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.

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: October 26, 2017

Conviva Care Center, LLC and similar health care providers are required by the Health Insurance Portability Accountability Act of 1996 (“HIPAA”) to maintain the privacy of patients' protected health information and to abide by the terms of its Notice of Privacy Practices ("Notice"). This Notice describes how we may use and disclose your protected health information to carry out treatment, receive payment or to support the operations of the health care facility or for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your protected health information.

Protected health information refers to information about you, including demographic information that may identify you and relates to your past, present, and future physical or mental health or condition, and related health care services. It does not include certain information including employment records, certain education and student records, or records of people who have been deceased for more than 50 years.

Conviva Care Center, LLC is required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices, to provide notice of breaches to affected individuals, and to abide by the terms of this Notice. The terms of this notice may be changed at any time. If this happens, the terms of the new notice will be effective for all protected health information that we maintain at that time. You may request to receive a revised Notice of Privacy Practice by calling your medical center and requesting a revised copy be mailed to you, or by asking for one at the time of your next appointment. It will also be available on our website as set forth below.

Your Health Information Rights

You have the following rights with respect to your protected health information:

You have the right to obtain a paper copy of this Notice upon request. Upon request, you have the right to obtain a paper copy of this notice from us, even if you have agreed to accept this notice electronically. To obtain a paper copy, contact your center administrator. You may also obtain a copy of this Notice at our facility or at our Internet website: www.convivacarecenters.com

You have the right to inspect and copy your protected health information. You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain such information. A designated record set contains medical, billing and any other records that your physician or the medical center uses for making decisions about you.

If your request can be granted, then Conviva Care Center will provide you with your protected health information that we maintain in our designated record set in the form and format request, including electronically for electronic records, if it is readily producible in such form or format or, if not, in a readable hard copy form or such other format as agreed to by Conviva Care Center and you. You may request that we transmit a copy of your protected health information directly to another person, provided your request is in writing, signed by you, and you clearly identify the designated person and where to send the copy of your protected health information. We may charge you a fee for the costs of copying mailing, and supplies that are necessary to fulfill your request. We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your protected health information, you may request that this denial be reviewed.

You have the right to request a restriction on certain uses and disclosures of your protected health information. This means you may ask us not to use or disclose any part your information for the purposes of treatment, payment, healthcare operations or to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. You must state the specific restriction and to whom it applies.

We are required to agree to a request to restrict the disclosure of your protected health information to a health plan if: (A) the disclosure is for the purposes of carrying out payment or health care operations and is not otherwise required by law; and (B) the PHI pertains solely to a health care item or service for which you, or a person on your behalf other than the health plan, has paid the covered entity out-of-pocket in full. We may not be required to agree to all other restriction requests and, in certain cases, we may deny your request. The Request for Restriction form is available upon request from your center administrator.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. For example, you may request that we contact you about medical matters only in writing or at a different residence or post office box. We will accommodate reasonable requests. We may need to ask you information as to how payment will be handled or specifics on an alternative address or method of contact. We will not ask you the reason for your request. Please write to your medical center administrator to make this request.

You may have the right to have your physician amend your protected health information. You may request an amendment to your protected health information in a designated record set for as long as we maintain this information. In certain circumstances, your request for an amendment may be denied. If your request is denied, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement. If this were the case, we will provide you with a copy of the rebuttal. If you have questions about amending your record, please contact your medical center administrator.

If we have made certain disclosures of your protected health information, you have the right to receive an accounting. This applies to certain disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. You have the right to receive specific information regarding such disclosures that occur for six years prior to your request. Depending on the compliance date required by law for a particular record, an accounting of disclosures from an electronic health record will include disclosures for treatment, payment, or health care operations. Records of such disclosures from an electronic health record must be maintained for three years. Your right to receive this information is subject to certain exceptions, restrictions and limitations. To request an accounting, contact your center administrator.

The right to receive written notification of a breach of your unsecured protected health information. We have a legal duty to provide you with written notification of a breach where your unsecured protected health information has been accessed, used, acquired, or disclosed to an unauthorized person as a result of such breach, and the breach compromises the security and privacy of your protected health information. Unless specified in writing by you to receive this breach notification by electronic mail, we will provide this notification by first-class mail or, if necessary, by such other substituted forms of communication allowable under the law.

Uses and Disclosures of Protected Health Information

The following examples explain the type of uses and disclosures of your protected health care information that our medical office is permitted to make. These examples are not meant to be exhaustive.

Uses and disclosures of protected health information for treatment

Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more health care providers. For example, your protected health information may be shared, if necessary, with other health care providers who may be treating you or to whom you have been referred to ensure that they have the necessary information to diagnose or treat you. We may share your information with medical students if they were to see patients in the office. We may ask that you sign your name and indicate your physician on a sign-in sheet at the registration desk. We may call you by your name in the waiting room when your physician is ready to see you. We may contact you to remind you of an appointment. We may exchange your protected health information electronically for treatment and other permissible purposes.

Uses and disclosures of protected health information for payment

Payment includes, but is not limited to, actions to make coverage determinations and receive payment. For example, your health insurance plan may need this information to be able to determine if approval or payment for services we recommend is warranted by reviewing eligibility or coverage, medical necessity and undertaking utilization review activities.

Uses and disclosures of protected health information for health care operations purposes

Health care operations include, but are not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, and otherwise supporting the business activities of your medical center. For example, these activities include, but are not limited to: quality assessment, employee review, medical student training, licensing, and creating de-identified data. We may use or disclose your information to be able to provide you with treatment alternatives and other health related benefits and services, use your name and address to mail you a newsletter, information about products or services that may be beneficial to you. If you do not wish to receive these materials, please contact your medical center administrator.

Use of business associates

There are some services provided by or to us through arrangements with our business associates. Examples of business associates include claims processors or administrators, records administrators, attorneys, etc. We may disclose protected health information to our business associates that help us with our administrative activities. We may use business associates or subcontractors to provide legal services to us, to bill you or your third party payor for services rendered, to assist us with responding to a request for records, or any other permissible activities. Those business associates may disclose information to their subcontractors and as needed for their own proper management and administration or to fulfill their legal responsibilities. We will make sure that we have a written contract with these business associates that contains terms protecting the privacy of your health information.

Uses and disclosures of protected health information based upon your written authorization

Under certain circumstances, your protected health information will be used or disclosed only with your written authorization, unless otherwise permitted or required by law as described in this Notice. For example, we will obtain your written authorization before using or disclosing your protected health information for the following purposes: (i) most uses and disclosures of psychotherapy notes; (ii) uses and disclosures of protected health information for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of protected health information; uses and disclosures for the purposes of fundraising; and (v) other uses and disclosures not described in this Notice. Unless

otherwise permitted by applicable laws and rules or by your written authorization, we will not directly or indirectly receive remuneration in exchange for your protected health information. You may revoke your authorization, in writing, at any time, except to the extent that your physician or the center has taken an action in reliance on the use or disclosure indicated in the authorization. If you wish to revoke your authorization, you can follow the instructions on the authorization form.

Florida Law

Florida law generally requires your written authorization in order for us to disclose your protected health information for payment, health care operations, or certain other non-treatment purposes. Conviva Care Centers will request your written authorization that you allow these disclosures.

Uses and disclosures permitted and required that may be made without your authorization or opportunity to object

Under the following circumstances, your protected health information may be used or disclosed without you having the opportunity to agree or object to all or part of this use and disclosure.

Communication with individuals involved in your care or payment for your care: Health care professionals, using their professional judgment, may disclose your protected health information to a family member, other relative, close personal friend or any person you may identify, when such communication is relevant to that person's involvement in your care or payment related to your care.

Fundraising communications: We may contact you to raise funds for our benefit. You have the right to opt out of receiving such communications. Your choice to opt out is treated as a revocation of your authorization. Some information is permitted to be released without your authorization, such as treating physician information.

Limited data set and de-identified information: We may use or disclose your protected health information to create a limited data set or de-identified data, and use and disclose such information as permitted by applicable laws and rules.

Emergencies: We may use and disclose your protected health information as necessary in an emergency treatment situation.

Required by law: We will use and disclosure your protected health information as required by law. This information will be limited to the relevant requirements of the law. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

Public health: To comply with the request of a public health authority that is authorized by law to receive this information for the purpose of controlling disease, injury or disability. If directed by the public health authority, we may have to disclose your information to a foreign government agency that is collaborating with the health authority.

Disease prevention: If authorized by law, the information may be released to a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading the disease or condition.

Health oversight: If requested by a health oversight agency, protected health information may be released for activities authorized by law such as audits, investigations, and inspections. Examples of oversight agencies are government agencies overseeing the health care system, government benefit programs, and other government regulatory programs and civil rights laws.

Victims of abuse, neglect or domestic violence: If requested by a public health authority authorized by law to receive reports of child abuse or neglect. We may also release this information, consistent with the requirements of applicable federal or state laws, to the government entity authorized to receive such information if we believe that you have been a victim of abuse, neglect or domestic violence.

Food and Drug Administration: Protected health information may be released to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biological products deviations, track products, enable product recalls, make repairs or replacements or conduct post marketing surveillance, as required.

Judicial and administrative proceedings: We may use and disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in response to a subpoena, discovery request or other lawful process.

Law enforcement: We may use and disclose your protected health information for law enforcement purposes when applicable legal requirements are met which include 1) legal processes and otherwise required by law, 2) limited information requests for identification and location purposes, 3) when pertaining to victims of a crime, 4) when there is suspicion that death has occurred as a result of criminal conduct, 5) in the event that a crime occurs on the premises of the medical center, and 6) in the event of a medical emergency (not on the center's premises) where it is likely that a crime has occurred.

Coroners, medical examiners, funeral directors, and organ or tissue procurement organizations: We may use and disclose your protected health information when requested by a coroner or medical examiner for identification purposes, to determine cause of death or to perform other duties authorized by law. If the information requested by a funeral director as authorized by law, we may use and disclose protected health information to allow the director to carry out their duties. Protected information may be released in reasonable anticipation of death or for cadaver organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the proposal and established protocols to ensure the privacy of your protected health information.

To avert a serious threat to health or safety: We will use and disclose your protected health information when we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military and veterans, national security and intelligence activities, and protective services for the President and others: If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate military authority. We may release your protected health information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law. We may disclose your protected health information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Worker's compensation: We may use and disclose your protected health information to comply with worker's compensation laws and other similar legally established programs.

Correctional institutions: If you are, or become an inmate of a correctional institution, may be disclose your protected health information to the institution or its agents when necessary for your health or the health and safety of others.

Facility Directory: Unless you object, we may use and disclose certain limited information about you in our directory while you are a patient. This information may include your name, your location within our facility, your general condition and you religious affiliation. Our directory will not include specific medical information about you. We may disclose directory information, except for your religious affiliation, to people who ask for you by name. We name provide directory information, including you religious affiliation, to a member of the clergy.

National Security and Intelligence Activities; Protective Services for the President and Others: We may disclose protected health information to authorized federal officials conducting national security and intelligence activities or as needed to provide protection to the President of the United States, certain other persons or foreign heads of states or to conduct certain special investigations.

Disaster Relief: We may use or disclose you protected health information to an organization assisting in a disaster relief effort.

Proof of Immunizations to Schools: We may disclose proof of immunization(s) to a school where State of other law requires the school to have such information prior to admitting the student. We are required to obtain an agreement from you, which may be oral, or from a parent, guardian or other person acting in loco parentis for the individual, or from the individuals himself or herself, if the individual is an adult or emancipated minor.

Appointment Reminders: We may use or disclose protected health information to remind you about appointments.

Treatment Alternatives and Health-Related Benefits and Services: We may use or disclose your protected health information to inform you about treatment alternatives and health-related benefits and services that may be of interest to you.

Special rules regarding disclosure of psychiatric, substance abuse and HIV-related information:

For disclosures concerning protected health information related to care for psychiatric conditions, substance abuse, or HIV-related information, special restrictions may apply, For example, we generally may not disclose this specially protected information in response to a subpoena, warrant or other legal process unless you sign a special authorization or a court orders the disclosure. A general release of your protected health information will not be sufficient for purposes of disclosing psychiatric, substance abuse or HIV-related information.

> **Psychiatric information:** We will not disclose records relating to a diagnosis or treatment of your mental condition between you and the psychiatrist without specific written authorization or as required or permitted by law.
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> **HIV-related Information:** HIV-related information will not be disclosed, except under limited circumstances set forth under state or federal law, without your specific written authorization. A general authorization for release of medical information will not be sufficient for purposes of releasing HIV-related information. As may be required by state law, if we make a lawful disclosure of HIV-related information, we will enclose a statement that notifies the recipient of the information that they are prohibited from further disclosing the information.
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> Substance abuse treatment: If you are treated in a specialist substance abuse program, information which could identify you as an alcohol or drug-dependent patient will not be disclosed without your specific authorization except for purposes of treatment or payment or where specifically required or allowed under state or federal law.

For More Information or to Report a Problem

If you have questions or would like more information about Conviva's privacy practices, you may contact the Privacy Officer, Conviva Care Center, 4960 SW 72nd Avenue, Suite 406, Miami, Florida 33155 or (305) 662-5200, or the on-site HIPAA Coordinator (Center Administrator). If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at the above address or with the Secretary of the Federal Department of Health and Human Services at the address below. Be assured that you will not be retaliated against for filling a complaint.

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W., Room 509F
HHH Building
Washington, D.C. 20201

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing below, I acknowledge that I have received a copy of Conviva Care Center, LLC's HIPAA Notice of Privacy Practices that is effective _______, 2018.

____

Patient name (please print)

_______________________________________ _________________

Patient's Signature Date Date

If this form is signed by someone who is not the patient listed above (e.g. a parent/guardian/legal representative), please provide the signor's name and his or her authority to act for the patient.

Signed by: ___________________________

Authority to Sign on patient's behalf:

____

Internal Use Only

If this acknowledgement is not signed, please provide a description of your efforts in obtaining the signed acknowledgement and the reason the acknowledgment was not obtained.

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____

Print Name:

Date:

[Note - The following authorization can be incorporated into your standard intake paperwork where you currently get authorization to release patient information to payors, consent to treatment, etc.]

Authorization to Release Health Information

I understand that under state and federal law, I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used and given out for the purposes described on the HIPAA Notice of Privacy Practices (Notice) I have received. I authorize my health information to be used and given out by Conviva Care Center, LLC and its affiliated health care providers as explained in that Notice. For example, my information will be used and disclosed to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I understand that this information may relate to sensitive conditions (if any), including, but not limited to:

• Drug, alcohol or substance abuse;
• Psychological, psychiatric or other mental impairment(s) or developmental disabilities;
• Sickle cell anemia;
• Birth control and family planning;
• Records which may indicate the presence of communicable disease or non-communicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis;
• Genetic (inherited) diseases or tests.

I specifically authorize to the uses and disclosures of these sensitive conditions for treatment, payment, health care operations, and other purposes as explained in the Notice. I understand that the Notice explains how I can request restrictions to uses and disclosures of my information. I understand that my provider does not always have to agree to my requests.

I have read and understand the Notice containing a more complete description of the uses and disclosures of my health information. I understand that Conviva Care Center has the right to change its Notice from time to time and that I may contact Conviva at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name: ____

(Please Print)

______________________________ ___________________________
Patient's Signature **Date**

If this form is signed by someone who is not the patient listed above (e.g. a parent/guardian/legal representative), please provide the signor's name and his or her authority to act for the patient.

Signed by: ____________________
Authority to Sign on patient's behalf: