PLOTSKY MEDICAL ASSOCIATES | **Notice of Privacy Policy & Practices**

Plotsky Medical Associates PC is required by law to protect the privacy of your personal health information (PHI) and to inform you of our policies to do so. In order to comply with HIPAA regulations, Federal and State laws, we adhere to this Privacy Policy. We reserve the right to change this policy and if we do so, we will post written notification of the policy changes and effective dates. The following is a guideline of our PHI compliance:

- We do not fax patient PHI other than to other physician offices, hospital, health care facilities, or insurance carriers. Only at the patient's request will send PHI to the patient's home or place of employment.
- We do not discuss patient information with anyone either over the phone or in person without the written authorization of the patient (this includes family members of minors).
- We will not give out patient demographic information without the patient's written consent unless for ongoing health care for the patient. When requested by other health care providers, we will confirm that provider's identity and relationship with the patient.
- We will speak in soft or low tones in the office to minimize the possibility of being overheard.
- We will not release patient information such as referrals, test results, prescriptions, or orders to anyone other than the patient unless written authorization is given from the patient. Below, please provide those individuals who are authorized to receive your PHI.

I, _____, date of birth _____ hereby authorize Plotsky Medical Associates PC to speak to the following individuals on my behalf, pick up lab orders, referrals, prescriptions and/or copies of any lab or imaging results that I request:

NAME/RELATIONSHIP	**TELEPHONE**

Plotsky Medical Associates PC also has my permission to include information that may pertain to AIDS, ARC, HIV-related disease, blood alcohol content, and alcohol/substance abuse in the course of your health care operations. This authorization does not expire. I understand that I have the right to withdraw this authorization at any time except to the extent that action has been taken based on this authorization

Patient/Responsible Party Signature	*Printed Name*	*Date*
Witness	*Printed Name*	*Date*