Metro Healthcare Partners

THIS OFFICE IS IN COMPLIANCE WITH THE FEDERAL HIPAA GUIDELINES FOR PRIVACY
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.

Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluation your health, diagnosing and providing treatment.

Your health information may be used as necessary to support day-to-day activities and management of **Metro Healthcare Partners (MHP).**

Your health information may be disclosed to law enforcement agencies and or public health agencies, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting (such as public health reporting of communicable diseases).

Use or disclosure of your health information for any other purpose other than those listed above requires your written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

In addition, your health information may be used by our staff to send you appointment reminders, and/or information on the treatment and management of your medical condition.

You have certain rights under the federal privacy standards. These include: 1) The right to request restrictions on the use and disclosure of your protected health information. 2) The right to receive confidential communications concerning your medical condition. 3) The right to inspect and copy your protected health information. 4) The right to amend or submit corrections to your protected health information. 5) The right to receive an accounting of how and to whom your protected health information has been disclosed. 6) The right to receive a printed copy of this notice.

MHP is required by law to maintain the privacy of your information and to provide you with this notice. We reserve the right to amend or modify our privacy policies and practices as permitted by law. Any changes may be mandated by changes in federal law. If any changes occur, we will provide you with a revised notice upon your next visit. The revised notice will apply to all protected health information that we maintain.

You may generally inspect or copy the protected health information we maintain. As permitted by federal regulations, we require that all requests to inspect or copy protected health information be submitted in writing.

If you have any comments or complaints about our privacy practices, or if you feel like your privacy rights have been violated, please contact us in writing, or address the issue with our office manager in person. **Our contact address is**: 3500 Nostrand Avenue, Brooklyn, N.Y. 11229

This notice is effective as of December 1st, 2002.

Metro Healthcare Partners

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect__/__/__ and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our practices or for additional copies of this notice please contact us using this information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment payment and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

PAYMENTS: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTH CARE OPERATIONS: We may use and disclose you health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities. Reviewing the competence or qualifications of health care professionals, evaluating practitioners and provider performance conducting training programs accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment payment or health care operations you may give us written authorization to use you health information or to disclose it to anyone for any purpose if you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while in effect. Unless you give us a written authorization we cannot use or disclose you health information for any reason except those described in this notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you as described in this patient rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify or assist in the notification of including identifying or locating a family member your personal representative or another person responsible for you care of you location you general condition or death. If you are present then prior to use or disclosure of your health information we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practices to make reason able inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x- rays or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIERED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to you health or safety or the health or safety of others.

Metro Healthcare Partners

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgement **

I, (full name)_____, did receive a copy of

this office's Notice of Privacy Practices on (today's date)_____

_____ _____

Signature of Patient or Parent/Guardian Date

BELOW LINE FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

( ) Individual refused to sign
( ) Communications barriers prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining
( ) Other (please specify)

_____

_____

_____

Metro Healthcare Partners
3500 Nostrand Avenue
Brooklyn, New York 11229

Metro Healthcare Partners

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give consent for Metro Healthcare Partners to furnish medical care and treatment necessary in treating his/her physical condition.

→_____ _____

Signature of Patient/Guardian Date

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I, hereby assign medical benefits to which I am entitled, including Medicare, private insurance, no fault insurance, workers compensation insurance and third party payers to Metro Healthcare Partners. A photo copy of this assignment is information necessary including medical records, to secure payment.

→_____ _____

Signature of Patient/Guardian Date

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize Metro Healthcare Partners to obtain any and all medical records concerning my care from any physician, hospital, or health care professional that has provided medical care to me in the past.

I also authorize Metro Healthcare Partners to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to myself / and or child at any time.

→_____ _____

Signature of Patient/Guardian Date

ACKNOWLEDGEMENT FORM

I acknowledge that I have been given a copy of the Practice's "HIPAA Privacy Policy Notice", which describes the Practice's obligations to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how the Practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the Practice's HIPAA Privacy Notice and to ask questions about it. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice.

I further acknowledge that the Practice can change its HIPAA Privacy Notice in the future and that I can receive a copy of the Practice's current Privacy Notice at anytime.

I understand that I have the right to request that the Practice restricts its users and disclosures of my health information for treatment, payment or health care operations. If my restrictions are accepted by the Practice, these restrictions will be binding on the Practice. I also understand that the Practice is not required to agree to my requested restrictions.

I do not request any restrictions on the Practice's uses and disclosures of my health information for treatment, payment or health care operations. →_____ (Initial)

By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment and health care operations. I understand that I have the right to revoke this consent at anytime in writing, but if I do, my revocation will not have any effect on any actions the Practice has already taken in reliance of this consent.

→_____ _____

Signature of Patient/Guardian Date