

## **Seaview Orthopaedic & Medical Associates Atlantic Medical Associates**

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

### **Introduction**

At Seaview Orthopaedic & Medical Associates and Atlantic Medical Associates, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information which does not include Independent Medical Examinations (IME's). This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

### **Understanding Your Health Record/Information**

Each time you visit Seaview Orthopaedic & Medical Associates or Atlantic Medical Associates, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical records, serves as a:

- Basis for planning your care and treatment
- Means of communicating among the many health professionals who contribute to your care
- Legal documents describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and nation
- A source of data for our planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

### **Your Health Information Rights**

Although your health record is the physical property of Seaview Orthopaedic & Medical Associates or Atlantic Medical Associates, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect and copy your health record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

## **Our Responsibilities**

Seaview Orthopaedic & Medical Associates and Atlantic Medical Associates is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us or, if you agree, we will email the revised notice to you.

We will not disclose your health information without your authorization except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

## **For More Information or to Report a Problem**

If you have questions and would like additional information, you may contact the company's Practice Administrator, 1200 Eagle Avenue, Ocean, New Jersey 07712 or at (732) 660-6200.

If you believe your privacy rights have been violated, you can file a complaint with the company's Practice Administrator or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Practice Administrator or the Office for Civil Rights. The address for the OCR is listed below:

*Office For Civil Rights*  
U.S. Department of Health and Human Services  
200 Independent Avenue, S.W.  
Room 509F, HHH Building  
Washington, DC 20201

**ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE  
AND DESIGNATION OF DISCLOSURE**

**I. Acknowledgement of Practice's Notice of HIPAA Privacy:**

I have received a copy of the Notice of HIPAA Privacy for the Physician Practice.

\_\_\_\_\_  
Name of Patient                      Date of Birth                      Signature of Patient/Parent/Guardian                      Date

**II. Designation of Certain Relatives, Close Friends and Other Caregivers:**

A. I agree that the practice may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice 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 wish to be contacted in the following manner (check all that apply):

**Telephone, Written and Fax Communication**

**Home Telephone Number:**

- OK to leave message with detailed information  
 Leave message with call back numbers only

**Written Communication:**

- OK to mail to my home address  
 OK to mail to my work/office address

**Work Telephone Number:**

- OK to leave message with detailed information  
 Leave message with call back numbers only

**Fax Communication:**

- OK to fax to this number: \_\_\_\_\_  
Other: \_\_\_\_\_

B. I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name: \_\_\_\_\_ Last four digits of his/her SS Number (required): \_\_\_\_\_

Print Name: \_\_\_\_\_ Last four digits of his/her SS Number (required): \_\_\_\_\_

Print Name: \_\_\_\_\_ Last four digits of his/her SS Number (required): \_\_\_\_\_

C. The following person(s) are not authorized to receive my Patient Health Information:

Print Name: \_\_\_\_\_ Print Name: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Parent/Guardian                      Date

III. The Privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for, Patient Health Information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/guardian. Healthcare entities must keep a record of Patient Health Information disclosures. Information provided below will constitute an adequate record. Uses and disclosures for Treatment, Payment, and health Care Operations may be permitted without prior consent.