NOTICE OF PRIVACY PRACTICE

MANHATTAN OTOLARYNGOLOGY HEAD AND NECK SURGERY
1421 3RD AVE., 4TH FLOOR
NEW YORK, NY 10028
(212)452-1500

Privacy Officer: Seva Karambasis
Effective date: 04-14-2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. WE ARE REQUIRED BY LAW TO PROTECT PRIVACY OF YOUR HEALTH INFORMATION AND TO PROVIDE YOU WITH THIS NOTICE WHICH DESCRIBES OUR PRIVACY PRACTICES. PRLEASE REVIEW IT *CAREFULLY*. IF YOU HAVE ANY QUESTIONS PLEASE CONTACT OUR OFFICE ADMINISTRATOR.

We are required to obtain a one-time consent from you, before we use or share your health information with others. Such disclosure will be for the sole purpose of providing treatment to you, obtain payment for our services, and running our business operations. You may revoke this consent at any time by contacting our office administrator. We are also requires to obtain a written authorization from you for the use or disclosure of your health information for purposes other than those stated in consent. Written authorization is not required in the following situations:

Your health information may be disclosed to:

- Doctors or medical personnel who are involved in taking care of you or doctors to whom you have been referred for other treatment.
- Your insurance company, in order to obtain reimbursement for services rendered, or to obtain pre-approval for your treatment.
- Our business associates who need the information in order to assist us with obtaining payment or carrying out our business operations **(in these cases, we will have a written contract with our business associates which will insure that they will also protect the privacy of your health insurance.)**
- Family and individuals involved in your care.
- Authorized public health officials, so that they may carry out their public health activities, including the review or reports of abuse, neglect, or domestic violence.
- Government agencies authorized to conduct audits, investigations, and inspections of our facility.
- A person or company that is registered with Food and Drug Administration.
- Law enforcement officials, authorized federal officials, or if you are a member of the Armed Forces, to military command authorities.
- A medical examiner or organization investigation organ donation or transplantation.

We may also disclose your information under circumstances in which:

- You require emergency treatment, or if we are required by law to treat you but are unable to obtain written consent.
- We are ordered to do so by a court that is handling a lawsuit or other dispute.
- It is necessary to prevent serious threat to your health and safety, the health and safety of others, or the health and safety of the public.
- For workers compensation or similar program that provides benefits for work related injuries.
- We have removed any information that has the potential to identify you, so that the information is "de-identified".
- We need to evaluate the performance or our staff in caring for you or to educate our staff on how to improve the care provided to you.
- We need to remind you of appointments, to recommend possible treatment alternatives or to inform you of health related benefits and services that may be of interest to you.

YOUR RIGHTS AS OUR PATIENT:

1. **You have the right to inspect and obtain a copy of your health information, including medical and billing records, for as long as we maintain this information in our records.**
2. **You have the right to correct your health information if you believe that the information is incorrect or incomplete.**
3. **You have the right to receive an "accounting of disclosures", that is, to whom we have disclosed your health information.**
4. **You have the right to request that we further restrict the use or disclosure of your health information.**
5. **You have the right to request that we communicate with you about your medical condition in a more confidential manner.**
6. **You have the right to name a personal representative who may act on your behalf to control the privacy of your medical information.**
7. **You have the right to request a copy of this notice.**
8. **You have the right to request a copy of any revisions of this notice.**
9. **You have the right to file a complaint if you believe your privacy rights have been violated.**

All the requests must be in writing and sent to the attention of our office administrator. The practice has 10 days to respond to a patients request for records, and 30 days to provide the patient with copies of their records. If we deny part or the entire request, we will provide you with a written notice that explains our reasons for doing so.

NOTICE OF PRIVACY PRACTICE PATIENT ACKNOWLEDGMENT

I. I, hereby state that I have received the above notice of the Privacy Practices of DR. _____.

_____
Name of Patient

_____ / / _____
Signature Date Received

_____
Signature of Patient Representative Relationship to Patient

II. I, hereby state that I have received, read, and understand The Notice of Privacy Practices of Dr. _____. I have certain rights to privacy in regards to my protected health information (PHI). As such, I give consent to Dr. _____ to use or share my health information for the purposes of treating me, obtaining payment for that treatment, and running the business operations for the practice.

_____
Name of Patient

_____ / / _____
Signature Date Received

_____
Signature of Patient Representative Relationship to Patient

III. The Patient was given the Notice of Privacy Practices of Dr. _____, and refused to sign.

_____
Employee Name (Please Print)

_____ / / _____
Signature Date Received