Suburban Medical Group

8207 Main Street, Suite 7 & 8
Williamsville, NY 14221
(716) 626-4200 (phone) & (716) 626-4201 (fax)

Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA" 45 C.F.R. Parts 160 and 164), I have certain rights to privacy regarding my protected health information. I understand that this information can *only* be used for the following as listed below, unless I approve otherwise:

- Conduct, plan, and direct my treatment and follow-up treatments among multiple healthcare providers who may be involved in that direct or indirect treatment.
- Obtain payment for third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I am aware of my rights to obtain and read the Suburban Medical Group, Notice of Privacy, which contains a more complete description of the uses and disclosure of my health information. I understand that this practice has the right to change its Notice of Privacy from time to time and that I may contact this practice at any time, at the address above to obtain a current copy of the updated Notice of Privacy.

I understand that I may request in writing, regarding restriction on how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that if and when Suburban Medical Group agrees to my requested restriction, you are bound to such request.

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above statements.

Date:_____ **Patient Name:**_____ **SS Number:**_____

Signature:_____
(You have the right to receive a copy of this form after you have signed it).

1. **Authorization**
   I authorize Suburban Medical Group to use and disclose the protected health information described below to:

   Name:_____

   Relationship:_____ Telephone:_____

   Name:_____

   Relationship:_____ Telephone:_____

   Name:_____

   Relationship:_____ Telephone:_____

Date:_____ **Patient Name:**_____**SS Number:**_____

2. **Effective Period**
   This authorization for release of information covers the period of health care from:

   a. ☐ _____ to _____
   b. ☐ All past, present, and future periods.

3. **Extent of Authorization**

   a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.

   *** OR

   b. ☐ I authorize the release of my complete health record with the following information:

      ☐ Mental health records
      ☐ Communicable diseases (including HIV and AIDS)
      ☐ Alcohol/Drug Abuse Treatment
      ☐ Other (please specify):_____

4. This authorization shall be in force and effect until changed, unless otherwise stated (_____), at which time this authorization expires. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity as already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

6. 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.

I have read and understand the information in this authorization form.

Signature:_____ **Date**:_____

Print Name:_____