Mount Sinai UNITE HERE HEALTH

Patient Name:_____ **D.O.B:**_____

Address:_____ **Home Phone:**_____

_____ **Cell Phone:**_____

Insurance ID#:_____ **Group:**_____

Emergency Contact:_____ **Phone Number:**_____

HIPAA Notice of Privacy Practice

NOTICE OF PRIVACY PRACTICES

Effective Date: October 1, 2017

This Notice applies to individuals receiving services from the **UHH-MSHP** and does not require your response. **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.**

YOUR RIGHTS

- **Right to see and copy your records.** In most cases, you have a right to view or get copies of your records. You must make your request in writing. We will provide a response to your request within thirty (30) days. You may be charged a fee for the cost of copying your records.
- **Right to an electronic copy of your medical records.** If your information is maintained in an electronic format, you may request that your electronic records be transmitted to you or another individual or entity. We will respond to your request within thirty (30) days.
- **Right to correct or update your records.** You may ask us to correct your health information if you think there is a mistake. You must make your request in writing and provide a reason for your need to correct the information.
- **Right to choose how we communicate with you.** You may ask us to share information with you in a certain way. For example, you can ask us to send information to your work address instead of your home address. You must make this request in writing. You don't have to explain a reason for the request. We may deny unreasonable requests.
- **Right to get a list of disclosures.** You have a right to ask us for a list of disclosures made after April 07,2016. You must make a request in writing. This will not include information shared for treatment, payment or health operation purposes. We will provide one accounting a year free of charge, but may charge a cost for additional lists provided within the 12 month period.
- **Right to get notice of a breach.** You have a right to be notified upon a breach of any of your protected health information.
- **Right to request restrictions on uses or disclosures.** You have a right to ask us to limit how your information is used or shared with others. You must make the request in writing and indicate what information should be limited. We are not required to agree to a requested restriction. If you paid out-of-pocket expenses in full for a specific item or service, you have a right to ask that your information with respect to that item or service not be disclosed. We will always honor that request.
- **Right to revoke authorization.** If we ask you to sign an authorization to use or disclose your information, you can cancel that authorization at any time. You must make that request in writing. Your request will not affect information that has already been shared.
- **Right to get a copy of this notice.** You have a right to ask for a paper copy of this notice at any time
- **Right to file a complaint.** You have a right to file a complaint if you don't agree with how we have used or disclosed your information.
- **Right to choose someone to act for you.** If someone has been legally designated as your personal representative, that person can exercise your rights and make choices about your health.

Other Uses and Disclosures that Require Your Written Authorization

- **For All Other Situations.** We will ask for your written authorization before using or disclosing information for any other purpose than what is mentioned above. Special circumstances that require an authorization include most uses and disclosures of your psychotherapy notes, certain disclosures of your test results for the human immunodeficiency virus or HIV, uses and disclosures of your health information for marketing purposes and for the sale of your health information with some exceptions. If you give us authorization, you can withdraw this written authorization at any time. To withdraw your authorization, please contact us at the number below. If you revoke your authorization, we will no longer use or disclose your health information as allowed by your written authorization, except to the extent that we have already relied on your authorization.
- **As Required by Other Laws.** We will ask for your written authorization to comply with other laws protecting the use and disclosure of your information.

FILING A COMPLAINT

You may use the contact information below if you want to file a complaint or to report a problem regarding the use or disclosure of your health information. Treatment or services being provided to you will not be affected by any complaints you make. UHH-MSHP opposes any retaliatory acts resulting from participation in an HIPAA investigation.Unite Here Health-Health Center-Mount Sinai Health Partners,P.C,1801 Atlantic Ave,3rd Fl,Atlantic City,NJ 08401.609-345-8212

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document and understand that I may obtain a copy for my records upon request.

Patient signature:_____

Date:_____