Ihor Magun M.D., F.A.C.P.
2000 North Village Avenue Suite 202
Rockville Centre, NY 11570
Phone (516) 766-5147
Fax (516) 766-5483

Effective April 14, 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.

The privacy of your medical information is important to us. You may be aware that U.S. government regulators established a privacy rule ("HIPAA") governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

The Office Manager is in charge of privacy matters at our office. You can contact her at (516) 766-5147 if you desire further information, or have any questions or concerns.

USE AND DISCLOSURE OF PROTECTED INFORMATION

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. (For example, "if we refer you to a specialist, we may provide laboratory or test data to that specialist (subject to more stringent New York laws, such as restriction on disclosure of information concerning HIV/AIDS)").

Federal Law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you. (For example, "under your health plan, we are required to provide them with a diagnosis code for your visit and a description of the services rendered").

Federal law provides that we may use your medical information for health care operations without further specific notice to you, or written authorization by you. (For example, we may use your information for financial services and claim management purposes with our medical liability insurer).

We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:

1. Required by law;
2. Required for public health purposes;
3. Required by law to report child abuse;

4. Where required by health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or office of Professional Medical Conduct
5. Required by law in judicial or administrative proceedings;
6. Required for law enforcement purposes by a law enforcement official;
7. Required by a coroner or medical examiner;
8. Permitted by law to a funeral director;
9. Permitted by law for organ donation purposes;
10. Permitted by law to avert a serious threat to health or safety;
11. Permitted by law and required by military authorities if you are a member of the armed forces of the United States.

New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York state law with respect to such information.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering devices or with any person who answers the phone at your residence.

You can make reasonable requests in writing for us to use alternative methods communicating with you in a confidential matter. Space for this is provided below.

Other uses or disclosure of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights that you have

You have the right to request restrictions on certain uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information, except for: disclosures we make to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials

as permitted by law (or for research or public health purposes after being de-identified or limited to remove personally identifiable information) or disclosure made before April 14, 2003.

If you have received this notice electronically, you have the right to obtain a paper copy from our office.

Obligations that we have

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Security Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to Pat Swede, privacy officer, 2000 North Village Avenue Suite 202 Rockville Centre, New York 11570. No retaliatory action will be taken against you for any complaint you may make.

I have received a paper copy of this notice

_____ _____

Signature Date

_____

Print Name

I make the following special request for confidential communications:

_____

_____

_____

_____ _____

Signature Date

Ihor Magun M.D., F.A.C.P.
2000 North Village Avenue Suite 202
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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Dr. Ihor Magun may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Magun's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to me signing this consent. Dr. Magun reserves the right to revise his Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pat Swede, Privacy Office at 2000 North Village Ave, Suite 202, Rockville Centre, NY 11570.

With my consent, Dr. Magun may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Dr. Magun may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Dr. Magun may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Magun restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dr. Magun's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, Dr. Magun may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Patient's name Print Name of Patient or Legal Guardian

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PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Dr. Ihor Magun to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below. This authorization permits Dr. Magun to use or disclose to all third parties the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

_____

_____

_____

This authorization will expire on _____.
(Expiration date or defined event)

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure 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 Dr. Magun has acted in reliance upon this authorization. My written revocation must be submitted to Dr. Magun's Privacy Officer at 2000 North Village Avenue, Suite 202, Rockville Centre, NY 11570.

Signed by:_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian