

Northway Medical Associates

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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

Our Legal Duty

This notice of privacy practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This notice of privacy practice describes how we may use or disclose your protected health information with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access your protected health information. You have the right to approve or refuse the release of specific information outside of our Practice except when the release is required or authorized by law or regulation. This policy takes effect 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices at any time, provided such changes are permitted by applicable law. We will notify you in advance of any significant changes and will make the new notice available upon request.

Acknowledgment of Receipt of this Notice

You will be asked to provide a signed acknowledgment of receipt of this notice. The delivery of your health care services will in no way be condition upon your signed acknowledgment. If you decline to provide a signed acknowledgement, we will continue to provide you treatment, and will use and disclose your protected health information for treatment, payment and health care operations when necessary.

Uses and Disclosure of Health Information

We use and disclose your 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 healthcare provider providing treatment to you. In emergencies, we will use and disclose your protected health information to provide the treatment you require.

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

Healthcare Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We will share your protected health information with other persons or entities who perform various activities for our practice. These business associates will also be required to protect your health information.

Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it at any time in writing. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Marketing: We will not use your health information for marketing without your written authorization.

Individuals Involved In Your Care: Unless you object, we may disclose to a person involved in your care, your protected health information that directly relates to that person's involvement in your health care.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a 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 your health or safety, or the health and safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, postcards or letters.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing to obtain access to your health care information. You may also request access by sending us a letter. If you request copies, we will charge you \$.75 per page and postage if you want the copies mailed to you (to be paid prior to making the copies).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities beginning April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means (You must make your request in writing). Your request must specify the alternative means and provide satisfactory explanation how payment's will be handled under the alternative means you request.

Contact Information: Our privacy officer is our Office Manager and can be contacted by calling (315)598-7105. You may contact our privacy officer for further information about our complaint process, or for further explanation of this notice of privacy practices.

I HAVE RECEIVED AND READ THE NOTICE OF PRIVACY PRACTICES FROM NORTHWAY MEDICAL ASSOCIATES, PLLC.

SIGNED: _____ DATE: _____

PRINTED NAME: _____

<u>LEAVE APPOINTMENT MESSAGE ON:</u>	<u>ALL</u>	<u>LEAVE OTHER MEDICAL INFO ON:</u>	<u>ALL</u>
ANSWERING MACHINE?	<input type="checkbox"/>	ANSWERING MACHINE?	<input type="checkbox"/>
OFFICE VOICE MAIL?	<input type="checkbox"/>	OFFICE VOICE MAIL?	<input type="checkbox"/>
W/ ANOTHER PERSON?	<input type="checkbox"/>	W/ANOTHER PERSON?	<input type="checkbox"/>
SEND THROUGH MAIL?	<input type="checkbox"/>	SEND THROUGH MAIL?	<input type="checkbox"/>
CELL PHONE?	<input type="checkbox"/>	CELL PHONE?	<input type="checkbox"/>

PERSON(S) AUTHORIZED TO COMMUNICATE WITH:

RELATIONSHIP?