Compliance Officer, 3341 E. Livingston Avenue , Suite D,Columbus, Ohio 43227.
You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. within 180
days of a violation of your rights. We will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice of Privacy Practices is effective November 1, 2013.

ADDITIONAL INFORMATION

If you have any questions about this Notice, or need additional information related to this Notice, please contact the MFC Compliance
Officer at: 614-237-1067

REQUEST TO AMEND PROTECTED HEALTH INFORMATION (PHI)

Please Print

Patient's Name: ____ Date of Birth: ________________________

Last First Middle (M/D/Y)

Address: ____

Street City State Zip

Telephone Number Where You Can Be Reached: ____

Is the address above where you would like your response mailed: □ Yes □ No

If no, please provide an alternate mailing address:

____

Date of Request:_____________ Physician: _________________________________

Practice:_____________________________________

1. Please describe the health information you want to change (e.g. physician/nursing notes, lab results, etc.) and the reason you are making this request.

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2. Please give the date(s) of information to be changed (e.g. date of office visit).

____

3. What should the information say to be more accurate or complete? (Please be as specific as possible and attach documentation if necessary).

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MFC may accept or deny your request to amend as permitted by law. We cannot amend documentation that was not created by MFC. If your request is
denied, you will be informed in writing of the reason for the denial and what you should do if you disagree with the denial. You will be notified whether
your request is accepted or denied within sixty (60) days of receipt of this request. MFC can extend the response period for up to an additional thirty (30)
days by notifying you in writing.
If the amendment is approved, please specify any organizations or individuals that need to receive this amended information**.**

____

____

Name Street City State Zip

______________________________ _______

____

Name Street City State Zip

____________________________________ ____________________________

Signature of Patient Date

____________________________________ ____________________________

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Signature of Patient's Legal Representative Relationship to Patient Date

If signed by Patient's Legal Representative, please include a copy of the document authorizing your authority to act on behalf of the patient (e.g. health care power of attorney).

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For MFC Use Only – forward to MFC Compliance Officer

Date Request Received: ________________________ Amendment Was: □ Accepted □ Denied

If denied, check reason(s) for denial: □ The Request for Amendment Form was not complete. You may complete the missing information highlighted above and
resubmit your request to:MFC Compliance Officer, 3341 E. Livingston Avenue Suite # D , Columbus, Ohio 43227
The PHI or record is not available to the patient for inspection as required by federal law.
The PHI is accurate and complete as determined by review.

If your request is denied: 1. You may submit a statement disagreeing with the denial; 2. Request that your Amendment Request form and denial be attached to future
disclosures; and/or 3.File a complaint with the MFC Compliance Officer,3341 East Livingston, Ohio 43227 nor with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C.

Patient Notified By: □ Regular Mail □ Courier □ Certified Mail **Date Sent:** ______________________________

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____________________________________ ______________

Signature of MFC Authorized Representative (Name/Title) Date Signature of Health Care Provider (if applicable) Date

Form Revision: 11/20/13

REQUEST TO RESTRICT PROTECTED HEALTH INFORMATION (PHI)

Please Print

Patient's Name: ____ **Date of Birth:** _______________________

Last First Middle (M/D/Y)

Address: ____ _____________

Street City State Zip

Date of Request: _____________ **Physician:** ______________________________ **Practice:** ______________________________

Telephone Number Where You Can Be Reached: ____

I understand that I have the right to restrict how MFC uses and discloses my PHI except for those uses and disclosures that are required by
law. I also understand that MFC has the right to deny my request to restrict PHI and that I will be notified, in writing, of the denial
decision.

□ Restrict the information from my service/item on ______________ to my health plan because I have paid out of pocket and
in full for this service/item.

□ Restrict the following information: ____

Restrict access to the following: ______________________________ ____

Name Address City State Zip

______________________________ ____

Name Address City State Zip

Effective Date of This Restriction: ________________________ **Date Restriction is To End:** ___________________________

(M/D/Y) (M/D/Y)

____________________________________ _____________________________

Signature of Patient Date

____________________________________ ____________________________ ______________________________

Signature of Patient's Legal Representative Relationship to Patient Date

If signed by Patient's Legal Representative, please include a copy of the document authorizing your authority to act on behalf of the patient (e.g. health care power of
attorney).

____ ___________________

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For MFC Use Only – forward to MFC Compliance Officer

Date Request Received: ________________________ **Restriction Was:** □ Accepted □ Denied

If denied, check reason(s) for denial: □ The Request for Restriction Form was not complete. You may complete the missing
information highlighted above and resubmit your request to: MFC 3341 East Livingston Avenue Suite# D, Columbus, Ohio 43227

□ The item/service was not paid for out of pocket and in full.

□ The PHI cannot be restricted as required by law.

Comments:
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Patient Notified By: □ Regular Mail □ Courier □ Certified Mail **Date Sent:**
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_____________________________________ ___________ ________________________________
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Signature of MFC Authorized Representative (Name/Title) Date Signature of Health Care Provider (if applicable) Date
Form Revision: 11/2013

REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

Please Print

Patient's Name: ____ **Date of Birth:**
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Last First Middle (M/D/Y)

Address:
____
____

Street City State Zip

Telephone Number Where You Can Be Reached:
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I hereby request an accounting of disclosures of my protected health information. I understand the list will not include disclosures made:
1.) for purposes of payment, treatment or health care operations; 2.) to me, my caregivers or my legal health care representative; 3.) for
which I or my legal health care representative provided a written authorization; 4.) for national security or intelligence purposes; 5.) to
correctional institutions or law enforcement officials; 6.) for purposes of research or public health when direct patient identifiers are not
used; 7.) as required by law; 8.) to a health oversight agency in certain circumstances; 9.) before April 14, 2008. I also understand that, by
law, the maximum period the list will cover is 6 years immediately preceding this written request. I understand that the first request for an
accounting of certain disclosures in a 12 month period will be provided at no charge and, for any subsequent requests for an accounting of
disclosures in a 12 month period, I will be charged a reasonable fee based on MFC cost for the labor associated with preparing the
accounting of disclosures.

Date of Request:______________ **Physician:** __________________________ **Office Location:**
____

Beginning Date (cannot be prior to April 14, 2008): ______________________ **Ending Date:**
____

MFCbe informed in writing of
the reason(s) for the denial and what you should do if you disagree with the denial. You will be notified whether your request is accepted
or denied within sixty (60) days of receipt of this request. MFC can extend the response period for up to an additional thirty (30) days by
notifying you in writing.

___________________________________ ___________________________

Signature of Patient Date

___________________________________ ___________________________

____

Signature of Patient's Legal Representative Relationship to Patient Date
If signed by Patient's Legal Representative, please include a copy of the document authorizing your authority to act on behalf of the patient (e.g. health care power of attorney).

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For MFC Use Only – forward to MFC Compliance Officer

Date Request Received: ________________________ **Accounting Has Been:** □ Accepted □ Denied

If denied, check reason(s) for denial: □ The Request for Accounting Form was not complete. You may complete the missing
information highlighted above and resubmit your request to: MFC Compliance Officer,3341 E. Livingston Avenue Suite# D Columbus, Ohio 43227

□ The request covers a period greater than six years preceding the request.

□ The request beginning date is prior to April 14, 2008

□ The request is the second or more in a 12 month period and patient is unwilling to pay fee for preparation of accounting of disclosures.

Comments:

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____

Patient Notified By: □ Regular Mail □ Courier □ Certified Mail **Date Sent:**
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____ ____________ ____________________________________
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Signature o fMFCAuthorized Representative (Name/Title) Date Signature of Health Care Provider (if applicable) Date
Form Revision:11/20/12

AUTHORIZATION TO DISCLOSE (RELEASE) PROTECTED HEALTH INFORMATION (PHI)

Please Print

Patient's Name: ____ **Date of Birth:**
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Last First Middle (M/D/Y)

Address:

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____

Street City State Zip

Telephone Number Where You Can Be Reached:

____

Date of Request: _______________ **Physician:** ____________________________ **Practice**
:___________________________________

Purpose of Release:

□ Continuity of Care/Medical Treatment □ Insurance □ Research

□ Disability □ Legal Reasons □ Employment Related

□ Other (please specify):

____

Information to be Released:

☐ History and Physical ☐ X-rays/X-ray Reports ☐ Physician's Progress Notes

☐ Operative/Procedure Reports ☐ Lab Results/Reports ☐ Summary Reports

☐ Other (please specify):____

Date(s) of Service:

____

Release To:

____

____

Name Street City State Zip

_____________________ ____________________________ ________________________ ___________________________

Phone Number Fax Number E-Mail To the Attention Of

Method of Release:

☐ Mail ☐ Fax ☐ E-mail ☐ Other (please specify): ____

Expiration: This authorization for release of protected health information for the date(s) of service indicated is effective until

_________________ or for a maximum of one year from the date signed below.

Revocation: I understand that I may revoke this authorization, in writing, at any time except to the extent that MFC has relied on this
authorization to release protected health information. Revocation may be made in writing and submitted to the MFC Compliance Officer
at 3341 E. Livingstone Avenue Suite # D, Columbus, Ohio 43227.

Redisclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The
Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the
written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of
medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally
investigate or prosecute any alcohol or drug abuse patient.

I authorize the release of the information identified above. I understand and acknowledge that this authorization may include information
concerning testing, diagnosis or treatment of HIV (Human Immunodeficiency Virus), AIDS (Acquired Immune Deficiency Syndrome),
psychiatric and/or drug/alcohol treatment and/or assault records that may be in my medical record.

____________________________________ ____________________________

Signature of Patient Date

____________________________________ ____________________________ ____________________________

Signature of Patient's Legal Representative Relationship to Patient Date

If signed by Patient's Legal Representative, please include a copy of the document authorizing your authority to act on behalf of the patient (e.g. health care power of attorney).

Form Revision:11/20/13