NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH 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

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described while it is in effect. This notice takes effect 4/14/2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notices available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may use and disclose health information about you in the following situations. These situations are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare operations: We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, training of medical students and residents, licensing or arranging for other business activities. We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever we share your health information with a business associate, we will have a written contract that contains the terms that will protect the privacy of your protected health information.

Required by law: We may use or disclose your health information when we are required to do so by law.

Public Health: We may disclose your protected health information for public health activities and purpose to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court of administrative tribunal, or in certain conditions in response to a subpoena, discovery request or other lawful process.

Coroners and Funeral Directors: We may disclose protected health information to a coroner, medical examiner or funeral director for identification purposes, determining cause of death or to perform other duties authorized by law.

PATIENT RIGHTS

Access: You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of your protected health information for so long as we maintain this information. As permitted by federal or state law, we may charge you a reasonable fee for a copy of your records.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. This request must be made in writing and must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Notice: You have the right to obtain a paper copy of this notice.

COMPLAINTS: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Patricia Moriarty at 973-748-3800 or pat@northjerseycardio.com for further information about the complaint process.

NORTH JERSEY CARDIOVASCULAR CONSULTANTS, L.L.C.

329 Belleville Avenue
Bloomfield, NJ 07003
Phone: 973-748-3800
Fax: 973-748-3540

80 Bloomfield Avenue
Caldwell, NJ 07005
Phone: 973-364-1444
Fax: 973-364-0101

96 Millburn Avenue
Millburn, NJ 07041
Phone: 973-762-2782
Fax: 973-762-1946

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents, I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____hereby authorize _____

Name of Insured Name of Insurance Company

To pay and hereby assign directly to North Jersey Cardiovascular Consultants, LLC, all benefits, if any, otherwise payable to me for their services. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to North Jersey Cardiovascular Consultants, LLC will be credited to my account, in accordance with the above said assignment.

_____ _____

Authorized Signature of Insured Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name _____ Date of Birth _____

I authorize the use and/or disclosure of the above –named individual's protected health information, as described below:

The following individual or organization is authorized to use and/or make disclosure:

329 Belleville Avenue Bloomfield, NJ 07003	80 Bloomfield Avenue Caldwell, NJ 07006	96 Millburn Avenue, Suite 200B Millburn, NJ 07041

The protected health information (PHI) may be used by the above-named organization for the purpose of, but not limited to, treatment activities of any health care provider, and disclosure for the purpose of health care operations

The information to be disclosed shall be limited to that information necessary to fulfill the above-stated purpose(s).

This authorization may be revoked by me at any time except to the extent that North Jersey Cardiovascular Consultants, LLC has already acted in reliance on this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to the organization's Privacy Officer.

Signature of Patient or Legal Representative _____

If signed by Legal Representative, relationship to patient _____

Date _____

ACKNOWLEDGMENT OF RECEPIT OF NOTICE OF PRIVACY PRACTICES

I _____ have received and/or reviewed a copy of this office's Notice or Privacy Practices.

_____ _____

Signature Date