two river | ALLERGY AND ASTHMA GROUP

Two River Allergy and Asthma Group E-Newsletter

_____Yes, I give my permission to receive the Two River Allergy and Asthma Group e-newsletter, which includes news and useful tips about allergies and asthma. (We will not share your e-mail address.) My e-mail is____

_____No, please do not add me to the e-newsletter list.

Authorization for Disclosure of Protective Health Information

Our office reserves the right to leave messages on your answering machine regarding your appointment and/or billing issues, if our attempts to speak with you personally have failed.

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

_____ Myself only
_____ My spouse, significant other, or parent (specify name)
_____ Other (specify name)____

Please check your choice on information to be disclosed

_____ Yes, I give my permission for medical information to be left on my answering system.

Please check if yes!
- _____ Lab/Test results
- _____ Diagnosis
- _____ Prescriptions

_____ No, I do not want medical information left on my answering system.

I, ____________________________________, have received a copy of this office's Notice of Privacy Practice
Please Print Patient's Name

This Authorization shall be effective until January 1, 2012.
I understand that I have the right to revoke this authorization in writing to the office manager at the below address. I understand that disclosed information pursuant to this authorization may no longer be protected by the federal HIPAA Privacy rule or State law.

____ ____________________
Signature of patient or personal representative Date

____ ____________________
Print name of patient or personal representative Date

____ ____________________
Relationship of personal representative to patient Date

709 Sycamore Avenue Tinton Falls, NJ 07701-4930 Tel# 732.747.8188 Fax: 732.747.5946

(PLEASE KEEP FOR YOUR RECORDS)

NOTICE OF PRIVACY PRACTICE

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you or to check you out at the reception desk. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorizations. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.