



**Insall Scott Kelly
Orthopaedics & Sports Medicine
Lenox Hill Hospital**

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14th, 2003

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.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our hospitals and medical group, its medical staff and affiliated health care providers who jointly perform health care services with our hospitals and medical group, including physicians and physician groups who provide services at our facilities. A copy of our current notice will always be posted at all registration/admission points. You will also be able to obtain your own copies by accessing our website at www.lenoxhillhospital.org, calling the Director of Patient Relations at 212-434-2095 for Lenox Hill Hospital and Manhattan Eye, Ear, and Throat Hospital or by calling the Supervisor of Patient Registration at 212-423-3128 for the Lenox Hill Community Medical Group.

If you have any further questions about this notice or would like further information, please contact the above referenced individuals.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information include information indicating that you are a patient of our hospitals or the medical group or receiving health-related services from our facilities, information about your health care benefits under an insurance plan, each when combined with identifying information, such as your name, address, social security number or phone number.

REQUIREMENT FOR WRITTEN AUTHORIZATION

Generally, we will obtain your written authorization before using your health information or sharing it with others outside our hospitals and the medical group. If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to the Medical Record Correspondence unit at the hospitals or the Medical Group. You may also initiate the transfer of your records to another person by completing a written authorization form.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

There are some situations when we do not need your written authorization before using your health information or sharing it with others. They are:

1. Treatment, Payment and Health Care Operations.

Treatment. We may share your health information with doctors or nurses at the hospitals or at the medical group who are involved in taking care of you, and they may in turn use that information to diagnose or treat you. A doctor at our facilities may share your health information with another doctor at our facilities, or with a doctor at another hospital, to determine how to diagnose or treat you. Your doctor may also share your health information with another doctor to whom you have been referred for further health care.

Payment. We may use your health information to share it with others so that we may obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

Health Care Operations. We may use your health information or share it with others in order to conduct our business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you.

2. Appointment Reminders, Treatment Alternatives Benefits and Services.

In the course of providing treatment to you we may use your health information to contact you with a reminder that you have an appointment for treatment or services or in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

3. Fundraising.

We may use demographic information about you, including information about your age and gender, where you live or work, and the dates that you received treatment, in order to contact you to raise money to help us operate. If you do not want to be contacted for these fundraising efforts, please contact the Director of Annual Campaigns at Lenox Hill Hospital at 212-434-2451.

4. Business Associates.

We may disclose your health information to contractors, agents, and other “business associates” who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company, or we may share your health information with an accounting firm or law firm that provides professional advice to us. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information.

5. Patient Directory.

If you do not object, we will include your name, room number, general condition and your religious affiliation in our Patient Directory while you are a patient in one of our hospitals listed at the beginning of this notice. This directory information, except for your religious affiliation, may be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if he or she doesn't ask for you by name.

6. Friends, Family Designated To Be Involved In Your Care.

If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for your care.

7. Emergencies or Public Need.

Emergencies or as Required by Law We may disclose your health information if you need emergency treatment or if we are required by law to do so, and we will notify you of these uses and disclosures if notice is required by law.

Public Health Activities. We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities under law, such as controlling disease or public health hazards. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if permitted by law. And finally, we may release some health information about you to your employer if your employer hires us to provide you with a physical exam and we discover that you have a work related injury or disease that your employer must know about in order to comply with employment laws.

Victims of Abuse, Neglect or Domestic Violence. We may release your health information to a public health authority to receive reports of abuse, neglect, or domestic violence.

Health Oversight Activities. We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facilities. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Product Monitoring, Repair and Recall. We may disclose your health care information to a person or company that is regulate by the Food and Drug Administration for purposes related to the quality, safety, or effectiveness of an FDA-regulated product, including, for example (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

Lawsuits and Disputes. We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if required judicial or other approval or necessary authorization is obtained.

Law Enforcement. We may disclose your health information to law enforcement officials for certain reasons, such as complying with court orders, assisting in the identification of fugitives or the location of missing persons, if we suspect that your death resulted from a crime, or if necessary, to report a crime that occurred on our property or off-site in a medical emergency.

To Avert a Serious and Imminent Threat to Health or Safety. We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or if we determine that you escaped from lawful custody (such as a prison or mental health institute).

National Security and Intelligence Activities or Protective Services. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

Military and Veterans. If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Inmates and Correctional Institutions. If you are an inmate or you are desired by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

Worker's Compensation. We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

Coroners, Medical Examiners and Funeral Directors. In the event of your death, we may disclose your health information to a coroner or medical examiner. We may also release this information to funeral directors as necessary to carry out their duties.

Organ and Tissue Donation. In the event of your death or impending death, we may disclose your health information to organization that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

Research. In most cases, we will ask for your written authorization before using your health information or sharing it with others in order to conduct research. However, under some circumstances, we may use and disclose your health information without your written authorization if we obtain approval through a special process to ensure that research without your written authorization poses minimal risk to your privacy. Under no circumstances, however, would we allow researchers to use your name or identity publicly. We may also release your health information without your written authorization to people who are preparing a future research project, so long as any information identifying you does not leave our facility. In the unfortunate event of your death, we may share your health information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.

8. Completely De-identified or Partially De-identified Information. We may use and disclose your health information if we have removed any information that has the potential to identify you so that the health information is “completely de-identified.” We may also use and disclose “partially de-identified” health information about you if the person who will receive the information signs and agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will *not* contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

9. Incidental Disclosures. While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

You have the following rights to access and control your health information:

1. Right to Inspect and Copy Records. You have a right to inspect and obtain a copy of any of your health information that may be used to make decision about you and your treatment for as long as we maintain this information in our records, including medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the Medical Record Correspondence Unit of Lenox Hill Hospital or Manhattan Eye, Ear, and Throat Hospital, or the Lenox Hill Community Medical Group as applicable. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. Our hospitals and the medical group charge a reasonable fee to cover the cost of copying and mailing. This fee must generally be paid before or at the time we give the copies to you. We will respond to your request for inspection of records within 10 days. We ordinarily will respond to request for copies within 30 days if the

information is located in our facility and within 60 days if it is located off site at another facility. If we need additional time to respond to a request for copies, we will notify you in writing within the time frame above to explain the reason for the delay and when you can expect to have a final answer to your request. Under certain very limited circumstances, we may deny part or all of your request to inspect or obtain a copy of your information. If we do, we will provide a written denial that explains our reasons for doing so, and a complete description of your rights to have that decision reviewed and how you can exercise those rights.

2. **Right to Amend Records.** If you believe that the health information that we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is kept in our records by writing to the Medical Record Correspondence Unit at the Lenox Hill Hospital, Manhattan Eye, Ear and Throat Hospital, or the Lenox Hill Community Medical Group as applicable. Your request should include the reasons why you think we should make the amendment. If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records.
3. **Right to an Accounting of Disclosures.** You have a right to request an “accounting of disclosures,” which is a list with information about how we have shared your health information with others. Many routine disclosures we make will not be included in this accounting; however, the accounting will include many non-routine disclosures. To obtain a request form for an accounting of disclosures, please write to the Medical Record Correspondence Unit at Lenox Hill Hospital or Manhattan Eye, Ear and Throat Hospital, or the Lenox Hill Community Medical Group as applicable. You have a right to receive one list every 12 month period for free. However, we may charge you for the cost of providing any additional lists in that same 12 month period.
4. **Right to Request Additional Privacy Protections.** You have the right to request that we further restrict the way we use and disclose your information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to your family and friends involved in your care. To request restrictions, please write to the Medical Record Correspondence Unit at Lenox Hill Hospital or Manhattan Eye, Ear and Throat Hospital, or the Lenox Hill Community Medical Group as applicable. We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law. Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so.
5. **Right to Request Confidential Communications.** You have the right to request that we contact you about your medical matters in a more confidential way, such as calling you at work instead of at home, by notifying the registration associate who is assisting you. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.

6. **Right to Have Someone Act on Your Behalf.** You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf. For adults, a personal representative is someone who is authorized under New York law to make health care decisions on another person's behalf.

7. **Right to Obtain a Copy of Notices.** If you are receiving this notice electronically, you have the right to a paper copy of this notice which you may request at any time by asking the registration associate who registers you or by visiting our website at www.lenoxhillhospital.org we may change our privacy practices from time to time. If we do, we will revise this notice and post any revised notice in our registration area. You will also be able to obtain your own copy of the revised notice. The effective date of the notice will always be noted in the top right corner of the first page. We are required to abide by the terms of the notice that is currently in effect.

8. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us by calling the Privacy Office at 212-434-6896, or with the Secretary of the Department of Health and Human Services. The hospital will not withhold treatment or take action against you for filing a complaint.

9. **Use and Disclosures Where Special Protections May Apply.** Some kinds of information, such as HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information. If you have any questions or concerns about the ways these types of information may be used or disclosed, please speak with your health care provider.

Orthopaedics & Sports Medicine
210 East 64th Street 4th Floor
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(212) 434-4300

ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospital and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information from my Health Care Provider. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the hospital, its staff, and the facilities listed at the beginning of this notice.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date: