



ACKNOWLEDGEMENT FORM

NOTICE OF PRIVACY PRACTICES

EFFECTIVE APRIL 14, 2003

This Acknowledgement Form is provided to you as required by the Privacy Rule and related Regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

You are asked to sign this form so that we can confirm that you have received it. Your signature only confirms that you have received this Form. Your signature does not mean that you agree with any of the policies and procedures outlined herein.

You may refuse to sign this Acknowledgement Form, at which time our staff is required to document the date and time of your refusal, as well as your reason for not signing.

I acknowledge that I have received a copy of New York Physicians LLP Notice of Privacy Practices, as of the date indicated below.

Name of Patient

Signature of Patient

Date Signed

If checked, please see reverse side or page 2 for Patient's Refusal to Sign

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:

<input type="checkbox"/> Spouse/Domestic Partner _____	<input type="checkbox"/> Translator _____
<input type="checkbox"/> Guarantor _____	<input type="checkbox"/> Health attendant _____
<input type="checkbox"/> Emergency Contacts _____	<input type="checkbox"/> Private nurse _____
<input type="checkbox"/> Adult Children _____	<input type="checkbox"/> Fitness trainer _____
<input type="checkbox"/> Family member, specify name & relationship: _____	<input type="checkbox"/> Administrative/personal assistant _____
<input type="checkbox"/> Significant other, specify name: _____	<input type="checkbox"/> Other, specify name & relationship: _____

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

PLEASE CHECK ALL THAT APPLY

<input type="checkbox"/> All of the information below	
<input type="checkbox"/> Name	<input type="checkbox"/> Health plan beneficiary number
<input type="checkbox"/> Address	<input type="checkbox"/> Account # with us, any other unique identifying #
<input type="checkbox"/> All dates	<input type="checkbox"/> Medications
<input type="checkbox"/> Telephone number	<input type="checkbox"/> Office and/or hospital notes
<input type="checkbox"/> Fax number	<input type="checkbox"/> Diagnosis
<input type="checkbox"/> Electronic mail and/or IP address	<input type="checkbox"/> Diagnostic test results
<input type="checkbox"/> Social Security number	<input type="checkbox"/> Prognosis and treatment plan
<input type="checkbox"/> Medical record number	<input type="checkbox"/> 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