PRIVACY NOTICE

This Notice 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. (PHI) which 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.

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

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 whom 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.

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 protected health information be disclosed to the health plan to obtain approval for the hospital admission.

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 not 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:

a) Medical school students, interns and/or residents who see patients at our office.
b) We may use a sign-in sheet or daily patient log
c) We may call you by name in the waiting room when we need to see you
d) We may use or disclose your protected health information, as necessary to contact you to remind you of your appointment, or if necessary to inform you that you missed your scheduled appointment.
e) With your specific approval, leave information at your home on your answering machine.

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

a) As required by law.
b) Public Health issues as required by law (communicable diseases, health oversight, abuse or neglect).
c) Legal Proceedings
d) Law enforcement, Criminal activities, Inmates
e) Coroners, Funeral Directors, and Organ Donation.
f) Research
g) Military Activity, National Security
h) Worker's 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 that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. The following is a statement of your rights with respect to your protected health information:

a) You have the right to inspect and receive a copy of your protected health information. Under federal law, however, you may not inspect or copy Psychiatric notes.
b) Information compiled in reasonable anticipation of, or use in, a civil, criminal or

Administrative action.

c) Protected health information that is subject to law that prohibits access to protected health information.

d) You have the right to request a restriction of your protected health information. This means You may ask us not to use of 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 this Notice of Privacy Procedures. Your request must state the specific restrictions requested and to whom you want the restrictions to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes that 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 health care professional.

e) You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a copy of this notice upon request.

f) You 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 you with a copy of any such rebuttal to your statement.

g) 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 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 the Department of Health and Human Services if you believe that your privacy right have been violated by us. You may file a complaint with us by notifying a member of our staff.

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 objection to this form, please notify our office at (212) 427-2020
Please answer and sign the questions below, acknowledging that you have received this Notice of our Privacy Policy and Procedures which has provided specific direction and authorization in protecting your health information.

- Who may we provide with your personal health information? (check all that apply)
  Spouse_____ Children_____ Parent_____ Other________________________
  (if multiple contacts are being authorized, the specific names should be listed)

- Your consent gives us the capability to leave personal health information on your answering machine at home. Yes_________ No ____________

- Your consent gives us the capability to phone, mail, or fax prescriptions to your pharmacy
  Yes__________ No ____________

- Your consent gives us the capability to release select medical information to your employer regarding reasons for absence from your place of work.
  Yes__________ No ____________

I have reviewed and received a copy of this Notice of Privacy Practice.

Patient's Name:________________________________Patient's Signature:__________________________

Signature of Patient Representative____
(Required if patient is a minor or an adult who is unable to sign this form)
Name & Relationship of Patient Representative to Patient_______________________________________
Date:_____________________