Hudson Infectious Disease Associates

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Notice of Privacy Practices

127 Woodside Avenue, Briarcliff Manor, NY 10510
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HUDSON INFECTIOUS DISEASES ASSOCIATES

NOTICE OF PRIVACY PRACTICES

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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.

If you have any questions about this notice, please contact the Practice Manager at 914 762-2276.

Who will follow this notice?

This notice describes our office practices and that of:

- Any health care professional authorized to enter information into your chart.
- All employees, staff and other personnel.

Our pledge regarding medical information:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our offices or otherwise brought to our attention. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the office personnel.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

1. make sure that medical information that identifies you is kept private;
2. give you this notice of our legal duties and privacy practices with respect to medical information about you; and
3. follow the terms of the notice that is currently in effect.

How we may use and disclose medical information about you.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use of disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

Effective Date: 4/14/2003

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For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other individuals who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. We also may disclose medical information about you to people outside the office who may be involved in your medical care such as family members.

- **For Payment**. We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.

- **For Health Care Operations**. We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, and other personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

- **Appointment Reminders**. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the office.

- **Treatment Alternatives**. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services**. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

- **Individuals Involved in Your Care or Payment For Your Care**. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care.

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- **Research**. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects however are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the office. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care.

- **As Required By Law**. We will disclose medical information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Special situations

- **Organ and Tissue Donations**. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

- **Worker's Compensation**. We may release medical information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

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- **Public Health Risks**. We may disclose medical information about you for public health activities. These activities generally include the following:

  - To prevent or control disease, injury or disability;
  - To report births and deaths;
  - To report child abuse or neglect;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **Health Oversight Activities**. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

- **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request.

- **Law Enforcement**. We may release medical information if asked to do so by a law enforcement official:

  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive material witness, or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About a death we believe may be the result of criminal conduct;
  - In emergency circumstances to report a crime; the location of the crime or victim: or the identity, description or location of the person who committed the crime.

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- **Coroners, Medical Examiners and Funeral Directors**. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) for the safety and security of the correctional institution.

Your rights regarding medical information about you:

You have the following rights regarding medical information we maintain about you:

- **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.

    - To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Hudson Infectious Diseases Associates P.C. If you request a copy of the information, we may 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 health care professional chosen by the office 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 that 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 by the office.

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To request an amendment, your request must be made in writing and submitted to Hudson Infectious Diseases Associates, P.C. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by the office;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosure."
  - All patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your individually identifiable health information (IIHI) for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing in Hudson Infectious Diseases Associates, P.C. All request for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge. But our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with addition requests, and you may withdraw your request before you incur any costs.

- **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 treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

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 emergency treatment.

To request restrictions, you must make your request in writing to Hudson Infectious Diseases Associates, P.C. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both: and (3) to whom you want the limits to apply, for example, disclosure to your spouse.

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- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. If you communicate with us by electronic mail we will assume that we can reply to you at the same electronic mail address from which sent your communication to us. Unless your communication expressly says that we may not.

  To request confidential communication, you must make your request in writing to Hudson Infectious Diseases Associates, P.C. 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.

- **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.

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 receive in the future. We will post a copy of the current notice in the office. The notice will contain on the first page, in the top right hand corner, the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the office or the Secretary of the Dept. of Health and Human Services. To file a complaint with the office, contact [Ms. Bush, Practice Manager, 914-762-2276 at Hudson Infectious Diseases Associates P.C.] All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

Other uses of medical information

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 permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

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I acknowledge receipt of a copy of
Hudson Infectious Diseases Associates, P.C.'s
Notice of Privacy Practices

_____
Patient Name

_____
Signature of Patient or Legal Guardian Date

_____
Relationship to Patient

Effective Date: _____

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Patient Consent for use and disclosure
Of protected health information

I hereby give my consent for Hudson Infectious Diseases Associates, P.C. to use and disclose Protected Health Information (**PHI**) about me to carry out Treatment, Payment and Healthcare Operations (**TPO**). (Hudson Infectious Diseases Associates, P. C.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Hudson Infectious Diseases Associates, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Hudson Infectious Diseases Associates, P.C. at 540 North State Road, Briarcliff Manor, NY 10510.

With this consent Hudson Infectious Diseases Associates, P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice carrying out **TPO**, such as appointment reminders, insurances items, and any calls pertaining to clinical care, including laboratory results among others.

With this consent, Hudson Infectious Diseases Associates, P.C. may mail to my home or other alternative location any items that assist the practice in carrying out **TPO**, such as appointment reminder cards and patient statement.

By signing this form, I am consenting to Hudson Infectious Diseases Associates P.C.'s use and disclosure of my **PHI** to carry out **TPO**.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Hudson Infectious Diseases Associates, P.C. may decline to provide treatment to me.

Please list any restrictions you may have:

We will do our best to comply with your request

_____
Print Patient Name

_____ _____
Signature of Patient or Legal Guardian Date

_____
Relationship to Patient