

BARRY W. JAFFIN, M.D.
ANTHONY WEISS, M.D.
620 COLUMBUS AVENUE
NEW YORK, NY 10024
Phone (212) 721-2600
Fax (212) 721-6230

NOTICE OF PRIVACY PRACTICES

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.

We understand your medical information is private and we strive to protect the confidentiality of your medical records. The new federal regulations require that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this to abide by the terms if the Notice of Privacy Practices currently in effect and to provide notice of its legal duties and privacy practices with respect to the protected health information.

Prior to making important changes to our privacy practices, we will make available on request a revised Notice of Privacy Practices.

This notice will be followed by any health care professional authorized to enter information in your medical record. All employees, staff and other personnel who may need access to your information must abide by this Notice. All subsidiaries, business associates. Sites and locations of this practice may share medical information which each other for treatment, payment purposes or health care operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be used.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categorized describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

For Treatment: We may use and disclose medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you are allergic to specific drugs that could influence which medications we prescribe for the treatment purpose.

For Payment: We may use and disclose medical information about you so that treatment and services you receive from us may be billed and payment may be collected from your insurance, third party or you. Example: We may need to send your protected health information, such as your name, address, office visit date and codes identifying your diagnosis and treatment to your insurance company for payment.

Health Care Operations: We may use and disclose medical information about you for health care operations you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- ⌘ As required during an investigation by Law enforcement agencies.
- ⌘ To avert a serious threat to public health and safety
- ⌘ As required by military command authorities for their medical records
- ⌘ To workers' compensation or similar programs for processing of claims
- ⌘ In response to legal proceeding
- ⌘ To a coroner or medical examiner for identification of body
- ⌘ If an inmate, to the correctional institution or law enforcement official
- ⌘ As required by the US Food and Drug Administration (FDA)
- ⌘ Other healthcare providers' treatment activities
- ⌘ Other covered entities' healthcare operations activities (to the extent permitted under HIPPA)
- ⌘ Uses and disclosures required by law
- ⌘ Uses and disclosures in domestic violence or neglect situation
- ⌘ Health oversight activities
- ⌘ Other public health activities
- ⌘ We may contact you to provide appointment reminders of information about treatment alternative or other health related benefits and services that may be of interest to you.

Uses and Disclosures Protected Health Information Requiring Your Written

Authorization; Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use, or disclose medical information about you for the reasons covered by your written authorization. You understand that we're unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Right Regarding Your Medical Information

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for your treatment, payment or health care operations or to someone who is involved with or in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want limited.

Right to request Confidential Communications: You have the right to request how we should send communications to you about medical matters and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal or administrative action or proceeding and protected health info which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition you must provide a reason that supports the request. In addition, we may deny request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for an amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Changes to This Notice: We reserve the right to change this notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we retrieve in the future. We will post a copy of the current notice, with the effective date in the upper right corner of the first page.

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

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Patient Name: _____ Date of Birth: _____

I understand that, under the Health Insurance Portability Accountability of 1996, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understood The Notice of Privacy Practice.

The Practice reserves the right to change the terms of its Notice of Privacy Practice. I understand the Practice will provide current Notice of Privacy Practice on request.

Signature: _____

Relationship: _____

Date: _____

I _____ was unable to obtain the patients signature.
Name of person obtaining signature

Date: _____ Name of Patient: _____

Reason:

