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518.584.6111

HIPAA Privacy Statement

This notice describes how health information about you, if you decide to become a patient of this practice, may be used or disclosed, and how you can obtain access to your health information. This is required by the Privacy Regulations because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Commitment to your privacy:

This practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the integrity of your health information. We realize that these laws are complicated but we must provide you with the following information.

We will release your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. For lawsuits and similar proceedings in response to a court order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat or safety of another individual or the public. We will only make disclosures to a person or an organization able to prevent the threat.
5. If you are a member of the US Military Forces and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. For Workers Compensation and similar programs.

Rights regarding your health information:

You can request that our practice communicate with you about your health in a particular manner. We will accommodate reasonable requests.

1. You can request a restriction in our use or disclosure of your health information for treatment and payment of healthcare operations.
2. You have the right to inspect and obtain a copy of your health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to your physician's name, 205 Lake Avenue, Saratoga Springs, NY 12866. We will respond within 10 days.
3. You may ask to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by our practice. To request amendment, your request must be made in writing and submitted to this office. You must provide a reason that supports your request for amendment.
4. You have a right to the copy of this notice.
5. You have the right to file a complaint. If you believe that your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
6. You have the right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

I acknowledge that I have received and read the above Privacy Policy.

Signature: ____ **Date**: _________________________________

Print Name: ____

HIPAA

Acknowledgement of Receipt and General Consent

I acknowledge that I have received a copy of the Notice of Privacy Practices.

I further consent to the release of my health information for purposes of treatment, payment, and healthcare operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices.

Patient Name: ____ **Date**: ______________________________

Signature: _________________________________ Relationship to Patient (if under 18): _____________________________

For Patients Who Are 18 Years and Older

I give my permission to those listed below to have access to my medical information and to discuss matters relating to my care. I recognize that if I do not list anyone below, I am the only person who will have access to information regarding my medical information and care.

Name: ____ Relationship: _______________________

Name: ____ Relationship: _______________________

Name: ____ Relationship: _______________________

Name: ____ Relationship: _______________________

Patient Name:____ **Date**: _____________________________

Signature: ____