

# Digestive Disease Associates of Rockland, PC

## Notice of Health Information Privacy Practices

**THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED WITHIN THIS ORGANIZATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE READ THIS CAREFULLY.**

Digestive Disease Associates of Rockland (DDAR) is required by law to maintain the privacy of your personal medical information and to provide you with this notice of its privacy policies.

### **Uses and Disclosures:**

**Treatment:** DDAR may use your information to provide or coordinate your care. We may disclose all or any portion of your medical information to any of our physicians, other consulting or referring physicians, nurses or nurse practitioners, physician assistants, and other employees who have a legitimate need for such information to provide or coordinate your care.

**Payment:** We may release your information to determine coverage by an insurer for our services, billing, and claims processing. The information may be released to an insurance company, third party payer or other organization involved in the payment of your bill. This information may include copies or excerpts of your medical information that is necessary to receive payment.

**Routine Operations:** We may use and disclose your information during routine operation of the practice. An example of routine operations would be to contact you to remind you of an appointment or to disclose information to transcriptionists, attorneys or consultants working for the practice. These entities are called "Business Associates". We require our Business Associates to treat your information in the same manner that we do.

**Research:** Under certain circumstances, we may use and disclose your information within approved clinical research studies. Most clinical research studies require specific patient consent; however there may be some cases where a review of your information without patient contact may be conducted by the researchers.

**Regulatory Agencies:** We may disclose your information to state, local or federal agencies authorized by law to conduct inspections, audits, or investigations of the practice.

**Law Enforcement/Litigation:** We may disclose your information for valid law enforcement purposes as required by law or in response to a court order or subpoena.

**Public Health:** We may disclose your information to public health authorities as authorized by law and related to the prevention or control of certain diseases.

**Workers Compensation:** We may release your information to Worker's Compensation agencies in the event your illness or injury may be related to your work.

**Military/Veterans:** If you are a member of the armed forces or a veteran, we may release your information as required by military command authorities.

**As Otherwise Required:** We may disclose your information in any situation in which such disclosure is required by law (for example, child or domestic abuse).

**Test Results:** If we are unable to contact you personally by telephone, we will leave a normal result on your answering machine, unless you direct us otherwise

**Prohibited Uses:** We will not disclose your information to persons outside the practice for purposes other than treatment, payment, or healthcare operations without your authorization in writing. If you provide such an authorization to us, you may revoke it in writing at anytime in the future and we will honor that request.

**Your Rights Related to Your Health Information:** Although all records concerning your treatment at DDAR are the property of DDAR, you have certain rights concerning this information as follows:

**Right to Confidentiality:** You have the right to receive confidential communication of your health information by alternative means or at alternative locations, if you so request in writing.

**Right to Inspect and Copy:** You generally have the right to inspect and receive a copy of your health information from DDAR, unless that is restricted by law or your physician. You will need to pay for copies of any records we provide.

**Right to Amend:** You have the right to request an amendment or correction to your health information. If we agree that information is appropriate, we will include that information in your medical record.

**Right to Accounting:** You have the right to obtain a record of disclosures that we make of your health information for other than treatment, payment or routine operation of the practice.

**Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of your health information. We will abide by these requests to the extent that we are able.

**Right to Revoke Authorization:** You have the right to revoke your prior authorization to release your health information except to the extent action was taken in reliance of your original authorization.

**Right to Complain:** You have the right to formally complain about our handling of your health information. You may contact the practice administrator below or the Department of Health and Human Services. If you complain, we will not retaliate against you in any way.

**For more information regarding this policy please contact the practice administrator at 845-354-3700**

**Changes to this Notice:** DDAR will abide by the terms of this Notice currently in effect. However, DDAR reserves to change the terms of the Notice at any time. Any new notice provisions will be effective for all health information from the time that the changes are effective within DDAR.

**Effective Date of this Notice: April 1, 2003**

Amended: November 1, 2009

**Digestive Disease Associates of Rockland, PC**

**NOTICE OF PRIVACY PRACTICE**  
**ACKNOWLEDGEMENT**

(After review of this document, please sign and return THIS PAGE ONLY to the receptionist)

I, \_\_\_\_\_, hereby acknowledge that I have received and reviewed the "Notice of Privacy Practices" which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations.

\_\_\_\_\_  
**Signature of Patient or Patient's Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed name of Patient or Patient's Representative**

\_\_\_\_\_  
**If representative, specify Relationship**

**I Authorize DDAR to Leave a Message:**

At Home

Answering Machine

At Work

Cell Phone

Third Party \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_