New York Physicians LLP
635 Madison Avenue • New York, New York 10022
Tele (212) 317-4500 • Fax (212) 752-2454

April 14, 2003

Dear Patient:

With the passage of the Health Insurance Portability and Accountability Act (HIPAA), the federal government has new rules about how physicians and medical practices use your personal medical information. Maintaining patient confidentiality and safeguarding the appropriate use and disclosure of this information have always been a part of our practice. The new law is largely a formal, regulated framework for privacy issues.

We are providing you with our formal Notice of Privacy Practices. Please take the time to review it carefully. The new law requires us to verify that we have provided this Notice to you today. We would appreciate your signature on the next page acknowledging the receipt of the New York Physicians Notice of Privacy Practices.

Thank you very much.

Sincerely,
New York Physicians LLP

ACKNOWLEDGEMENT OF RECEIPT OF THE
NEW YORK PHYSICIANS LLP
NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the New York Physicians LLP Notice of Privacy Practices.

_____ _____

Patient's Signature Date

_____

Patient's Name (please print)

NEW YORK PHYSICIANS LLP

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize New York Physicians LLP to use and/or disclose PHI about me to the following person(s) and entity(ies):

PLEASE CHECK and specify name if desired:

__ Spouse/Domestic Partner	__ Translator
_____	_____
__ Guarantor	__ Health attendant
_____	_____
__ Emergency Contacts	__ Private nurse
_____	_____
__ Adult Children	__ Fitness trainer
_____	_____
__ Family member, specify name & relationship:	__ Administrative/personal assistant
_____	_____
__ Significant other, specify name:	__ Other, specify name & relationship:
_____	_____

I authorize New York Physicians LLP to use and/or disclose the information I mark:

PLEASE CHECK, NOT COMPLETE

__ **All of the information below**

__ Name	__ Health plan beneficiary number
__ Address	__ Account # with us, any other unique identifying #
__ All dates	__ Medications
__ Telephone number	__ Office and/or hospital notes
__ Fax number	__ Diagnosis
__ Electronic mail and/or IP address	__ Diagnostic test results
__ Social Security number	__ Prognosis and treatment plan
__ Medical record number	__ Outstanding account balance

The information will be used or disclosed at my request.

This authorization will be valid until I revoke it in writing or note its expiration here.

I do not have to sign this authorization in order to receive treatment from New York Physicians LLP. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: New York Physicians LLP, 635 Madison Avenue, New York, New York 10022.

Signed by: _____ _____

Signature of Patient/Patient Representative Relationship to Patient

_____ _____

Print Patient or Patient Representative's Name Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION