



Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

The federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is to provide you with a description of the types of information that we gather about you, with whom that information may be shared, the safeguards we have in place to protect it, and your rights to access and amend your health information. Because this notice only describes your privacy protections and other rights related to your medical information under HIPAA, you may be afforded additional protections and rights under other federal laws and/or state laws that are not described in this notice. If the practices in this notice meet your expectations, there is nothing further you need to do. If you prefer that we not share certain information, you may make a written request, as described below.

Our Pledge Regarding Your Medical Information

We understand that information about you and your health is personal. We are thus committed to protecting the confidentiality of your medical information. As part of our routine operations, we create a record of the medical care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care, whether made by your personal doctor or other personnel. Whenever we use the term "*medical information*" in this notice, we mean information created or received about you that concerns your health care and payment for that health care. This notice tells you about the ways we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Federal law requires us to:

- Maintain the privacy of your medical information
- Provide you with notice of our duties and privacy practices related to your medical information
- Notify you when there is a breach, or unlawful access, use, or disclosure of your information
- Follow the terms of this privacy notice

How We May Use and Disclose Your Medical Information

The following describes different ways that we may use and disclose your medical information. For each category of uses or disclosures we will explain what the category means and give examples. These examples are not exhaustive;

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you. *For example: A Doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietician if you have diabetes so that we can arrange for appropriate meals.* Different departments of the facility also may share medical information about you to coordinate the different things you need such as prescriptions, lab work, and x-rays. When necessary, we may also disclose medical information about you to people outside the facility who may be involved in your medical care.

As Required By Law: We will disclose medical information about you when required to do so by federal, state, or local law.

Workers' Compensation: We may release medical information about you to your employer's insurance carrier, to the Workers' Compensation Board, or to similar programs.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health, and Genetic Information: Special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, psychotherapy notes (under federal law), and genetic information. If your care involves these special areas, please contact your health care providers or counselors for more information about these additional protections.

Legal Proceedings: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.



Your Rights Regarding Your Medical Information

Right to Access and Copy: You have the right to request access to, and obtain a copy of, information that may be used to make decisions about you and your care. This information includes medical and billing records, but does not include psychotherapy notes or information pertaining to an ongoing clinical trial. You have the right to request that copies of electronic records be provided in electronic form. To access and copy information that may be used to make decisions about you and your care, please submit your request in writing to the facilities Health Information Management Department.

If you request that a copy of the information be provided to you, we may charge a fee to cover the cost of copying, preparing, and mailing the request. If you are denied access to the information, we will provide you with a written explanation.

Right 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 obtained your notice electronically, you are still entitled to a paper copy of this notice. You may also obtain a copy of this notice at our website, www.painfreenyc.com. To obtain a paper copy of this notice, please request one from the facility's Admitting or Registration Department.

Complaints

If you believe your privacy rights have been violated, or have concerns about our privacy practices, you may file a complaint with the Secretary of the Department of Health and Human Services. To file a complaint, please call the toll-free Complaint Hotline at 1-866-HELP-HHC. **You will not be penalized for filing a complaint.**

Other Uses and Disclosures of Medical Information

Other uses and disclosures of medical information that are not covered by this notice, or by applicable federal, state, and local laws, will only be made with your written permission. If you provide us with permission to use or disclose your medical information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will cease to use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures that we have already made with your permission and that we are required to retain in our records of the care that we provided to you.

Acknowledgement

By signing and dating the form below, I acknowledge that I have received a copy of LR Medical, PLLC's Privacy Practice Notice, in compliance with the New York City Health and Hospitals Corporation Privacy Notice and the Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

Patient's Name: _____

Patient's Signature: _____

Date: _____

If executed by a patient's personal representative, please complete the section below.

Personal Representative's Name: _____

Personal Representative's Signature: _____

Relationship to Patient: _____



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:	
8. Name and address of person(s) or category of person to whom this information will be sent: T: 718-998-9890 F: 718-998-9891 Dr. Reyfman, Leonid- Pain Physicians NY: 2279 Coney Island Avenue, Suite 2 Brooklyn, NY 11223	
9(a). Specific information to be released: <input type="checkbox"/> Medical Record from (insert date) _____ to (insert date) _____ <input type="checkbox"/> Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers. <input type="checkbox"/> Other: _____ Include: (Indicate by Initialing) _____ Alcohol/Drug Treatment _____ Mental Health Information _____ HIV-Related Information	
Authorization to Discuss Health Information (b) <input type="checkbox"/> By initialing here _____ I authorize _____ Initials Name of individual health care provider to discuss my health information with my attorney, or a governmental agency, listed here: _____ (Attorney/Firm Name or Governmental Agency Name)	
10. Reason for release of information: <input type="checkbox"/> At request of individual <input type="checkbox"/> Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of patient or representative authorized by law. Date: _____

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Instructions for the Use
of the HIPAA-compliant Authorization Form to
Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.