Notice of Privacy Practices: Acknowledgement

How to use this form: print it, or type into it on screen and then print it. Sign it by hand and **bring it to your appointment**. Please do not email a completed form: it contains private health information. Questions? Call us at (808) 546-9544.

1314 S. King Street, #604 Honolulu, HI 96814

808-546-9544

JEN MEDICAL AESTHETICS BEAUTY & WELLNESS

NOTICE OF PRIVACY PRACTICES

Effective Date: November 20, 2026

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Jen Medical Aesthetics Beauty & Wellness

1314 S. King Street, #604 Honolulu, HI 96814

www.Jenmedicalaesthetics.com

Privacy Contact: Jennifer Lee (808) 546-9544 jen19@hawaiiantel.net

This Notice of Privacy Practices ("Notice") describes how Jennifer M. Lee FNP, LLC, a Hawaii limited liability company dba Jen Medical Aesthetics Beauty & Wellness ("We", "Us", or "Our") may use and disclose your protected health information ("PHI") under the Health Insurance Portability and Accountability Act ("HIPAA") to carry out treatment, payment, or business operations and for such other purposes as permitted or required by law. This Notice also describes Our rights to access and control your PHI, our legal obligation to maintain the privacy of your PHI, and your rights regarding your PHI. PHI is information about you, including demographic information, that may identify you, and that relates to your past, present or future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of PHI**.

The law permits or requires Us to use or disclose your PHI for various reasons. We have included some examples of uses but We have not listed every permissible use or disclosure. When using or disclosing PHI or requesting your PHI from another source, we will make reasonable efforts to limit Our use, disclosure, or request about your PHI to the minimum We need to accomplish our intended purpose.

a. Treatment. We may use or disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes coordinating or managing your health care with a third party, including, but not limited, to physicians, nurses, technicians, or hospital staff involved in your care. For example, your PHI may be provided to a physician to whom you have been referred to, to ensure that the physician has the necessary information to diagnose or treat you.

b. Payment. Your PHI may be used, if requested, to obtain payment for the services provided to you. For example, your PHI may be provided to your health insurance plan so it will pay for the services you receive.

c. Business Operations. We may use or disclose, as needed, your PHI in order to support Our practice and improve your care. For example, we may use your PHI to monitor the quality of Our health care services.

d. Other Uses and Disclosures. We may share your PHI in other ways, such as for legal compliance or public health and safety activities. For example, we will share your PHI if the Department of Health and Human Services requires it when investigating Our compliance with privacy laws.

e. Revocation of Authorization. You may revoke this authorization at any time, but it will not affect PHI that We have already used and disclosed.

2. **Your Rights.**

The following section explains your rights and some of Our responsibilities to help you.

You have the right to:

a. Inspect and Obtain a Copy of Your PHI. You have the right to see or obtain an electronic or paper copy of the PHI that We maintain about you.

b. Request Additional Restrictions. You have the right to ask Us to limit what We use or share about your PHI. You may also request that any part of your PHI not be disclosed to family members or friends that may be involved in your care or for notification purposes as described in this Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your additional restriction. We may say “no,” for example, where your requested restriction will negatively impact your health care.

c. Request Confidential Communications. You have the right to request that We communicate with you about health matters in a certain way or at a certain location. You also have the right to obtain a paper copy of this Notice from Us.

d. Make Amendments. You have the right to ask Us to correct or amend PHI that We maintain about you that you think is incorrect or inaccurate. If We deny your request for amendment, you have the right to file a statement of disagreement with Us and We may prepare a rebuttal to Our statement and will provide you with a copy of any such rebuttal.

e. Make Complaints. You have the right to complain if you feel we have violated your rights. We will not retaliate against you for filing a complaint. You may either file a complaint (i) directly with Us by contacting the Privacy Contact set forth above and submitting a complaint in writing, or (ii) with the Office for Civil Rights at the US Department of Health and Human Services. For more information, visit www.hhs.gov/ocr/privacy/hipaa/complaints/.

☐ I, (individual’s name), acknowledge that on (date), I received a copy of Jen Medical Aesthetics Beauty & Wellness Notice of Privacy Practices and that I read and understood it.

Signature (sign by hand)

Print Name

Date of birth (MM/DD/YYYY)

Date (MM/DD/YYYY)

Relationship to Patient (if applicable):

FOR OFFICE USE ONLY:

Good Faith Effort to Obtain Acknowledgement Form

Name of Patient:

Date of Birth:

The undersigned attempted to obtain the patient's or the patient's representative's signature on the foregoing Notice of Privacy Practices Acknowledgement Form, but was unable to do so as documented below:

Reason:

Name:

Date:

Signature: