

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other *(Please provide specific details)*

Employee signature

Date



Westchester Health

WESTCHESTER HEALTH ASSOCIATES, PLLC 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.

State and Federal laws require Westchester Health Associates, PLLC ("WHA") to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice of Privacy Practices (this "Notice"). We must follow the privacy practices as described below. This Notice was last updated on September, 2013 in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we do so, this Notice will be amended to reflect the changes and we will make the new Notice available and distribute it as required.

You may request a copy of our current Notice at any time by contacting our Privacy Officer, Angela Mulroy, R.N. Contact information is provided below. You have a right to obtain a paper copy of this Notice upon request.

We are committed to protecting the privacy of your health information and only using and disclosing it as described herein. In the event that there is a Breach of your health information, you will be notified in writing.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

There are certain ways in which we use and disclose your health information in the normal course of operations. For these uses and disclosures, the law does not require us to seek written authorization from you first. The purposes for which we may use your health information without an authorization are as follows:

Treatment: We may use your health information to provide you with our professional services. We have established minimum necessary or need to know standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to undergo training and to sign a confidentiality statement. Health care professionals may also disclose your health information to each other in order to provide you with health services.

Individuals Involved In Your Care: Your health information may be disclosed to your family, friends, or other persons you choose to involve in your care or the payment for your care, only if you do not object to such disclosure.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may be involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers, attorneys, and accountants. All such individuals are under obligations to maintain the confidentiality of your health information.

Required by Law: We may use and disclose your health information when we are required to do so by law, including by court or administrative orders, subpoena, discovery request or another lawful process. We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse and Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health responsibilities: We will disclose your health information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Military: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards, or letters.

USES AND DISCLOSURES OF YOUR INFORMATION THAT REQUIRE PRIOR WRITTEN AUTHORIZATION

For other types of uses and disclosures of your health information, we will first seek written authorization from you. For example, only after we obtain a written authorization from you will we: use or obtain your psychotherapy notes (with certain limited exceptions, such as use by the originator of the notes to carry out your treatment); use or disclose your health information for marketing purposes; or sell your health information. You may also provide us with a written authorization asking us to disclose certain health information to other parties, such as family members not involved in your care or your employer.



YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Access: Upon written request, you have the right to inspect and/or obtain copies of your health information (and that of an Individual for whom you are a parent or legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. If you request a copy of your medical record, WHA reserves the right to charge for reasonable costs of producing and, if applicable, mailing such copies. You may also request a summary or explanation of your health information.

Amendment: You have the right to amend your health information, if you feel it is inaccurate or incomplete. Your request for an amendment must be in writing and must include an explanation of which information should be amended in which specific way (s). Under certain circumstances, your request may be denied.

Non-Routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. Requests may be for specific time periods within the six year period prior to the date of request. Such an accounting of disclosures will not include, by way of example, disclosures made for the purposes of treatment, payment, and health care operations, nor will such an accounting including disclosure made directly to you per your request.

Restrictions: You have the right to request that we place additional restrictions on your use or disclosure of your health information. We generally do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. If you request that WHA restrict disclosures of your health information to a health plan where the disclosures are for payment or health care operations and pertain to a health care item or service for which you have already paid in full, then WHA must agree to such request. Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

Confidential Communications: You have the right to receive confidential communications of your health information. For example, you may request that WHA contact you with appointment reminders or test results on your cell phone instead of your home phone.

WHA must accommodate reasonable requests to receive communications of health information by alternative means or at alternative locations.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer, as should any questions about this notice. If you feel we may have violated your privacy rights, you may request a Complaint Form from our Privacy Officer and submit your complaint to us in writing. Please find contact information below.

If you believe that we have violated your privacy rights. You may also file a complaint with the U.S. Department of Health and Human Services.

WHA will not retaliate against you in any way for issuing a complaint.

HOW TO CONTACT US

Practice Name: Westchester Health Associates

Privacy Officer: Angela Mulroy R.N.

Telephone: 914-401-8045

Fax: 914-269-9621

Email: amulroy@Westchesterhealth.com

Address: 60 Goldens Bridge Road Katonah, New York 10536