

HEALTHCARE ASSOCIATES in MEDICINE P.C.

ACKNOWLEDGEMENT of PRIVACY PROCEDURES

Please Print Patient's Name

Date of Birth

Social Security Number

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 AND ANSWER ALL THE QUESTIONS.

This Acknowledgement of Privacy Procedures describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment and/or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" 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.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, and any other use required by law.

TREATMENT:

We will use your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you, to a physician to who you have been referred to ensure that the physician has the necessary information to diagnose or treat you, and/or to review your health information with a case manager who is coordinating your care.

PAYMENT:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to your health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS (TPO):

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting/arranging for other business activities. For example, we may disclose your protected health information to:

- Medical school students that see patients at our office.
- We may use a sign-in sheet at the registration desk where you are asked to sign your name and indicate your physician.
- We may call you by name in the waiting room when your physician is ready to see you.
- We may use or disclose your protected health information, as necessary to contact you to remind you of your appointment.
- With your specific approval, leave information at your home on an answering machine or to a duly authorized person acting on your behalf.

We may use or disclose your protected health information in the following situations without your authorization.

These situations include:

- As Required By Law;
- Public Health Issues as required by law – communicable diseases, health oversight, abuse or neglect;
- Food and Drug Administration requirements;
- Legal proceedings;
- Law enforcement, Criminal activity, Inmates;
- Coroners, Funeral Directors and Organ Donation;
- Research;
- Military Activity, National Security;
- Workers Compensation.

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.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or the disclosure indicated in the authorization.

YOUR RIGHTS:

Following is a statement of your rights with respect to your protected health information.

- You have the right to inspect and receive a copy your protected health information. Under federal law, however, **you may not** inspect or copy Psychotherapy notes.
- Information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding;
- Protected health information that is subject to law that prohibits access to protected health information.
- You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to your family members or friends who may be involved in your care or for notification purposes as described in the Acknowledgement or Privacy Procedures. Your request must state the specific restriction(s) requested and to whom you want the restriction(s) to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
- You have the right to request to receive confidential communication from us by alternative means or an alternative location. You have the right to obtain a copy of this notice, upon request.
- You may have the right to have your physician amend your protected health information. 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 your statement and will provide a copy of any such rebuttal.
- You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You have the right to object or withdraw as provided in this notice.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying any supervisor, a member of our administration, or our designated Privacy Officer.

This notice was published and becomes effective April 14th, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy procedures with respect to your protected health information. If you have any objections to this form, please notify Administration at (718) 448-3210.

Please answer the questions below and affix your printed name and signature acknowledging that you received our Privacy Policy and that we have provided specific direction and authorization in protecting your health information.

- Who may we provide with your personal health information? ☐ NO ONE EXCEPT ME

(Indicate Relationship.) ☐ Spouse ☐ Children ☐ Parent ☐ Guardian

List Name(s) *please print clearly*: _____

- May we leave personal health information on your answering machine at home? ☐ YES ☐ NO

Patient's Signature

Today's Date

Guardian's Signature

Relationship