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COMPREHENSIVE PODIATRY SERVICE

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

All communication regarding our privacy practices including form requests and complaints, should be directed to:

PHI Privacy Administrator
7212 4th Ave
Brooklyn, NY 11209-2552
Phone (718) 745-0256
Fax (718) 833-0505

Trust and confidentiality between you and your physician are not new. Wide electronic transmission of information, and casual travel and relocation of people's jobs and lives, however, are new. It is because of the latter that these agreements between doctors and patients have been formalized into law. This summary will assist you in understanding the attached ***Notice of Privacy Practices*** which contains detailed descriptions of how our office protects your health information, protects your rights as a patient, and outlines our common practices in dealing with patient health information. Please refer to that *Notice* for further information.

Health Information Uses and Disclosures.

In our medical practice, we routinely record, use and disclose your health information in order to treat you and to assist other health care providers in treating you. We also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services that we or other health care providers give to you. Finally, we may need to use and disclose your health information for certain limited business operational activities such as practice management, training, licensing, accreditation and quality assessment.

Other Uses and Disclosures Not Under Your Control.

We may need to disclose your health information without your written authorization in the following situations:

- To contact you by telephone, fax and regular or electronic mail to remind you of your appointments or to respond to your questions.
- To family members or close friends who are involved in your health care;
- For purposes of public health and safety, such as to the FDA to report product defects or incidents;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- For research purposes of a limited nature in a limited manner;
- For providing benefits under Workers Compensation;
- To the Military and Department of Veterans Affairs;
- To law enforcement authorities to assist in apprehending criminal offenders;
- To government authorities for prevention of child abuse or domestic violence;
- When required by law, search warrants, subpoenas or court orders.
- To Federal, State and Local law enforcement authorities involved in security activities as required;

Uses and Disclosures Controlled by You.

We will not use or disclose your health information without your prior written authorization, except for those uses we have stated in greater detail in the *Notice of Privacy Practices.*

Your Patient Rights.

As our patient, you have the following rights:

- To receive a Notice of Privacy Practices, which this summarizes.
- To get access to and/or a copy of your health information;
- To request that we communicate with you confidentially, by reasonable alternative means;
- To request restrictions on how we handle or disclose your health information;
- To request amendments to your health information;
- To request and receive an accounting of certain disclosures which we made of your health information;

Should you have any questions, concerns or complaints regarding our privacy practices, now or in the future, you will find the details of whom to contact on the current *Notice of Privacy Practices.*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES #_____ _____ _____

Version Serial# State

I acknowledge that I was provided a copy of the Notice of Privacy Practices from the above named Medical Care Organization/Provider for me to keep and that I have read (or had the opportunity to read if I so chose) and understood the Notice. This acknowledgement is requested per government statute.

____________________ PATIENT Name (please print)

____________________ Print Name of Parent/Responsible Party (if applicable)

▶ ____________________ SIGNATURE of Patient/Parent/Responsible Party

___/___/___ DATE

____________________ Relationship to Patient

Patient's Date of Birth___/___/___

Patient Identification # (or Social Security No.) ____________________

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Summary / Acknowledgement of Receipt of Notice of Privacy Practices