WESTFIELD AND RAHWAY PODIATRY GROUP
PRIVACY NOTICE – EFFECTIVE NOVEMBER 15, 2002

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of "protected health information." That includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

This notice provides you with information about your rights, and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information.

PERMITTED USES AND DISCLOSURES

We can use or disclose your protected health information for purposes *of treatment, payment and health care operations.*

- *Treatment* means the provision, coordination or management of your health care, including consultations between health care providers regarding your care, and referrals for health care from one health care provider to another. 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. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.

- *Payment* means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide information to your HMO about your medical condition, to determine whether the proposed course of treatment will be covered. When we subsequently bill the HMO for the services rendered to you, we can provide the HMO with information regarding your care, if necessary to obtain payment.

- *Health care operations* means the support functions of our practice related to *treatment* and *payment,* such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff when caring for you. We may also combine medical information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.

OTHER USES AND DISCLOSURES

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment.

We will allow your family and friends to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, and similar forms of protected health information, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

We may contact you as part of our marketing efforts as permitted by applicable law.

Except for the special situations prescribed by law, and the general uses and disclosures described above, we will not use or disclose your protected health information for any other purposes unless you provide a written

authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request.

2. You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.

3. Subject to payment of a reasonable copying charge[1], you have the right to inspect and copy the protected health information contained in your medical and billing records and in any other Practice records used by us to make decisions about you, except for: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and confidential information concerning certain laboratory tests

   We may also deny a request for access to protected health information if:
   - a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person;
   - the protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
   - the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person.

   If we deny a request for access for any of the three reasons described above, then your have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. You have the right to request a correction to your protected health information, but we may deny your request for correction if we determine that the protected health information or record that is the subject of the request: was not created by us, is not part of your medical or billing records, is not available for inspection as set forth above, or is accurate and complete. In any event, any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.

5. You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you, except for disclosures:
   - to carry out treatment, payment and health care operations as provided above;
   - to persons involved in your care or for other notification purposes as provided by law;
   - for national security or intelligence purposes as provided by law;
   - to correctional institutions or law enforcement officials as provided by law; or
   - that occurred prior to April 14, 2003.

6. You have the right to request and receive a paper copy of this notice from us.

CONTACT PERSON

If you believe that your privacy rights have been violated, or if you have any questions or would like further information about this notice, you should contact Carol Seaton, our Privacy Officer at 732-388-1803. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

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[1] If you cannot afford to pay for copies, you will not be denied access.

ACKNOWLEDGMENT

I, ____, acknowledge that I have been provided with a copy of Westfield and Rahway Podiatry Group's privacy notice and have been given an opportunity to read and ask questions about the notice.

Date: ________________________200___

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Signed

Rahway & Westfield Podiatry
674 St. Georges Avenue
Rahway, NJ 07065
(732) 388-1803

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE FORM

1. **Acknowledgement of Privacy Practice Notice**
   I have received a copy of **Rahway & Westfield Podiatry** Notice of Privacy Practices.

   ______________ ______________ ______________________________

   Patient's Name   Date of Birth   Signature of Patient/Parent/Guardian   Date

2. **I wish to be contacted in the following manner (check all that apply).**

   Home Telephone ______________

   OK to leave message with detailed information

   Leave message with call back number only

   Written Communication

   OK to mail to my home address

   OK to mail to my work/office

   OK to fax to this number
   Fax Number:__________

   Work Telephone ______________

   OK to leave message with detailed information

   Leave message with call back number only

3. **Designation of Certain Relatives, Close Friends and Other Caregivers**
   I agree that **Rahway & Westfield Podiatry** may disclose certain of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, **Rahway & Westfield Podiatry** will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.
   I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose **Rahway & Westfield Podiatry** to make a the type of disclosures listed above. (I understand that I am not required to list anyone ad that I may change this list at any time in writing).

Print Name/Relationship/DOB/Telephone#:______________________________

Print Name/Relationship/DOB/Telephone#:______________________________

Print Name/Relationship/DOB/Telephone#:______________________________

Print Name/Relationship/DOB/Telephone#:______________________________

Print Name/Relationship/DOB/Telephone#:______________________________

______________________________   ______________

Signature of Patient/Parent/ Guardian   Date