Dr. Scott L. Cooper

NOTICE OF PRIVACY PRACTICES

OUR LEGAL DUTY - We are required by law to maintain the privacy of your protected health information (PHI). We are also required to give you this Notice about our privacy practices and your rights concerning your PHI. We must follow the practices described in this Notice, which takes effect on 4/14/03, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice ant any time as permitted by law, effective for all PHI that we maintain, even that which was received or created before the changes in policy. You may request and we will furnish to you at any time a copy of this Notice.

USES AND DISCLOSURES OF PHI – We use and disclose PHI about you for treatment, payment, healthcare operations, and as required by law.

Treatment: We may use or disclose your PHI to a physician or other healthcare provider who may be providing treatment to you or to whom we may be referring you, including coordinating your care with a third party such as a hospital, nursing facility, or home health agency.

Payment: We may use and disclose your PHI to obtain payment for services provided to you, or to obtain authorizations for procedures/treatment plans.

Healthcare Operations: We may use or disclose your PHI in order to support the business activities of the practice. These activities include, but are not limited to, quality assurance, employee review, training of staff or medical students, licensing, credentialing, and certification. In addition, we may use a sign-in sheet at the registration desk, call you in by name from the waiting room, or contact you to remind you of your appointment.

Persons Involved in Care: We may use and disclose your PHI to notify, or assist in the notification of a family member, you personal representative or another person responsible for your care, of your location, general condition, or death. If you are present then we will provide you the opportunity to object to such uses or disclosures. In the event of your incapacity or under emergency circumstances, we will use our professional judgment in disclosing only health information that is directly relevant to that person's involvement in your care. We will also use our professional judgment and our experience with common practice to make a reasonable inference of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of PHI on your behalf.

Required by Law: We may also use and disclose your PHI without your permission in the following situations - Public health issues, Communicable Diseases, Health Oversight, Abuse or Neglect, FDA requirements, Workers Compensation, and Coroners, Criminal, HHS investigations, as required by law.

Your Authorization: In addition to our use or your PHI as noted above, you may give us written authorization to use or disclose your PHI to anyone for any purpose. If you give us an authorization, you may revoke it at any time. Your revocation will not affect any use or disclosure made while it was in effect. Unless you give us a written authorization we cannot use or disclose your PHI for any reason except those described in this Notice.

PATIENT RIGHTS – The following is a statement of your rights with respect to your PHI.

Access: You have the right to inspect and get copies of your PHI, with limited exceptions such as psychotherapy notes and information for use in civil, criminal, or administrative proceedings. You must make a request in writing to obtain access to your PHI. You may obtain a form to request access by contacting the contact information listed at the end of this Notice. We may charge you a reasonable cost-based fee for expenses such as copies and staff time.

Restriction: You have the right to request that we place additional restrictions on our use and disclosure of your PHI. The request must be in writing. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your PHI. Your request must be in writing and explain why you feel the information should be amended. We may deny your request, and if you file a statement of disagreement we will prepare a rebuttal statement and provide you with copies of it.

Alternative Communication: You have the right to request that we communicate with you about your PHI by alternative means or to an alternative location. You must make your request in writing and must specify the alternate means or location, and explain how payments will be handled under the alternative you request.

Disclosure Accounting: You have the right to receive a list of instances in which we, or our business associates, disclosed your PHI for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request an accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

QUESTIONS AND COMPLAINTS – If you want more information about our privacy practices or have any questions, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may complain to us using the contact information at the end of this notice. You may also submit a written complaint to the U.S. Dept. of Health and Human Services. We will provide you with the address upon request. We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the Secretary, HHS.

Contact Officer: Maria Shteysel Telephone: (718) 744-7209 Fax (718) 488-1919
Mailing Address: Dr. Scott L. Cooper 585 Fulton Brooklyn, NY 11201

The signature below is only acknowledgement that you have received this Notice of Privacy Practices

Print Name:_____ **Signature:**_____ **Date:**_____

Dr. Scott L. Cooper

AUTHORIZATION TO DISCLOSE PHI

I authorize Dr. Scott L. Cooper to disclose and discuss my protected health information (PHI), including future conditions, treatments and prognosis, to the below listed individuals.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization will remain in effect until I request it to be rescinded. This request must be made in writing.

Patient Name: _____ Signature: _____

Date: _____