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:

____ Spouse/Domestic Partner ____	____ Translator ____
____ Guarantor ____	____ Health attendant ____
____ Emergency Contacts ____	____ Private nurse ____
____ Adult Children ____	____ Fitness trainer ____
____ Family member, specify name & relationship: ____	____ Administrative/personal assistant ____
____ Significant other, specify name: ____	____ Other, specify name & relationship: ____

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

PLEASE CHECK ALL THAT APPLY

____ **All of the information below**

____ Name	____ Health plan beneficiary number
____ Address	____ Account # with us, any other unique identifying #
____ All dates	____ Medications
____ Telephone number	____ Office and/or hospital notes
____ Fax number	____ Diagnosis
____ Electronic mail and/or IP address	____ Diagnostic test results
____ Social Security number	____ Prognosis and treatment plan
____ Medical record number	____ 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