

Haddon Renal Medical Specialists, PA

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HIPPA NOTICE OF PRIVACY PRACTICES

If you have any questions about this notice, please contact our office manager.

Effective date: 9/01/05

WHO WILL FOLLOW THIS NOTICE

This notice describes information about privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by healthcare providers you consult with by telephone (when your regular healthcare provider form our office is not available) who will provide "call coverage" for your healthcare provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the healthcare and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and out obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We must have your written, signed consent to use and disclose health information for the following purposes:

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that the doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other healthcare providers may be part of your medical care outside this office and may require information about you that we have.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Healthcare Operations: We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders: We may contact you as reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services: We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health related products and services. If you advise us in writing (at the address listed at the top of this notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

You may revoke your consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures that occurred before that time.

If you do revoke your consent, we will not be permitted to use or disclose information for purposes of treatment, payment or healthcare operations, and we may therefore choose to discontinue providing you with healthcare treatment and services.

401 Kings Hwy South, Bldg 5
Cherry Hill, NJ 08034
(856) 428-8992
Fax (856) 428-9614

100 Brick Rd, Ste 207
Marlton, NJ 08053
(856) 988-7009
Fax (856) 988-7098

630 Bellevue Avenue
Hammonton, NJ 08037
(856) 428-8992
Fax (856) 428-9614

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes: We may use or disclose your protected health information in the following situations with your authorization.. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Director, Organ Donation, Research, Criminal Activity, Military Activity and National Security, Worker’s Compensation, Inmates, Required Uses and Disclosures, Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Family and Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information of your family or friends if we can infer from the circumstances, abased on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to inspect and copy: 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 to our office manager in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs or copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend: If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. To request an amendment, complete and submit a Medical Record Amendment/Correction Form to our secretary. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: a) We did not create, unless the person or entity that created the information is no longer available to make the amendment, b) Is not part of the health information that we keep, c) You would not be permitted to inspect and copy, d) Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures.” This is a list of the disclosures, we made of medical information about you for purposes other than treatment, payment and healthcare operations. To obtain this list, you must submit your request in writing to our secretary. It must state a time period, which may not be longer than six years and we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to some one who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request: If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions you may complete and submit the Request for Restriction on Use/Disclose of Medical Information to our secretary.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication to the office manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Rights to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our secretary.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and to make the revised or changed notice effective for Medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our office manager. You will not be penalized for filing a complaint.

YOUR SIGNATURE BELOW ACKNOWLEDGES THAT YOU HAVE RECEIVED THIS NOTICE OF OUR PRIVACY PRACTICES:

Print Name: _____ Signature: _____ Date: _____

Request for Restriction on Disclosure/Communication of Medical Information

Our doctors, nurses and office staff may need to contact you for such purposes as: appointment reminders, relaying test results and instructions, answering or asking questions regarding your health status, or general medical follow-up.

List any person(s) we may talk to about your health.

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____

May we leave a voice message when calling your house? _____ Yes _____ No _____ Brief _____ Extended

May we leave a voice message when calling your work? _____ Yes _____ No

May we leave a voice message when calling your cell? _____ Yes _____ No _____ Brief _____ Extended

Other specific instructions you may have:

Name of Patient (Print) _____

Signature of Patient _____ Date: _____

Signature of Patient Representative _____

Relationship of Patient Representative to Patient _____