BUCKS COUNTY ALLERGY & ASTHMA ASSOCIATES

Notice Regarding Privacy of Personal Health Information

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to protect the privacy of this information. We are also required to post our practices. If you have any questions or concerns please contact our Privacy Officer.

WHO WILL FOLLOW THIS NOTICE

Any health care professional authorized to enter information into your medical record. All employees, staff and other personnel at this practice who may need access to your information must abide by this notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways we may use and disclose medical information without your specific consent or authorization:

We may use medical information about you to provide you with treatment or services, in our practice and with other healthcare providers, pharmacies or facilities that we refer you to for treatment or evaluation.

We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment collected from you, an insurance company or a third party.

We may use and disclose medical information about you for the health care operations to ensure that you receive quality care as required during an investigation by law enforcement agencies, to avert a serious threat to public health or safety, in response to a legal proceeding or disclosure required by law, to a coroner or medical examiner for identification of a body or for use and disclosures in domestic violence or neglect situations.

We may use and disclose medical information about you as required by military command authorities for their medical records, to workman's compensation or similar agencies for processing claims and any other covered healthcare operation activities (covered under HIPAA) such as audits, investigations or inspections.

We will not use or disclose your health information for any purpose other than those identified in this section without your specific, written authorization. If you wish to revoke authorization it must be in writing.

We will not release any HIV or substance abuse information without your written consent.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request in order to have copies of your records. We may charge a fee for the cost of copying, mailing or other associated charges. Ample time is required to comply with your request.

If you believe your health information we have about you is incorrect or incomplete, you may ask us to amend the information. We may deny your request if it is not in writing or does not include a reason to support your request.

You have the right to request restrictions or limitations on the health information we use or disclose about you for treatment, payment or healthcare operations to someone who is involved in your care or the payment for it. All requests must be in writing. We have the right to not agree with your request and would inform you of that decision.

We have the right to change this notice or make revisions.

If you believe your privacy has been violated, you may file a complaint with our office.

Bucks County Allergy & Asthma Associates

Dr. Ira Spitzer
370 Middletown Blvd
Suite 504
Langhorne, PA 19047
215-750-0315

<u>ACKNOWLEDGEMENT</u>

I, _______________________________, acknowledge that I have received a copy of *The Bucks County Allergy & Asthma Associates Notice Regarding Privacy of Personal Health Information.*

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Patient's Signature

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Date

PATIENT CONSENT, AGREEMENT AND AUTHORIZATION

I AUTHORIZE *Bucks County Allergy & Asthma Associates* to use and disclose information in my medical records for treatment, payment and health care operations purposes. I understand that the information in my medical records may be used and disclosed to other persons other than to carry out their responsibilities in connection with my medical/health care treatment, in payment for health care services and activities related to health care operations.

I understand that medical treatment is necessary. I hereby consent to and authorize administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the physicians of *Bucks County Allergy & Asthma Associates*. I reserve the right to refuse any and all treatments.

I understand and agree that I am ultimately responsible to pay the charges for all services rendered to me. I understand that if for some reason under my insurance guidelines, a service is determined to be non-covered, partially paid, or denied. I will be responsible for payments.

I request that payment for authorized insurance benefits be made on my behalf to *Bucks County Allergy & Asthma Associates* or any services rendered to me by said group. Photocopy of this authorization shall be considered effective and valid as the original.

If I am currently pregnant or planning to become pregnant over the next year, if I am currently using birth control or breast feeding, it is my responsibility to inform *Bucks County Allergy & Asthma Associates.*

I have read the above statements, understand and agree to them. I understand that they are a permanent part of my file. Should I wish to rescind my authorization, I must do so in writing.

I acknowledge that I have received *Bucks County Allergy & Asthma Associates* Notice of Practices for Protected Health Information.

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Signature of Patient or Patient Representative Date

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Printed Name of Patient Patient's Date of Birth