Medical Associates of Mendham
5 Cold Hill Road South, Suite 9
Mendham, NJ 07945
Phone: 973. 813. 4111
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Notice of Health Information Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information when necessary. Please review it carefully.

Introduction

At Mendham Associates of Mendham we are committed to treating information about you and your health responsibly. This Notice of health information practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice applies to all protected health information as defined by federal regulations.

Understand Your Health Record/Information

Each time you visit Medical Associates of Mendham a record of you visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as:

- A basis for planning your care and treatment
- A means of communication among the many health professionals who contribute to your care
- A legal document describing the care you received
- A means by which you or a third party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials
- A source of data for our planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understand what is in your record and how your health information is used helps you to ensure its accuracy, better understand who may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is a physical property of Medical Associates of Mendham the information belongs to you. You have a right to:

- Inspect and copy your health record
- Amend your health record
- Obtain and accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction of certain uses and disclosures of your information
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

Medical Associates of Mendham is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact Dr Christie Prestifilippo and or Dr Allison Connolly973. 813.4111

Examples of Disclosures for Treatment, Payment and Health Operations

For Treatment: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record the expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

For Payment: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

For Health Operations: Members of the medical staff, the risk or quality improvement manager, and members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and other like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Notification: In the event of an emergency, we may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your situation.

Communication with family: Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend and any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers, provided their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law, in order for them to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury and disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes and required by law in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

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Patient Consent Form

Patient consent to the use and disclosure of health information for treatment, payment or healthcare operations

I understand that as port of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information (PHI) to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

_____
Patient's Signature

_____
Date

I wish to have the following restrictions to the use or disclosure of my health information:

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