185 Fairfield Avenue, Suite 1B
Caldwell, NJ, 07006-6417
Phone - (973) 228-2335

# 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 the information listed at the end of this notice.

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## 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 your 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 your 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.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgement **

I, _____ _____ , did receive a copy of this office's Notice of Privacy Practices on

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## 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 theacknowledgement
( ) An emergency situation prevented us from obtaining
( ) Other (please specify)

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**Patient Signature**