SHORE PULMONARY, PA

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.

USES AND DISCLOSURES

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Shore Pulmonary. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of 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 to revoke your authorization. For example, if you require a disability form or return to work/school form to be completed, this would require a specific written authorization to be completed.

ADDITIONAL USES OF INFORMATION

Appointment reminders. Your health information will be used by our staff to send/call you about appointment reminders, referrals needed and to call our office for test results.

Individuals involved in your care or payment for your care. We may release medical information about you to a family member or significant other who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell a family member or significant other your medical condition and why you are hospitalized (if needed).

INDIVIDUAL RIGHTS- You have certain rights under the federal privacy standards. These include:

*The right to request restrictions on the use and disclosure of your protected health information.

*The right to receive confidential communications concerning your medical condition and treatment.

*The right to inspect and copy your protected health information.

*The right to amend or submit corrections to your protected health information.

*The right to receive an accounting of how and to whom your protected health information has been disclosed.

*The right to receive a printed copy of this notice.

SHORE PULMONARY, PA duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to revise privacy practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to inspect protected health information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Front Desk Receptionist or our Office Manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Dr. Frederick Potulski, MD-Privacy Officer, 301 Bingham Ave., Suite B, Ocean, N.J. 07712

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact person – The name and address of the person you may contact for further information concerning our privacy practices is: Office Manager, 301 Bingham Ave., Suite B, Ocean, NJ 07712, 732-775-9075.

Effective date – This notice is effective on or after April 1, 2003.

Acknowledgment of Receipt of Notice of Privacy Practices

SHORE PULMONARY, PA reserves the right to modify the privacy practices outlined in the notice.

Signature
I have received a copy of the Notice of Privacy Practices for Shore Pulmonary, PA.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

Members of My Family or Significant Others that May Receive Medical Information Concerning my Condition and Care:

NAME:_____SSN OR DOB_____

NAME:_____SSN OR DOB_____

ACKNOWLEDGMENT OF "WELCOME LETTER"

I have reviewed a copy of the Welcome Letter from Shore Pulmonary, PA.

_____
Signature of Patient

_____
Date