Exhibit A

Authorization for Use and/or Disclosure of Protected Health Information

PLASTIC SURGERY CENTER, P.A.
Authorization for Use and/or Disclosure of Protected Health Information

Patient Name	Birth Date	Social Security Number

1. I hereby authorize PLASTIC SURGERY CENTER, P.A., its employees, agents, and assigns (collectively, "PSC") to use and/or disclose the protected health information identified in Section 3, below, as set forth herein.

2. I authorize PSC to disclose the information identified in Section 3, below, to the following individuals:

_____
Name(s) of authorized person(s)

_____
Name(s) of authorized person(s)

3. The information which I am authorizing to be used and/or disclosed is (where applicable, identify the date of service or type of treatment):_____

_____

4. I authorize the information identified in Section 3, above, to be used and/or disclosed for the following purpose(s):

_____
If the request if initiated by the patient (or his or her personal representative) insert "at the request of patient" otherwise, describe the purpose of the use or disclosure. If the purpose relates to marketing, indicate whether PSC will receive remuneration.

5. This authorization will expire on _____or upon the occurrence of _____.
6. In signing this authorization, I understand and acknowledge the following (initial in the space provided):

_____ I understand that this authorization is voluntary and that I may refuse to sign it.

_____ I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

_____ I understand that I may revoke this authorization at any time by notifying PSC in writing of my intent to revoke this authorization, except to the extent that action has been taken in reliance on this authorization. Any notice of termination must be sent to the Privacy Officer, 1861 North Webb Road, Wichita, Kansas 67206.

_____ I understand that, unless otherwise revoked, this authorization will expire upon the date or event set forth in Section 5, above.

_____ I understand that once the disclosures authorized herein have been made, the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.

I, the undersigned, do hereby swear that I am the above-mentioned patient or a legal representative of the above-mentioned patient. I have read and understand the above information.

_____ _____
Date *Signature of Patient/Legal Representative*

_____ _____
Printed Name of Legal Representative *Description of Legal Representative's Relationship to Patient*

Exhibit B

Data Use Agreement

DATA USE AGREEMENT

This **DATA USE AGREEMENT** (the "Agreement"), is entered into this _____ day of _____ 20__, by and between **PLASTIC SURGERY CENTER, P.A.**, with an address at 1861 North Webb Road, Wichita, Kansas 67206 ("PSC"), and_____, a_____ _____("Recipient").

WHEREAS, PSC is a healthcare provider and is a covered entity for purposes of the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

WHEREAS, in the course of its business relationship with Recipient, it is necessary for PSC to disclose certain information which is considered "protected health information" for purposes of HIPAA; and

WHEREAS, the parties desire to enter into this Agreement to limit Recipient's use and disclosure of information disclosed to it by PSC in accordance with HIPAA.

NOW THEREFORE, in consideration of the foregoing recitations, the mutual covenants hereinafter set out and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. **Disclosures of Information in Limited Data Set.** PSC agrees to disclose protected health information to Recipient as necessary for recipient to carry out its [research/public health/health care operations] activities (the "Information"); provided, however, that the parties understand and agree that PSC will only disclose the Information in the form of a limited data set, as that term is defined by HIPAA. The parties understand and agree that PSC will only disclose the Information to those persons within Recipient's organization which are identified on Exhibit I, attached hereto and incorporated herein by this reference. The parties further understand and agree that Recipient has no ownership rights with respect to the Information.

2. **Recipient's Use and Disclosure of the Information.** Recipient agrees to only use and disclose the Information as necessary to carry out its [research/public health/health care operations] activities. Recipient agrees not to use or disclose the Information in any manner that would not be permitted by HIPAA or other relevant federal, state, or local law; provided, however, that in no event shall Recipient be allowed to use or disclose the Information in a manner which would not be allowed by PSC under federal, state, or local law. Recipient shall not attempt to re-identify any of the Information and shall not attempt to contact any individual who is the subject of the Information.

3. **Recipient's Agents.** Recipient agrees to ensure that any agents, including subcontractors, to whom it provides the Information, agree in writing to the same restrictions and conditions that apply to Recipient with respect to such Information. Recipient shall implement and maintain sanctions against agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation.

4. **Safeguards.** Recipient agrees to implement and utilize appropriate safeguards to prevent the use or disclosure of the Information other than as permitted by this Agreement or as required or permitted by law, which safeguards shall include, but not be limited to, limiting access to the Information to only those persons who require such access to perform their job function.

5. **Notification of Breach.** During the Term of this Agreement, Recipient shall notify PSC within five (5) days of any suspected or actual breach of security, intrusion, or unauthorized use or disclosure of the Information. Recipient shall take prompt corrective action to cure any such deficiencies and any action pertaining to such unauthorized disclosure that is required by applicable federal, state, or local law. If Recipient is unable to cure the breach within thirty (30) days of the notifying PSC of said breach, PSC shall terminate this Agreement or, if termination is not feasible, PSC shall report Recipient's breach or violation to the Secretary of the Department of Health and Human Services.

6. **Indemnification.** The parties agree to indemnify, defend and hold harmless each other and each other's respective employees, directors, officers, subcontractors, agents or other members of its Workforce (each of the foregoing hereinafter referred to as "Indemnified Party"), against all actual and direct losses suffered by the Indemnified Party and all liability to third parties arising from or in connection with any breach of this Agreement. The indemnification obligations set forth in this Section 6 shall survive the expiration or termination of this Agreement for any reason.

7. **Amendments; Waiver.** This Agreement may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed by authorized representatives of the parties. A waiver with respect to one event shall not be construed as continuing, or as a bar to or waiver of any right or remedy as to subsequent events.

8. **No Third Party Beneficiaries.** Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and the respective successors or assigns of the parties, any rights, remedies, obligations, or liabilities whatsoever.

9. **Notices.** Any notices to be given hereunder shall be made via U.S. Mail or express courier to the address given below, and/or (other than for the delivery of fees) via facsimile to the facsimile telephone numbers listed below.

If to PSC:

PLASTIC SURGERY CENTER, P.A.
1861 North Webb Road
Wichita, Kansas 67206
Fax: (316) 688-7543

with a copy to:

Hinkle Law Firm LLC
Attn: Laura D. Fent
1617 North Waterfront Parkway, Suite 400
Wichita, Kansas 67206
Fax: (316) 631-1718
E-mail: lfent@hinklaw.com

If to Recipient:

_____
_____
_____
Facsimile No. _____

with a copy to:

_____
_____
_____
Facsimile No. _____

Each party may change its address and that of its representative for notice by the giving of notice thereof in the manner herein above provided.

10. Counterparts. This Agreement may be executed in any number of counterparts (including execution by facsimile), each of which shall be deemed an original.

11. Contract Modification for Prospective Legal Events. In the event any state or federal laws or regulations, now existing or enacted or promulgated after the effective date of this Agreement, are interpreted by judicial decision, a regulatory agency or legal counsel to PSC in such a manner as to (i) indicate that the structure of this Agreement may be in violation of such laws or regulations, or (ii) materially reduce the benefits of this Agreement to either or both parties hereto, the parties shall amend this Agreement as necessary.

12. Governing Law. This Agreement shall be interpreted, construed, and governed according to the laws of the State of Kansas.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed as of the day, month and year first above written.

PLASTIC SURGERY CENTER, P.A.

By: _____ By: _____

Print Name: _____ Print Name: _____

Print Title: _____ Print Title: _____

Date: _____ Date: _____

EXHIBIT I

TO DATA USE AGREEMENT

LIST OF INDIVIDUALS ENTITLED TO RECEIVE INFORMATION

Exhibit C

Privacy Notice

PLASTIC SURGERY CENTER, P.A.
PRIVACY POLICY NOTICE TO CLIENTS

Effective: October 31, 2014

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 IS FOR YOUR INFORMATION. NO RESPONSE IS REQUIRED.

This Privacy Policy Notice to Clients is provided to you as a requirement of the Health Insurance Portability & Accountability Act of 1996 (HIPAA). It describes how we may use or disclose your protected health information (PHI) and certain rights you have with respect to your PHI. We are required by HIPAA to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI.

HOW WE MAY USE AND DISCLOSE YOUR PHI

The following categories describe different ways that we are permitted to use and disclose your PHI. To the extent state law requires your consent to these disclosures, we would not make the disclosure without first obtaining your consent. If state law does not require your consent, we are permitted to use and disclose your PHI for these purposes without a consent or authorization. For example, Kansas law requires disclosure of positive HIV or AIDS tests and other infectious diseases to certain public health officials and those who may come in contact with bodily fluids, such as other healthcare providers and law enforcement or corrections officers. State law also allows us to disclose HIV or AIDS information to a patient's spouse or partner who we have reason to believe is unaware of such exposure or risk of exposure. The information must be kept confidential by those to whom we are required or allowed to disclose it. Other state laws regarding disclosure include, but are not limited to, reporting abuse of children, reporting mental health or infectious diseases to the department of corrections, and requiring written consent for the disclosure of mental health and alcohol or substance abuse records in many circumstances. These state law requirements are state law specific examples of the following permitted uses of your PHI.

For Appointment Reminders and Treatment Alternatives: We may use your PHI to contact you to provide you appointment reminders and information about treatment alternatives, or other health-related benefits and services that may be of interest to you. For example, we may call you the day before your scheduled appointment to remind you about the appointment.

For Treatment: We may use and disclose your PHI to treat you. An example of a use of your PHI for your treatment purposes is recording information about you in a health record. An example of a disclosure for your treatment purposes is the consultation with another provider regarding your care.

For Payment: We may use and disclose your PHI for our payment purposes. An example of such a disclosure is providing your insurer information about services you received so that it will pay us or reimburse you for those services. We may also disclose your PHI to others as authorized by HIPAA for their payment purposes.

For Health Care Operations: We may use and disclose your PHI for various operational purposes. For example, your PHI may be disclosed to risk or quality improvement personnel to evaluate our performance in caring for you. In addition, we may disclose your PHI to others as authorized by HIPAA for their operational purposes.

To Others Involved in Your Healthcare: We have policies and procedures that provide for the release of information about your care or payment for such care to a member of your family, a relative, a close friend, or any other person involved in your care or payment for your care when you are not present or able to give authorization for the release of information. If you are present for such a disclosure (whether in person or on a telephone call), we will either seek your verbal agreement to the disclosure or provide you an opportunity to object to it.

As Required by Law: We may use or disclose your PHI to the extent we are required to do so by federal, state, or local law. For example, we may disclose your PHI for the following purposes: (i) judicial and administrative proceedings pursuant to legal authority; (ii) to report information related to victims of abuse, neglect or domestic violence; (iii) to assist law enforcement officials in their law enforcement duties; and/or (iv) to provide legally required notices of unauthorized access to or disclosure of your PHI.

For Public Health Activities: We may disclose your PHI for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability or for other health oversight activities authorized by law.

For Health and Safety: We may use or disclose your PHI if we, in good faith, believe it is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health or safety of others. Any disclosure, however, would only be made to someone reasonably able to help prevent or lessen the threat.

Correctional Institutions: We may disclose your PHI to a correctional institution or law enforcement official if you are in their custody if the disclosure is necessary for certain purposes, including the provision of your healthcare and the safety and health of others.

Business Associates: Information may be shared with third party "business associates" that perform various activities on our behalf. Whenever such an arrangement involves the use or disclosure of your PHI, we will have a written contract with such third party that contains terms designed to protect the privacy of your PHI.

Worker's Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We can use and disclose your PHI for the following other purposes: (i) organ donation; (ii) to coroners; (iii) research; and (iv) government functions. We may use or disclose your PHI, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. However, these are not uses or disclosures that we would typically make.

OTHER USES AND DISCLOSURES REQUIRE YOUR WRITTEN AUTHORIZATION

The following uses and disclosures of your PHI will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes; (ii) uses and disclosures of PHI for marketing purposes; and (iii) disclosures that constitute a sale of your PHI. Other uses and disclosures of health information not covered by this notice or the laws that apply to our office will be made only with your written authorization. You may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance on the use or disclosure permitted by the authorization. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written authorization. Of course, we are unable to take back any disclosures we have already made with your permission.

YOUR RIGHTS REGARDING YOUR PHI

Right to Request Restrictions: You have the right to request that we place restrictions on the way we use and disclose your PHI for treatment, payment or healthcare operations or as described in the section of this notice entitled *"To Others Involved in Your Healthcare."* You must make your request for restrictions in writing on the form provided by our office. However, we are not required to agree to these restrictions, except that we must comply with a requested restriction if (i) the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), except as otherwise required by law and (ii) the PHI pertains solely to a health care item or service for which we have been paid out of pocket in full. If we do agree to a requested restriction, we may not use or disclose your PHI in violation of that restriction, unless it is needed for an emergency.

Confidential Communications: You have the right to ask us to communicate with you about your PHI by alternative means or to alternative locations. You must make your confidential communication request in writing on the form provided by our office. We must accommodate any reasonable request for confidential communications.

Access to PHI: You have the right to look at or receive a copy of your PHI contained in a "designated record set," with a few exceptions. You must make your request in writing on the form provided by our office and provide us with the specific information we need to fulfill your request. We may deny your request in certain limited circumstances and in some cases, you may have the right to have the denial reviewed by a licensed health care professional who was not involved with the initial denial of the request.

Amendment of PHI: You have the right to request that we amend any PHI about you that is contained in a "designated record set" and which is incomplete or inaccurate. You must make your request for amendment in writing on the form provided by our office. If we agree that the original information was incomplete or inaccurate, we will correct our records. If we do not agree, you may submit a short statement of dispute, which we will include in any future disclosure of your PHI or, alternatively, you may request that we provide your request for amendment and the denial of such request with any future disclosures of the PHI at issue. We have the right to prepare a rebuttal to any statement of dispute submitted by you.

Accounting of Certain Disclosures: You have the right to request that we provide you with an accounting of certain disclosures we have made of your PHI by making a request in writing on the form provided by our office. The written request must state the time period desired for the accounting, which must be less than a 6-year period for paper records and which must be less than a 3-year period for electronic health records.

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.

To obtain the forms necessary to exercise your rights, contact the HIPAA Privacy Officer at (316) 688-7500. All completed request forms should be sent to PLASTIC SURGERY CENTER, P.A., Attn: HIPAA Privacy Officer, 1861 North Webb Road, Wichita, Kansas 67206.

We may change the terms of this notice at any time. The new notice will be effective for all PHI that we maintain, including PHI that was created or received prior to the date of such change. We will make any new Privacy Policy Notice to Clients available at our office whenever we make a material change in the privacy practices described in this notice. We are required to abide by the terms of the Privacy Policy Notice to Clients currently in effect.

Right to Receive Notice of a Breach: We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of unsecured PHI as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured PHI" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services ("DHHS") to render the PHI unusable, unreadable, and undecipherable to unauthorized users.

QUESTIONS AND COMPLAINTS

For additional information or if you have any questions regarding our privacy policy, please write to us at: PLASTIC SURGERY CENTER, P.A., Attn: HIPAA Privacy Officer, 1861 North Webb Road, Wichita, Kansas 67206 or call us at (316) 688-7500.

If you are concerned that your privacy rights have been violated, or if you disagree with a decision we made about access to your PHI, you may file a complaint with the HIPAA Privacy Officer at the above address or by phone at (316) 688-7500. You also have the right to file a complaint with the Secretary of DHHS. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred. Send your complaint to DHHS (OCR), 200 Independence Avenue, S.W., Washington D.C. 20201; or contact the OCR above at (877) 696-6775; or send the information to the following electronic message address: www.hhs.gov/ocr/privacy/hipaa/complaints. You may request a Health Information Privacy Complaint Form Packet at the above OCR office or you may obtain this form via the Internet at http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintpackage.pdf. You will not be penalized for filing a complaint.

Revised July 2013

Exhibit D

Request for Confidential Communications

PLASTIC SURGERY CENTER, P.A.
Request for Confidential Communications

Patient Name	Birth Date	Social Security Number

I understand that I have the right to ask that PLASTIC SURGERY CENTER, P.A. ("PSC") communicate with me on confidential matters by an alternative means (for example, telephone rather than mail) or to an alternative location (for example, my work address rather than my home address). I wish to exercise this right and hereby request that, in the future, communications to me about my Protected Health Information be made in the manner set forth below:

- I would like PSC to communicate with me in the following manner:
  - By telephone only
  - By mail only
  - By facsimile only
  - By e-mail only
  - Other _____
- I would like PSC to communicate with me at the following location (please identify the address, telephone number, facsimile number, or e-mail address at which you would like for us to communicate with you):_____
  _____

I understand that PSC may choose not to agree to the restriction(s) requested, but will notify me of its response to my request. I understand further that if my request is accepted, from this point forward all communications regarding me will be made in the manner requested above. Lastly, I recognize that electronic messaging is not a secure form of communication. Consequently, if I choose for PSC to communicate with me by e-mail, I understand that there are inherent privacy risks, and I am accepting these risks.

_____ _____
Signature of Patient /Legal Representative ***Date***

_____
Printed name and Description of Authority of Legal Representative

Response to Request for Confidential Communications

- ☐ We have received your request that we communicate with you by alternative means or at an alternate location. We have denied your request for the following reason:
  - ☐ We can not reasonably accommodate your request
  - ☐ Other_____
- ☐ We have received your request that we communicate with you by alternative means or at an alternate location. We have accepted your request and will follow the following process in communicating with you:

  _____

  _____

ORIGINAL — Medical File COPY — Patient

Exhibit E

Request for Additional Privacy Protections

PLASTIC SURGERY CENTER, P.A.
Request for Additional Privacy Protections

Patient Name	Birth Date	Social Security Number

Please check all that apply:

- ❑ I understand that, by law, PLASTIC SURGERY CENTER, P.A. ("PSC") is permitted to disclose certain information about my general condition or payment for my healthcare to family members, friends, etc. I hereby request that PSC restrict such disclosures in the following manner:

  _____

  _____

  Identify any family members, relatives, or other persons to whom you do not want PSC to disclose information

- ❑ I understand that, by law, PSC is permitted to use and disclose protected health information about me for treatment, payment and health care operations purposes. I hereby request that PSC restrict such uses and disclosures in the following manner:

  _____

  _____

  Identify the manner in which you desire such uses and disclosures to be restricted.

I understand that except as required by law, as further described in PSC's Privacy Policy Notice to Clients, PSC may choose not to agree to the restriction(s) requested, but will notify me of its response to my request.

_____ _____
Signature of Patient/Legal Representative *Date*

_____
Printed name and Description of Authority of Legal Representative

Response to Request for Additional Privacy Protections

PLASTIC SURGERY CENTER, P.A. has reviewed your Request for Additional Privacy Protections and has made the following determination with respect thereto:

- ❑ We received your request to place additional restrictions on disclosures of Protected Health Information ("PHI") to family members, friends, etc. and refuse to accept such restrictions.
- ❑ We received your request to place additional restrictions on disclosures of PHI to family members, friends, etc. and accept such restrictions. We will follow these restrictions unless we notify you otherwise or unless otherwise provided by law.
- ❑ We received your request to place additional restrictions on uses and disclosures of PHI for treatment, payment, and operations and refuse to accept such restrictions.
- ❑ We received your request to place additional restrictions on uses and disclosures of PHI for treatment, payment, and operations. We accept such restrictions outlined in the attached request and will follow them unless we notify you otherwise or unless otherwise provided by law.

Exhibit F

Request for Access to
Protected Health Information

PLASTIC SURGERY CENTER, P.A.
Request for Access to Protected Health Information

Patient Name	Birth Date	Social Security Number

You have the right to inspect, or to obtain a copy of your Protected Health Information maintained in the designated record set by PLASTIC SURGERY CENTER, P.A. ("PSC"). A "designated record set" includes medical records and billing information and information used to make decisions about you. It does not include (a) duplicate information maintained in other systems; (b) data collected and maintained for research; (c) data collected and maintained for peer review purposes; (d) psychotherapy notes; (g) information compiled in reasonable anticipation of litigation or administrative action; (h) employment records; (i) student records; and (j) source data interpreted or summarized in the individual's medical record (example: pathology slide and diagnostic film).

Your request for access must be made in writing using this form. If your request is granted, PSC will make every reasonable effort to provide the Protected Health Information requested in the format requested by you if it is readily available in such format, including electronic formats, if such information is maintained electronically. If it is not readily available in such a format, PSC will make every reasonable effort to provide access to the Protected Health Information in a legible, hard copy format or in such other form as agreed upon by you and PSC If the requested information is stored electronically but not readily available in the requested electronic format, PSC will provide such information in a readable electronic form agreed upon by you and PSC Your request may be denied under certain circumstances and, in some cases, you may have a right to a review of such denial.

PSC may provide you with a summary of the Protected Health Information requested, in lieu of providing access to the Protected Health Information, or may provide an explanation of the Protected Health Information to which access has been provided, if you agree in advance to the summary and explanation and to the fees imposed for such summary or explanation.

I hereby request that PSC copy the following records:

_____

Description of records to be copied including treatment dates

I hereby request PSC transmit the requested records to (check me or clearly identify a person you wish to designate to receive such records): me: _____ designated individual:_____

I hereby request PSC to transmit the requested records to me or my designated individual at: _____

_____

In signing this request, I understand and agree to the following (initial in the space provided):

_____ I agree to pay for the cost of copying the requested records; or

_____ PSC has advised me of the fee it will assess to provide a summary and explanation of the requested records and I agree to receipt of a summary and explanation of the requested records in lieu of a copy of such records and agree to pay the agreed upon fee for such summary and explanation.

_____ _____

Signature of Patient/Legal Representative *Description of Legal Representative's Authority to Act for Patient*

_____ _____

Printed Name of Legal Representative *Date*

ORIGINAL — Medical File COPY — Patient

Exhibit G

Response to Request for Access

PLASTIC SURGERY CENTER, P.A.
Response to Request for Access

Patient Name	Birth Date	Social Security Number

PLASTIC SURGERY CENTER, P.A. ("PSC") has reviewed your Request for Access and has made the following determination with respect thereto:

- ❑ We have granted your Request for Access and have attached the requested information to this form.

- ❑ We have reviewed your Request for Access and denied it because:
  - ❑ The information you requested is psychotherapy notes.
  - ❑ The information you requested was compiled in anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
  - ❑ The information you requested was obtained under a promise of confidentiality and the requested access would be reasonably likely to reveal the source of such information.

  You have no right to a review of our denial for the reason(s) stated above.

- ❑ We have reviewed your Request for Access and denied it because:
  - ❑ A licensed health care professional has determined, in the exercise of his/her professional judgment, that the requested access is reasonably likely to endanger the life or physical safety of you or another person;
  - ❑ The information requested makes reference to another person (other than a health care provider) and a licensed health care professional has determined, in the exercise of his/her professional judgment, that the requested access is reasonably likely to cause substantial harm to such other person;
  - ❑ The request was made by a personal representative and a licensed health care professional has determined, in the exercise of his/her professional judgment, that providing access to such personal representative is reasonably likely to cause substantial harm to you or another person.

  You have the right to request a review of this denial by sending a written statement of your disagreement and your reason(s) for believing the request should be granted to PLASTIC SURGERY CENTER, P.A., 1861 North Webb Road, Wichita, Kansas 67206. Your request for review will be considered by a licensed health care professional that had no direct involvement with the initial decision not to grant your Request for Access and you will be notified of such individual's decision in writing.

If you wish to file a complaint about our denial, you can file a written complaint with PSC by mailing it to PLASTIC SURGERY CENTER, P.A., Attention: Privacy Officer, 1861 North Webb Road, Wichita, Kansas 67206 or calling us at (316) 688-7500. PSC will review the complaint and inform you of the resolution.

You also have the right to file a complaint with the Secretary of the Department of Health and Human Services. Send your written complaint within 180 days of this denial to: Medical Privacy, Complaint Division, Office for Civil Rights, United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington DC, 20201.

Exhibit H

Request for Amendment of
Protected Health Information

PLASTIC SURGERY CENTER, P.A.
Request for Amendment of Protected Health Information

Patient Name	Birth Date	Social Security Number

I understand I have the right to request an amendment to Protected Health Information created by PLASTIC SURGERY CENTER, P.A. ("PSC") and maintained in a designated record set. PSC has the right to deny my request for amendment to the extent allowed by law. Pursuant to that right, I hereby request PSC to make the following amendment to my Protected Health Information record:

_____

_____

_____

_____

State the specified item to be changed by date and description and state the way in which you wish the item to be changed

The reasons I am requesting the change are as follows:

_____

_____

_____

_____

_____
Signature of Patient/Legal Representative

_____
Printed Name of Legal Representative

_____
Description of Legal Representative's Authority to Act for Patient

_____
Date

ORIGINAL — Medical File COPY — Patient

Exhibit I

Response to Request for Amendment

PLASTIC SURGERY CENTER, P.A.
Response to Request for Amendment

Patient Name	Birth Date	Social Security Number

PLASTIC SURGERY CENTER, P.A. ("PSC") has reviewed your Request for Amendment of Protected Health Information and has made the following determination with respect thereto:

- ❑ We have granted the Request for Amendment of Protected Health Information. We will make all the corrections to the affected records and will make reasonable efforts to inform our business associates and others that have received the information of the amendment so they will have the correction. Within ten (10) days of receipt of this Response to Request for Amendment, you must provide us with a list of persons who received the original record and with whom the amendment needs to be shared. This information should be sent to PLASTIC SURGERY CENTER, P.A., Attention Privacy Officer, 1861 North Webb Road, Wichita, Kansas 67206.

- ❑ We have reviewed your Request for Amendment and denied it because:
  - ❑ The record is complete and accurate.
  - ❑ The information was not created by Plastic Surgery Center, P.A
  - ❑ The information is not part of the designated record set.
  - ❑ Other_____

You have the right to file a written statement disagreeing with our denial of your request by sending it to PLASTIC SURGERY CENTER, P.A., Attention Privacy Officer, 1861 North Webb Road, Wichita, Kansas 67206. If you file a statement of disagreement, we will prepare a rebuttal statement, add it to the disputed record, and provide you with a copy. If you submit a statement of disagreement, the Request for Amendment of Protected Health Information, the Response to the Request for Amendment, the statement of disagreement, and the rebuttal statement will become part of your designated record set and will be included in future disclosures of the record.

If you do not submit a statement of disagreement, you may request that we include your Request for Amendment of Protected Health Information and our Response to Request for Amendment with future disclosures of the relevant record. You should note that we will include such documents with future disclosures **only if** you affirmatively request that they be included.

- ❑ Please check here if you do not wish to submit a written statement of disagreement, but do wish to have your Request for Amendment of Protected Health Information and our Response to Request for Amendment included in future disclosures and send a copy of this form back to PLASTIC SURGERY CENTER, P.A., Attention Privacy Officer, 1861 North Webb Road, Wichita, Kansas 67206.

If you wish to file a complaint about our denial, you can file a written complaint with PSC by mailing it to PLASTIC SURGERY CENTER, P.A., Attention Privacy Officer, 1861 North Webb Road, Wichita, Kansas 67206 or by calling us at (316) 688-7500. PSC will review the complaint and inform you of the resolution.

You also have the right to file a complaint with the Secretary of the Department of Health and Human Services. Send your written complaint within 180 days of this denial to: Medical Privacy, Complaint Division, Office for Civil Rights, United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington DC, 20201.

Exhibit J

Request for Accounting of Disclosures

PLASTIC SURGERY CENTER, P.A.
Request for Accounting of Disclosures

Patient Name	Birth Date	Social Security Number

I understand I have the right to request an accounting of certain disclosures of protected health information made by PLASTIC SURGERY CENTER, P.A. ("PSC"). I understand that an accounting of disclosures will NOT include disclosures:

- to carry out treatment, payment, or health care operations (except that an accounting of disclosures through an electronic health record must include disclosures for purposes of treatment, payment and health care operations)
- to myself or my personal representative
- made pursuant to a valid authorization
- incidental to a permitted or required disclosure
- to persons involved in my care or the payment for my care
- for national security or intelligence purposes
- to correctional institutions or law enforcement officials
- as part of a limited data set
- made before April 14, 2003

I understand that the accounting of paper records will include disclosures made within the last six years, unless I request a shorter time period. I understand that an accounting of electronic health records will include disclosures made within the last three years, unless I request a shorter time period.

I understand that I am entitled to receive one (1) accounting of disclosures without charge during a twelve (12) month period. In the event I receive more than one (1) accounting of disclosures during a twelve (12) month period, I understand that PSC may charge me a reasonable, cost-based fee for such accounting. By signing below, I am agreeing to any charges which may be imposed as a result of this request.

Pursuant to that right, I hereby request that PSC send an accounting of disclosures of my protected health information during the last _____*(designate months or years)* to my attention at the following address:

_____

_____

_____

_____

_____
Signature of Patient/ Legal Representative

_____
Printed Name of Legal Representative

_____
Description of Legal Representative's Authority to Act for Patient

_____
Date

Exhibit K

Complaint Form

PLASTIC SURGERY CENTER, P.A.
Complaint Form

If you have a complaint about the privacy policies and procedures of PLASTIC SURGERY CENTER, P.A. ("PSC") or feel that PSC has violated your privacy rights by failing to comply with its privacy policies and procedures, you should complete this form and return it to PLASTIC SURGERY CENTER, P.A., Attn: Privacy Officer, 1861 North Webb Road, Wichita, Kansas 67206.

1. Name of person making the complaint_____

2. Date and location of the alleged incident (if applicable)_____

3. Names of any other persons involved with the alleged incident (if applicable)_____

_____

4. A detailed description of your complaint, including a description of any harm to you_____

_____

_____

_____

I, the undersigned, do hereby swear that the foregoing statement(s) are true and correct.

_____ _____

Date *Signature of Person Filing Complaint*

Exhibit L

Employee Acknowledgement of Receipt of the HIPAA Privacy Manual

EMPLOYEE ACKNOWLEDGMENT OF
RECEIPT OF THE HIPAA PRIVACY MANUAL

I have been offered a copy of, and have access to, the HIPAA Privacy Manual of PLASTIC SURGERY CENTER, P.A. ("PSC"). If I have questions about any of the information contained in such manual, I understand that I may discuss such questions with PSC's Privacy Officer at any time. I understand that I am responsible for complying with the policy and procedures set forth in the manual and may be subjected to disciplinary action for violations of such policy and procedures.

Name (printed):_____

Signature: _____ Date:_____

Exhibit M

Disclosure Log

PATIENT HEALTH INFORMATION (PHI)
DISCLOSURE LOG

Patient's Name	Requesting Entity (Name/Address)	Record Requested	Purpose for Disclosure	Date Requested	Date Sent/ Initials of Sender

Exhibit N

(Reserved)

Exhibit O

Business Associate Agreement

Revised August 2013

BUSINESS ASSOCIATE AGREEMENT

This **BUSINESS ASSOCIATE AGREEMENT** (this "Agreement") is entered into _____, 20____ (the "Effective Date"), by and between _____, a _____ ("Business Associate"), and PLASTIC SURGERY CENTER, P.A., a Kansas professional corporation ("Covered Entity") (each a "Party" and collectively the "Parties").

WHEREAS, Covered Entity desires that Business Associate perform the services for or on behalf of Covered Entity as specified in that certain _____, dated _____, by and between Covered Entity and Business Associate (the "Services Agreement");

WHEREAS, Covered Entity is a Covered Entity for purposes of the Health Insurance Portability and Accountability Act of 1996, as amended from time-to-time ("HIPAA") and, as such, is permitted to Use or Disclose Protected Health Information only in accordance with HIPAA and the HIPAA Rules;

WHEREAS, Business Associate, as an entity which, for purposes of the Services Agreement, will act on behalf of Covered Entity and assist in the performance of certain functions or activities involving the Use and/or Disclosure of Protected Health Information is considered a Business Associate of Covered Entity for purposes of HIPAA; and

WHEREAS, the Parties are committed to complying with HIPAA and desire to enter into an agreement setting forth the terms and conditions pursuant to which Protected Health Information will be handled by Business Associate.

NOW THEREFORE, in consideration of the foregoing recitations, the mutual covenants hereinafter set out and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

ARTICLE I
DEFINITIONS

1.1 Definitions. In addition to other terms defined in this Agreement, the following terms whenever used in this Agreement with the first letter of each word capitalized shall have only the meanings set forth below, unless such meanings are expressly modified, limited, or expanded elsewhere herein:

(a) Business Associate. The term "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR § 160.103, and in reference to the Party to this Agreement, shall mean _____.

(b) Covered Entity. The term "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR § 160.103, and in reference to the Party to this Agreement, shall mean Plastic Surgery Center, P.A.

(c) HIPAA Rules. The term "HIPAA Rules" shall mean the privacy, security, breach notification, and enforcement rules at 45 CFR Part 160 and Part 164.

(d) PHI. The term "PHI" shall mean Protected Health Information. PHI and Protected Health Information are used interchangeably in this Agreement.

1.2 Other HIPAA Definitions. In addition to the definitions provided in Section 1.1 above, the following capitalized terms, whenever used in this Agreement, shall have the meanings set forth in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure (and variations thereof), Health Care

Operations, Individual, Limited Data Set, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, Use (and variations thereof), and Workforce.

ARTICLE II
OBLIGATIONS OF THE BUSINESS ASSOCIATE

2.1 Duties of Business Associate. Business Associate agrees to perform the services for or on behalf of Covered Entity as specified in the Services Agreement.

2.2 Not to Use or Disclose PHI Unless Permitted. Business Associate agrees not to Use or Disclose PHI other than: (i) as permitted or required by this Agreement and/or the Services Agreement; (ii) as Required By Law; and/or (iii) for Business Associate's proper management as long as Business Associate obtains reasonable assurances that PHI will be held confidentially.

2.3 Appropriate Safeguards. Business Associate shall use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164, including, without limitation, provisions relating to: (i) administrative safeguards (45 CFR § 164.308); (ii) physical safeguards (45 CFR § 164.310); (iii) technical safeguards (45 CFR § 164.312); and/or (iv) policies and documentation (45 CFR § 164.316). Without limiting any other requirements set forth in this Agreement and/or the Services Agreement, Business Associate agrees that it (a) will protect and safeguard from any verbal and written Disclosure all confidential information regardless of the type of media on which it is stored (e.g., paper, fiche, etc.) with which it may come into contact in accordance with applicable statutes and regulations, including, but not limited to HIPAA; (b) implement and maintain appropriate policies and procedures to protect and safeguard PHI; and (c) use appropriate safeguards to prevent Use or Disclosure of PHI other than as permitted by this Agreement and/or the Services Agreement and/or Required By Law. Business Associate acknowledges that Covered Entity is relying on the administrative, physical, and security safeguards of Business Associate in selecting Business Associate to provide services.

2.4 Reporting of Improper Use or Disclosure; Notification of Breach. During the term of this Agreement, Business Associate shall notify Covered Entity within twenty-four (24) hours of any suspected or actual Breach of security, intrusion, or unauthorized Use or Disclosure of PHI and/or any actual or suspected Use or Disclosure of PHI in violation of this Agreement and/or any applicable federal or state laws or regulations, including, without limitation, unsecured PHI in accordance with 45 CFR § 164.410. To the extent possible, Business Associate shall provide Covered Entity with the identity of each Individual affected by the Use and/or Disclosure. Business Associate shall (i) establish procedures for mitigating, to the greatest extent possible, any deleterious effects from any improper Use and/or Disclosure of PHI; and (ii) take prompt corrective action to cure any such deficiencies and any action pertaining to such unauthorized Disclosure that is required by applicable federal and state laws and regulations.

2.5 Agents of Business Associate. In accordance with 45 CFR § 164.502(e)(1)(ii) and 45 CFR § 164.308(b)(2), if applicable, Business Associate shall require all of its Subcontractors that create, receive, maintain, transmit, Use, or have access to PHI on behalf of Business Associate to agree to the same restrictions, conditions, and requirements that apply to Business Associate with respect to PHI hereunder. Business Associate shall implement and maintain sanctions against Subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation.

2.6 Access to PHI. Business Associate shall make PHI maintained by Business Associate or its Subcontractors in a Designated Record Set available to Covered Entity for inspection and copying within ten (10) days of a request by Covered Entity in order to enable Covered Entity to fulfill its obligations under HIPAA, including, but not limited to, its obligation to provide Individuals with access to their Protected Health Information maintained in a Designated Record Set pursuant to CFR 45 § 164.524. In addition, Business Associate shall, within fourteen (14) days of receipt of written request by Covered Entity, make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the Use and/or Disclosure of PHI for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of this

Agreement and/or the Services Agreement. If any Individual requests access to their PHI directly from Business Associate or its Subcontractors, Business Associate must notify Covered Entity in writing within five (5) days of the request. Any response to such request shall be the responsibility of Covered Entity and under no circumstance should Business Associate respond to such request.

2.7 Amendment to PHI. Within ten (10) days of receipt of a request from Covered Entity for an amendment of PHI or a record about an Individual maintained in a Designated Record Set, Business Associate or its Subcontractors shall make such PHI available to Covered Entity for amendment and shall incorporate any such amendment to enable Covered Entity to fulfill its obligations under HIPAA, including, but not limited to, its obligation pursuant to 45 CFR § 164.526 to provide Individuals with the right to request an amendment to Protected Health Information that is maintained in a Designated Record Set and which is inaccurate or incomplete. If any Individual requests an amendment of PHI directly from Business Associate or its Subcontractors, Business Associate must notify Covered Entity in writing within five (5) days of the request. Any response to such request shall be the responsibility of Covered Entity and under no circumstance should Business Associate respond to such request.

2.8 Accounting Rights. Business Associate shall account for all Disclosures of PHI made by it and its Subcontractors as necessary to satisfy Covered Entity's obligations under 45 CFR § 164.528 by documenting the date of the request, the requestor's name, the date of the Disclosure, PHI Disclosed, the purpose for the Disclosure, the name of the recipient of the information, and the name of the person making the Disclosure; provided, however, that Business Associate shall not be required to account for the following Disclosures:

(a) To carry out treatment, payment, and Health Care Operations as provided in 45 CFR 164.506;

(b) To Individuals of their own PHI as provided for in 45 CFR 164.502;

(c) Incidental Disclosures as provided for in 45 CFR 164.502;

(d) Made pursuant to an authorization as provided for in 45 CFR 164.508;

(e) To persons involved in the Individual's care or for other notification purposes as provided for in 45 CFR 164.510;

(f) For national security or intelligence purposes as provided for in 45 CFR 164.512(k)(2);

(g) To correctional institutions or law enforcement officials as provided for in 45 CFR 164.412(k)(5);

(h) As part of a Limited Data Set in accordance with 45 CFR 164.514(e); or

(i) That occurred prior to April 14, 2003.

The exception set forth in Section 2.8(a) above will not apply to Disclosures through an "electronic health record" or "EHR" (as that term is defined by HIPAA). Accountings of Disclosures through an EHR must include Disclosures for purposes of treatment, payment and Health Care Operations. The format for accountings of PHI maintained in an EHR will be consistent with regulations and guidance issued by the Secretary. Within ten (10) days of notice by Covered Entity of its receipt of a request for an accounting of Disclosures of PHI from an Individual, Business Associate and its Subcontractors shall make available to Covered Entity the information required to provide the requested accounting and fulfill its obligations under HIPAA, including, but not limited to its obligations to provide Individuals with the right to request an accounting of Disclosures. If any Individual requests an accounting of Disclosures directly from Business Associate or its Subcontractors, Business Associate must notify Covered Entity in writing within five (5) days of the request. Any response to such request shall be the responsibility of Covered Entity and under no circumstance should Business Associate respond to such request.

2.9 **Covered Entity Health Care Operations**. To the extent Business Associate is to carry out one (1) or more of Covered Entity's obligation(s) under Subpart E of 45 CFR 164, Business Associate agrees to comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s).

2.10 **Governmental Access to Records**. Business Associate shall make its internal practices, books and records relating to the Use and Disclosure of PHI available to the Secretary for purposes of determining Business Associate's compliance with HIPAA. Business Associate shall provide to Covered Entity a copy of any PHI that it provides to the Secretary concurrently with providing such information to the Secretary.

2.11 **Data Ownership**. Business Associate acknowledges that Business Associate has no ownership rights with respect to PHI.

2.12 **Compliance with HIPAA**. In addition to, and not in lieu of, the other terms and conditions of this Agreement, Business Associate shall comply with the HIPAA Rules, as required by such HIPAA Rules, including, without limitation, 45 CFR § 160.102 and 45 CFR § 164.302.

2.13 **Insurance**. Unless greater coverage is required under any other agreement between Covered Entity and Business Associate for the provision of services related to this Agreement, Business Associate shall maintain or cause to be maintained the following insurance covering itself and each Subcontractor, if any, through whom Business Associate provides services; (i) a policy of commercial general liability and property damage insurance, and electronic data processing insurance, with limits of liability not less than two million dollars ($2,000,000) per occurrence and two million dollars ($2,000,000) annual aggregate and (ii) such other insurance or self insurance as shall be necessary to insure it against any claim or claims for damages arising under this Agreement, and/or the Services Agreement, or from violating Business Associate's own obligations under HIPAA, including but not limited to, claims or the imposition of administrative penalties and fines on Business Associate or its Subcontractors, if any, arising from the loss, theft, or unauthorized Use or Disclosure of PHI. Such insurance coverage shall apply to all site(s) of Business Associate and to all services provided by Business Associate or any Subcontractors or under this Agreement and/or the Services Agreement.

ARTICLE III
PERMITTED USES AND DISCLOSURES

3.1 **Services Agreement**. Business Associate may only Use or Disclose PHI as necessary to perform the services for or on behalf of Covered Entity as specified in the Services Agreement.

3.2 **Required By Law**. Business Associate may Use or Disclose PHI as Required By Law.

3.3 **Minimum Necessary**. Business Associate agrees to make Uses and Disclosures and requests for PHI consistent with Covered Entity's Minimum Necessary policies and procedures.

3.4 **Consistent With Covered Entity's Requirements**. Business Associate may not Use or Disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by Covered Entity, except for the specific Uses and Disclosures set forth in Sections 3.5 and 3.6 below.

3.5 **[●***Optional Section***●] [● Management and Administration**. (a) Business Associate may Use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of Business Associate. (b) Business Associate may Disclose PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided the Disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is Disclosed that the information will remain confidential and Used or further Disclosed only as Required By Law or for the purposes for which it was Disclosed to the person, and the person notified Business Associate of any instances of which it is aware in which the confidentiality of the information has been Breached. **●]**

3.6 **[●*Optional Section*●] Data Aggregation**. **[●**Business Associate may provide Data Aggregation services relating to the Health Care Operations of Covered Entity. **●]**

ARTICLE IV
REPRESENTATIONS AND WARRANTIES

Business Associate represents and warrants to Covered Entity as follows:

4.1 **No Violation**. That neither the execution of this Agreement, nor its performance hereunder, will directly or indirectly violate or interfere with the terms of another agreement to which it is a party, or give any governmental entity the right to suspend, terminate, or modify any of its governmental authorizations or assets required for its performance hereunder. Business Associate further represents and warrants that it will not enter into any agreement the execution and/or performance of which would violate or interfere with this Agreement.

4.2 **Notification of Workforce**. That all of its employees, agents, representatives and members of its Workforce, whose services may be used to fulfill obligations under this Agreement and/or the Services Agreement are or shall be appropriately informed of the terms of this Agreement and/or the Services Agreement and are under legal obligation to it by contract or otherwise, sufficient to enable it to fully comply with all provisions of this Agreement and/or the Services Agreement.

4.3 **Federal and State Healthcare Programs**. That neither it, nor its shareholders, stockholders, members, managers, directors, officers, agents, employees or members of its Workforce have been excluded or served a notice of exclusion or have been served with a notice of proposed exclusion, or have committed any acts which are cause for exclusion, from participation in, or had any sanctions, or civil or criminal penalties imposed under, any federal or state healthcare program, including but not limited to Medicare or Medicaid, or have been convicted, under federal or state law (including without limitation a plea of nolo contendere or participation in a first offender deterred adjudication or other arrangement whereby a judgment of conviction has been withheld), of a criminal offense related to (a) the neglect or abuse of a patient, (b) the delivery of an item or service, including the performance of management or administrative services related to the delivery of an item or service, under a federal or state healthcare program, (c) fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a healthcare item or service or with respect to any act or omission in any program operated by or financed in whole or in part by any federal, state or local government agency, (d) the unlawful, manufacture, distribution, prescription or dispensing of a controlled substance, or (e) interference with or obstruction of any investigation into any criminal offense described in (a) through (d) above. Business Associate further agrees to notify Covered Entity immediately after becoming aware that any of the foregoing representation and warranties may be inaccurate or may become incorrect.

ARTICLE V
TERMS AND TERMINATION

5.1 **Term**. This Agreement shall become effective on the Effective Date and shall continue in effect until terminated as provided in this Article V. In addition, the provisions and requirements of Section 5.4 below shall survive the expiration or other termination of this Agreement for any reason.

5.2 **Breach by Business Associate**. Upon the breach by Business Associate of any provision of this Agreement, Covered Entity shall take the following steps: (i) provide Business Associate with written notice of the existence of an alleged breach and an opportunity to cure said breach within fourteen (14) days of receipt of such notice; (ii) in the event Business Associate does not timely cure the breach, Covered Entity may elect to take steps to cure the breach; and (iii) if Business Associate does not cure the breach and Covered Entity cannot or does not cure the breach, Covered Entity shall either terminate this Agreement or, if such termination is not feasible, shall report Business Associate's breach to the Secretary.

5.3 **Mutual Termination**. This Agreement may be terminated upon mutual agreement of the parties or by one Party providing the other Party with sixty (60) days written notice of its intent to terminate.

5.4 [●*Option 1 – If the Business Associate is to return or destroy all PHI upon termination*●] **[●Effect of Termination**. Upon the termination of this Agreement and/or the Services Agreement for any reason, Business Associate shall return all of PHI that it or its Subcontractors maintain in any form, and shall retain no copies of such PHI. ●]

5.5 [●*Option 2 – If the agreement authorizes Business Associate to Use or Disclose PHI for its own management and administration or to carry out its legal responsibilities and the Business Associate needs to retain PHI for such purposes after termination*●] **[●Effect of Termination**. Upon termination of this Agreement for any reason, Business Associate, with respect to PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, shall:

(a) Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

(b) Return to Covered Entity **[●***or, if agreed to by Covered Entity, destroy***●]** the remaining PHI that the Business Associate still maintains in any form;

(c) Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI to prevent Use or Disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate retains the PHI;

(d) Not Use or Disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at Section 3.5 (Management and Administration) which applied prior to termination; and

(e) Return to Covered Entity **[●***of, if agreed to by Covered Entity, destroy***●]** the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities. **●]**

ARTICLE VI
INDEMNIFICATION

6.1 **Indemnification**. Business Associate agrees to indemnify, defend and hold harmless Covered Entity and its employees, directors, officers, stockholders, Subcontractors, agents or other members of its Workforce against all actual and direct losses suffered by Covered Entity and all liability to third parties arising from or in connection with any breach of this Agreement or of any warranty hereunder or from any negligence or wrongful acts or omissions, including failure to perform its obligations under HIPAA, by Business Associate or its employees, directors, officers, stockholders, Subcontractors, agents or other members of its Workforce. Accordingly, on demand, Business Associate shall reimburse Covered Entity for any and all actual and direct losses, liabilities, lost profits, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be imposed upon Covered Entity by reason of any suit, claim, action, proceeding or demand by any third party which results from Business Associate's breach hereunder. Business Associate's obligation to indemnify Covered Entity shall survive the expiration or termination of this Agreement for any reason.

ARTICLE VII
MISCELLANEOUS

7.1 **HIPAA Construction**.

(a) A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

(b) Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

7.2 **Amendments; Waiver**. This Agreement may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed by authorized representatives of the Parties. A waiver with respect to one event shall not be construed as continuing, or as a bar to or waiver of any right or remedy as to subsequent events.

7.3 **Amendment to Comply with Law**. The Parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Agreement may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA and other applicable laws relating to the security or privacy of PHI, including, without limitation, the HIPAA Rules. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Agreement embodying written assurances consistent with the standards and requirements of HIPAA, the HIPAA Rules, and/or other applicable laws. Covered Entity may terminate this Agreement upon thirty (30) days written notice in the event (i) Business Associate does not promptly enter into negotiations to amend this Agreement when requested by Covered Entity to do so pursuant to this Section 7.3; or (ii) Business Associate refuses to enter into an amendment to this Agreement providing assurances regarding the safeguarding of PHI that Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA, the HIPAA Rules, and/or other applicable laws.

7.4 **No Third Party Beneficiaries**. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

7.5 **Notices**. All notices required or permitted under this Agreement shall be in writing and shall be deemed effective: (a) upon delivery, if delivered in person, or documented refusal to accept such delivery, whereupon such service shall be deemed complete; (b) one (1) day after delivery to Federal Express or other similar courier service, marked for next day delivery, addressed as set forth below; (c) three (3) days after deposit in United States Mail if sent by registered or certified mail, return receipt requested, addressed as set forth below; or (d) upon being sent by facsimile or electronic message transmission (including pdf), if confirmed by sending a copy by any other method specified herein, addressed as set forth below. The notice addresses of the parties are as follows:

If to Business Associate:

_____
_____
_____
Attention:_____
Fax:_____
Email: _____

with a copy to:

_____
_____
_____
Attention:_____
Fax:_____
Email: _____

If to Covered Entity:

Plastic Surgery Center, P.A.
1861 North Webb Road
Wichita, Kansas 67206

Attention:_____
Fax: (316) 688-7500
Email: _____

with a copy to:

Laura D. Fent
Hinkle Law Firm LLC
1617 North Waterfront Parkway, Suite 400
Wichita, Kansas 67206
Fax: (316) 631-1718
E-mail: lfent@hinklaw.com

Either party hereto may change the name and address of the designee to whom its notice shall be sent by giving written notice of such change to the other party hereto in the manner above provided, at least five (5) days prior to the effective date of such notice. Any legal counsel, as designated above, or by any party by written notice to the other party, is authorized to give notices under this Agreement on behalf of its respective client.

7.6 Counterparts; Facsimile Signatures. This Agreement may be executed in counterparts, all of which together shall constitute an agreement binding on all the parties hereto, notwithstanding that all such parties are not signatories to the original or the same counterpart. Facsimile signatures of the parties hereto shall be binding.

7.7 Governing Law; Venue. This Agreement shall be construed in accordance with and governed by the laws of the State of Kansas, without regard to its principles of conflict of laws. Any legal action brought to enforce or construe this Agreement shall be brought in the courts located in Sedgwick County, Kansas, and the parties hereby agree to the jurisdiction of such courts and agree that they will not invoke the doctrine of *forum non conveniens* or other similar defenses.

7.8 Incorporation of Recitals. The recitals set forth at the beginning of this Agreement are hereby incorporated into this Agreement as if fully set forth herein.

7.9 Integration. This Agreement sets forth the entire understanding between the Parties with respect to the subject matter hereof and cannot be amended except by a writing signed by both Parties. This Agreement contains the entire agreement among the parties and supersedes all prior discussions, agreements, arrangements and understandings relating to the subject matter hereof. This Agreement supersedes any and all prior business associate agreements by and between Covered Entity and Business Associate.

Signatures follow on the next page.

IN WITNESS WHEREOF, the undersigned have caused this Business Associate Agreement to be duly executed as of the day, month and year first-above written.

PLASTIC SURGERY CENTER, P.A. **_____**

By: _____
Name: _____
Title: _____

"Covered Entity"

By: _____
Name: _____
Date: _____

"Business Associate"

Exhibit P

Confidentiality Agreement

CONFIDENTIALITY AGREEMENT

In performing services on behalf of PLASTIC SURGERY CENTER, P.A. ("PSC"), the undersigned may receive, create or have access to confidential patient information and financial information of PSC ("Confidential Information"). In acknowledgment of this, the undersigned agrees to the following:

1. I understand that I have no right or ownership interest in any Confidential Information which I may create, receive, or access.

2. I understand that my obligations under this Agreement will continue after termination of my relationship (employment or otherwise) with PSC

3. The use and disclosure of Confidential Information is governed by federal and state laws and regulations as well as PSC's policies and procedures. The purpose of these specific requirements is to guarantee that Confidential Information remains confidential, *i.e.*, such information shall be used and disclosed only as necessary to accomplish PSC's mission. I agree to familiarize myself with and adhere to all of these requirements concerning Confidential Information.

4. If I have any question concerning whether certain information constitutes Confidential Information, I will bring the matter to the attention of the Privacy Officer for direction.

5. I will use, disclose and access Confidential Information only to the extent necessary to perform my assigned function on behalf of PSC Such use and disclosure shall be in a manner consistent with applicable policies and procedures of PSC My use or disclosure of Confidential Information for any reason other than the performance of my assigned function or my failure to conform to applicable policies and procedures shall constitute misuse of Confidential Information. I understand that any misuse of Confidential Information may be grounds for discipline (up to and including termination of my employment or other relationship with PSC) and/or the initiation of legal action against me.

6. If I have any question concerning whether I am permitted to use or disclose certain Confidential Information in a particular manner, I will bring the matter to the attention of the Privacy Officer for direction. If I have any question concerning the application of a particular policy or procedure to a particular use or disclosure of Confidential Information, I will bring the matter to the attention of the Privacy Officer for direction.

7. I will appropriately safeguard Confidential Information so as to prevent any inappropriate use or disclosure of such information. If I have reason to believe the confidentiality of information may have been compromised, I will report such concerns to the Privacy Officer as soon as possible.

By signing this document, I hereby certify that I have reviewed the foregoing Confidentiality Agreement, have been provided with an opportunity to ask questions concerning its terms, and understand the duties and obligations it imposes on me. I hereby agree to the duties and obligations as stated in this Confidentiality Agreement.

_____ _____

Signature Date

Exhibit Q

Job Description of Privacy Officer

JOB DESCRIPTION FOR

PRIVACY OFFICER

Position Title: Privacy Officer

General Purpose: The Privacy Officer shall be appointed by, and shall report to, the **Board** of PSC (the "**Board**"). The Privacy Officer oversees all activities related to compliance with federal regulations governing the privacy of health information. This includes the development, implementation, and maintenance of policies and procedures related to the privacy of and access to patient health information and compliance with federal and state information privacy laws.

Responsibilities:

- Provides leadership to PSC's committees, work groups, and task forces charged with creating and implementing an enterprise-wide privacy program.
- Develops privacy policies and procedures consistent with applicable laws, rules, and regulations.
- Ensures that processes are implemented to maintain compliance with federal and state laws related to privacy, security, confidentiality, and protection of information resources and PHI.
- Develops, implements, and administers company-wide consent and authorization procedures for access to, use, and disclosure of PHI.
- Develops, implements, and administers procedures to allow individuals to exercise their rights to PHI under applicable state and federal laws.
- Develops and implements privacy training programs for PSC's Workforce.
- Develops appropriate sanctions for employees or business partners that fail to comply with PSC's privacy policies and procedures.
- Performs such other duties as may be directed to perform from time-to-time by the Board.
- Reports regularly to the Board regarding the status of compliance with privacy policies and procedures.
- Works with legal counsel, management and committees to ensure that PSC maintains appropriate privacy consent and authorization forms, notices and other administrative materials in accordance with PSC management and legal requirements.
- Establishes and administrates a process for receiving, documenting, tracking, investigating and taking action on all complaints concerning PSC's privacy policies and procedures in coordination and collaboration with other similar functions, and, when necessary, with legal counsel.
- Monitors attendance at all privacy policies and procedures training sessions and evaluates participants' comprehension of the information provided at training sessions.
- Monitors technological advancements related to PHI protection and privacy for consideration of adaptation by PSC
- Coordinates and facilitates the allocation of appropriate resources for the support of and the effective implementation of the privacy policies and procedures.
- Initiates, facilitates and promotes activities to foster privacy information awareness within PSC

- Cooperates with the Office of Civil Rights, other legal entities, and the Board in any compliance reviews or investigations.

- Performs periodic risk assessments and ongoing compliance monitoring activities at each PSC location.

- Acts as a point of contact for PSC legal counsel in an ongoing manner and in the event of a reported violation.

- Maintains all business associate contracts and responds appropriately if problems arise.

- Acts as the point of contact for receiving, documenting and tracking all complaints concerning privacy policies and procedures of PSC