PRIVACY PRACTICES

Acknowledgement of Receipt of Notice of Privacy Practices

In accordance with New federal laws (HIPPA, Health Information Portability and Accountability Act) regarding privacy of medical file, we must ask that you read and sign acknowledgement that we provided you with our privacy practices. I have received a copy of the notice of Privacy Practices for Richmond Internal Medicine Group and acknowledge the same by signing below.

Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Richmond Internal Medicine Group for the purpose of diagnosis or treatment of me by Richmond Internal Medicine Group treating doctor may be conditioned upon my consent, as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Richmond Internal Medicine Group is not required to agree to the restrictions that I may request. However, if Richmond Internal Medicine Group agrees to a restriction that I request, the restriction is binding on Richmond Internal Medicine Group and Richmond's treating doctor.

I have the right to revoke this consent, in writing, at any time, except to the extent that RIMG treating doctor or RIMG has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health provider, a health plan, my employer or a health care clearing house. This protected health information relates my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Richmond Internal Medicine Group Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of RIMG. The notice of Privacy Practices also describes my rights and the Richmond Internal Medicine Group duties with respect to my protected health information.

Richmond Internal Medicine Group reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Authorization Form

I authorize my physician and/or administrative and clinical staff to use my protected health information for the purpose of evaluating health, diagnosing medical conditions, providing treatment, and securing payment for the same. This authorization shall be in force in perpetuity or as long as any open balances remain in effect.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact, Ricardo Baez, at 800 Manor Road, Suite 4, Staten Island, NY 10314. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party.

_____ Date: _____

Signature of Patient or Personal Representative

_____ _____

Print Name of Patient or Personal Representative

Relationship to Patient