Dear ____________________________

Welcome and thank you for choosing North Shore Hematology Oncology Associates, P.C. For over forty years, NSHOA has been an integrated cancer center providing premium healthcare for our patients using the latest treatment therapies. We are always on the cutting edge of technology and medicine, while ensuring that our patients are treated with dignity and respect.

You presently have a new patient appointment scheduled with:

Dr. ____________________________ Date: ____________________________ Time: ____________________________

Location: ____________________________

We ask that you please arrive 15 minutes prior to your scheduled appointment time for registration. We have enclosed forms for you to complete and bring with you, along with any records pertaining to your diagnosis and insurance cards. If you have an insurance that requires a referral, please obtain it prior to your appointment so there is no delay in your care at NSHOA. If your insurance requires a copay, it is due at the time of your appointment.

Please feel free to contact the New Patient Coordinator at 631-751-3000 and visit our website to learn more and for office locations and directions should you have any questions prior to your visit.

We look forward to seeing you.
Dear Patients,

I would like to inform you that we gladly dispose of our patient’s unused or expired medications and supplies. We offer this service to prevent the impact this has on our environment if disposed of improperly.

We also reuse unused medication that has not expired for our less fortunate patients. This is also true of supplies such as unused wigs, bandages, syringes and tubing. Many of our less fortunate patients rely on this service to meet their needs.

Please contact me if you have any of the above for donation or you may bring them to the office. I will screen for expiration dates and usefulness.

Thank you in advance for your help.

Kind Regards,

George N. Calcanes RN BS CCO
Chief Clinical Officer
Office: 631-675-5183
Fax: 631-751-1971
Email: georgenicholas26@aol.com
Patient Information Sheet

NEW ADDRESS/NEW NAME/NEW INSURANCE/NEW PATIENT/HOSPITAL FOLLOW UP

East Setauket/Patchogue/Smithtown/Port Jeff/Brightwaters/RT North/ RT South/Riverhead/Bay Shore/West Islip Date: 

Name: ____________________________________________ Marital Status: S___ M___ D___ W___

Address: ____________________________________________ Sex: Male____ Female____ Age: ______

_________________________________________________________ Date of Birth ____________________________

Ethnicity_______ Race__________ Pref. Language__________ Social Security #__________________________

Telephone__________________________________________ Cellphone______________________________

Email Address______________________________ Occupation: ________________________________

Preferred Method of contact: Email, Home phone, Text, or Cell phone__________________________

Patient’s Employer ________________________________________________________________

Employer Address__________________________________ Employer Telephone_____________ Full Time___________ Part Time________

Spouse’s Name_____________________________ Spouse’s Date of Birth________________ Spouse’s Social Security #________________

Pref Pharmacy:__________________________ Pharmacy Phone #_______________________

Primary Insurance_________________________ ID#__________________________ Group#________________

Subscriber Name_________________________ DOB__________________________ Relationship________________

NSHOA Cancer Center

631.751.3000 631.751.3553 fax WWW.NSHOA.COM
SETAUKET PATCHOGUE BRIGHTWATERS SMITHTOWN PORT JEFFERSON RIVERHEAD BAY SHORE WEST ISLIP SOUTHAMPTON
CHEMOTHERAPY INFUSION CENTERS RADIATION THERAPY CLINICAL TRIALS DIAGNOSTIC IMAGING PATHOLOGY CHEMISTRY & HEMATOLOGY LABS CTC TESTING PERSONALIZED MEDICINE
Patient Information Sheet Continued.

NEW ADDRESS/NEW NAME/NEW INSURANCE/NEW PATIENT/HOSPITAL FOLLOW UP

Subscriber Employer

Employer Address

Secondary Insurance_ ID# Group#

Subscriber Name DOB Relationship

Subscriber Employer

Employer Address

Referred by Family Physician

Person to Contact In Case of Emergency

Relationship to Patient

Advanced Directives (circle one) Living Will Durable Power of Attorney DNR

Assignment of Benefits:

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Private Insurance and any other Health Plan to: North Shore Hematology Oncology Associates, P.C

This assignment will remain in effect until revoked by me in writing. A photo copy of this assignment is to be considered as valid as a original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

*In the event this account is assigned to collection, I agree to pay all costs of collection, including reasonable attorney fees.

Patient Signature Date: 

Spouse Signature Date: 

*PLEASE NOTE ATTACHED NOTICE OF PRIVACY PRACTICE FORM AND PATIENT RECORD FORM AS REQUIRED UNDER HIPAA GUIDELINES MUST BE COMPLETED
NOTE: This is a confidential record and will be kept in your doctor’s office. Information contained here will not be released to anyone without your authorization to do so.

LAST NAME ______________________  FIRST NAME: ______________________  TODAY’S DATE ____________

Date of Birth ______________________  What was the date of your last physical exam ______________________

PRIMARY CARE PHYSICIAN ______________________  NEXT OF KIN ______________________

What is your chief complaint (Reason for VISIT) ______________________ ______________________________________

_____________________________________________________________ ______________________________________
_____________________________________________________________ ______________________________________

THESE ARE MANDATORY FIELDS --- YOU WILL NOT BE EXAMINED UNTIL THIS FORM IS FILLED OUT ENTIRELY

When was your LAST Colonoscopy ______________________  Where? ______________________  Never ______________________
When was your LAST Mammography ______________________  Where? ______________________  Never ______________________
When was your LAST Bone Density Exam ______________________  Where? ______________________  Never ______________________
When was your LAST Flu Shot? ______________________  When was your last Pneumococcal Vaccine? ______________________  Weight/Height ______________________
Do you Smoke? ______________________  Packs per Day ______________________  When did you Quit Smoking? ______________________
Do you want assistance with Smoke Cessation YES ______ NO ______ Alcohol use? YES ______ NO ______ Have you ever been exposed to toxic substances ie: Asbestos or chemicals YES ______ NO ______

FAMILY HISTORY WHICH IS PERTINENT TO YOUR VISIT.

<table>
<thead>
<tr>
<th>HEALTH</th>
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<tr>
<td>FAMILY MEMBER</td>
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<td>FATHER</td>
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<tr>
<td>MOTHER</td>
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<tr>
<td>SISTER</td>
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<td>BROTHER</td>
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<tr>
<td>SISTER</td>
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<td>BROTHER</td>
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DO ANY OF YOUR IMMEDIATE FAMILY HAVE THE FOLLOWING?

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>RELATION</th>
<th>DISEASE</th>
<th>RELATION</th>
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<tbody>
<tr>
<td>CANCER</td>
<td>GI (STOMACH PROBLEMS)</td>
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<tr>
<td>HIGH BLOOD PRESSURE</td>
<td>ARTHRITIS</td>
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<td>LUNG DISEASE</td>
<td>DIABETES</td>
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<tr>
<td>KIDNEY DISEASE</td>
<td>HEART DISEASE</td>
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<tr>
<td>ENDOCRINE (THYROID)</td>
<td>INFECTIOUS DISEASES</td>
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<tr>
<td>ANEMIA BLOOD DISORDER</td>
<td>GOUT</td>
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<tr>
<td>BLEEDING PROBLEM</td>
<td>MENTAL ILLNESSES OR NEURO</td>
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<tr>
<td>SEIZURES</td>
<td>URINARY PROBLEMS</td>
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<tr>
<td>SKIN DISORDERS</td>
<td>VASCULAR</td>
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PAST SURGERIES WHERE | PAST SURGERIES WHERE

| | |
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NSHOA Cancer Center

631.751.3000 631.751.3553 fax WWW.NSHOA.COM
SEATUCK PATCHOGUE BRIGHTWATERS SMITHTOWN PORT JEFFERSON RIVERHEAD BAY SHORE WEST ISLIP SOUTHAMPTON
CHEMOTHERAPY INFUSION CENTERS RADIATION THERAPY CLINICAL TRIALS DIAGNOSTIC IMAGING PATHOLOGY CHEMISTRY & HEMATOLOGY LABS CTC TESTING PERSONALIZED MEDICINE
North Shore Hematology / Oncology Associates, P.C.
Board Certified in Medical Oncology, Hematology & Internal Medicine
nshoa.com  631.751.3000

YOUR PAST MEDICAL HISTORY

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>CHECK BELOW</th>
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<tbody>
<tr>
<td>CANCER</td>
<td>GI (STOMACH PROBLEMS)</td>
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<td>HIGH BLOOD PRESSURE</td>
<td>ARTHRITIS</td>
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<td>URINARY PROBLEMS</td>
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<td>SKIN DISORDERS</td>
<td>VASCULAR</td>
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</table>

DO YOU HAVE ANY MEDICATION ALLERGENS: __
DO YOU HAVE ANY FOOD ALLERGENS: __

DO YOU HAVE A LATEX ALLERGY: ___

OTHER PHYSICIANS THAT CARE FOR YOU  YOUR LAST VISIT THERE  REASON FOR VISIT

PLEASE LIST ANY INFECTIONOUS DISEASES YOU HAVE OR ARE BEING TREATED FOR

HAVE YOU BEEN OUT OF THE COUNTRY RECENTLY_ TO WHERE_ WHEN_ 

IS THERE ANY OTHER PERTINENT INFORMATION WE SHOULD KNOW THAT WOULD IMPACT YOUR CARE AND TREATMENT?

YOUR SIGNATURE IS REQUIRED DATE

THANK YOU FOR YOUR HELP WITH THIS DATA COLLECTION. THIS INFORMATION IS INVALUABLE TO US AND HELPS US TO GET TO KNOW YOU BETTER. ALL OF THE INFORMATION IS CONFIDENTIAL AND WILL BE TREATED THAT WAY AT ALL TIMES. IF YOU HAVE ANY QUESTIONS REGARDING THIS INFORMATION OR NEED ANY HELP IN CLARIFYING THIS FORM FEEL FREE TO CALL.
The following information is mandatory and of great importance in your continued care and treatment with this facility. This information will assist us to get you better and make your medical records more accurate.

Name_________________________  Height_____________________
Date of Birth___________________  Weight_____________________

Circle One
Are you diabetic?  Yes  No
Are you insulin Dependent?  Yes  No

Pharmacy Name_______________  Town_______________  Phone#_____________

MEDICATION LIST:

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<tr>
<th>NAME</th>
<th>DOSE</th>
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<th>HOW OFTEN</th>
<th>WHEN</th>
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ALLERGIES:

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<th>ALLERGIC TO</th>
<th>REACTION</th>
<th>SEVERITY (MILD OR SEVERE)</th>
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</table>
CONSENT FOR RELEASE OF MEDICAL RECORDS

Date: ___________________________ Medical Record # ___________________________

Patient__________________________________________________________

Address________________________________________________________

Phone#_________________________ Date of Birth________________________

Authorization is hereby given to __________________________________________
To Provide North Shore Hematology Oncology Associates, P.C.
Phone#_________________________ Fax#_______________________________

With access to my MEDICAL AND/OR HOSPITAL RECORDS:

Review and request you provide such copies thereof that may be requested.

1. Records regarding admission and/or treatment for the following dates of service
   From: ___________________________ To: ___________________________

2. The Following specified information:

   A. Blood work  Yes___________  No___________
   B. X-Rays  Yes___________  No___________
   C. Pathology  Yes___________  No___________
   D. All of the above  Yes___________  No___________

   E. Specifics:_____________________________________________________
      ______________________________________________________________

Patient Signature_________________________________________ Date: ______________
Please send all results to:

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>DOB:</th>
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<tbody>
<tr>
<td>Doctor Name</td>
<td>Address</td>
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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone __________________________  ☐ Written Communication

☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only

☐ Work Telephone __________________________
☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only

☐ Other (LIST HERE ANY FAMILY MEMBER WE MAY RELEASE MEDICAL INFORMATION TO.)

NAME: ________________________________ RELATIONSHIP: ______ PHONE #: ______
NAME: ________________________________ RELATIONSHIP: ______ PHONE #: ______
NAME: ________________________________ RELATIONSHIP: ______ PHONE #: ______

______________________________  ______________________________
Patient Signature  Date

______________________________  ______________________________
Print Name  Birth Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.
AUTHORIZATION FORM FOR THE RELEASE OF PATIENT INFORMATION

Section A: Must be completed for all authorizations.

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that if a person or organization authorized to receive my information is not a health plan or health care provider, the released information may be subject to redisclosure and may no longer be protected by the federal privacy regulations.

Patient name: ___________________________  ID Number (if applicable): ___________________________

Persons/organizations authorized to use or disclose my information: ___________________________

Persons/organizations who may receive my information: ___________________________

Specific description of the information to be used or disclosed (including date(s)): ___________________________

Description of each purpose of the use or disclosure of my patient information: (Note: If the release of information is requested by the patient, please insert “at the request of the patient” here if the patient does not provide a statement of purpose.) ___________________________

For marketing authorizations only: Does the marketing for which this authorization is being requested involve direct or indirect remuneration from a third party to the health plan or health care provider?

______________________________
Section B: The patient or the patient’s representative must read and initial the following statements:

1. I understand that this authorization will expire on

   ____________________________

   Initials: __________

2. I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form.

   Initials: __________

3. I understand that I will get a copy of this form after I sign it.

   Initials: __________

4. I understand that I may revoke this authorization at any time by notifying NSHOA in writing, but if I do, the revocation will not have any effect on actions that NSHOA has already taken in reliance on this authorization.

Signature of patient or patient’s representative

(Note: This form MUST be completed before signing.)

Date

If this authorization is signed by a patient’s representative, please complete the following:

Printed name of patient’s representative:

Relationship to the patient:

Describe the representative’s authority to act for the patient:

______________________________

* YOU MAY REFUSE TO SIGN THIS AUTHORIZATION *
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: ____________________________________________________________

Date of Birth: ______________ Social Security #: ____________________________

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices, which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. If your first date of service with us was due to an emergency, we must try to provide you with our Notice and get your written acknowledgement for the Notice as soon as we can once the emergency has passed.

[ ] I have received the Notice of Privacy Practices (effective date April 14, 2003).

Patient’s (or Legal Representative’s) Signature) ____________________________ Date __________

Relationship of Legal Representative

For Office Use Only

To be completed only if Acknowledgement is not signed.

1) Was the patient given a copy of the Notice of Privacy Practices?
   [ ] Yes [ ] No

2) Please explain why the patient was unable to sign this Acknowledgement and our efforts to try to obtain the patient’s signature:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Name/Title ____________________________ Date __________
HIPAA NOTICE OF PRIVACY PRACTICES

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

INTRODUCTION

We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of “protected health information.” “Protected health information” or “PHI” includes any individually identifiable information that we obtain from you or others that relates to your past, present, or future physical or mental health, the health care you have received, or payment for your health care. We will share protected health information with one another, as necessary, to carry out treatment, payment, or health care operations relating to the services to be rendered at North Shore Hematology/Oncology Associates.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. You can always request a written copy of our most current privacy notice from our reception team or log onto NSHOA.com.

PERMITTED USES AND DISCLOSURE

We can use or disclose your PHI for purposes of treatment, payment, and health care operations. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

- **Treatment** means the provision, coordination, or management of your health care, including consultations between health care providers relating to your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to contact a physical therapist to create the exercise regimen appropriate for your treatment.

- **Payment** means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determination of eligibility and coverage, and other utilization review activities. For example, we may need to provide PHI to your Third Party Payer to determine whether the proposed course of treatment will be covered. When we subsequently bill the Third Party Payer for the services rendered to you, we can provide the Third Party Payer with information regarding your care if necessary to obtain payment. Federal or State law may require us to obtain a written release from you prior to disclosing certain specially protected PHI for payment purposes, and we will ask you to sign a release when necessary under applicable law.

- **Health care operations** means the support functions of North Shore Hematology/Oncology Associates related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your PHI to evaluate the performance of our staff when caring for you. We may also combine PHI about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose PHI for review and learning purposes. In addition, we may remove information that identifies you so that others can use the de-identified information to study health care and health care deliver without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may also use your PHI in the following ways:

- To provide appointment reminders for treatment or medical care.

- To tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.

- To your family or friends or any other individual identified by you to the extent directly related to such person’s involvement in your care or payment for your care. We may use or disclose your PHI to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care, of your location, general condition, or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.

- When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts.

- We will allow your family and friends to act on your behalf to pick up filled prescriptions, medical supplies, x-rays, and similar forms of PHI when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

- We may contact you as part of our fundraising and marketing efforts as permitted by applicable law. You have the right to opt out of receiving such fundraising communications.
We may use or disclose your PHI for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients who received a particular medication. All research projects are subject to a special approval process which balances research needs with a patient’s need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.

We will use or disclose PHI about you when required to do so by applicable law.

In accordance with applicable law, we may disclose your PHI to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or North Shore Hematology/Oncology Associates as required by applicable law.

**Note:** Incidental uses and disclosures of PHI sometimes occur and are not considered to be a violation of your rights. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

**SPECIAL SITUATIONS**

Subject to the requirements of applicable law, we will make the following uses and disclosures of your PHI:

**Organ and Tissue Donation.** If you are an organ donor, we may release PHI to organizations that handle organ procurement or transplantation as necessary to facilitate organ or tissue donation and transplantation.

**Military and Veterans.** If you are a member of the Armed Forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

**Worker’s Compensation.** We may release PHI about you for programs that provide benefits for work-related injuries or illnesses.

**Public Health Activities.** We may disclose PHI about you for public health activities, including disclosures:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect, or domestic violence.

We will only make this disclosure if the patient agrees or when required or authorized by law.

**Health Oversight Activities.** We may disclose PHI to federal or state agencies that oversee our activities (e.g., providing health care, seeking payment, and civil rights).

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI subject to certain limitation.

**Law Enforcement.** We may release PHI if asked to do so by a law enforcement official:

- In response to a court order, warrant, summons, or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime under certain limited circumstances;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct on our premises; or
- In emergency circumstances, to report a crime, the location of a crime or the victims, or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners, and Funeral Directors.** We may release PHI to a coroner or medical examiner. We may also release PHI about patients to funeral directors as necessary to carry out their duties.

**National Security and Intelligence Activities.** We may release PHI about you to authorized federal officials for intelligence, counterintelligence, other national security activities authorized by law, or to authorized federal officials so they may provide protection to the President or foreign heads of state.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

**Serious Threats.** As permitted by applicable law and standards of ethical conduct, we may use and disclose PHI if we, in good faith, believe that the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.

**Note:** HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records, and other specially protected health information may enjoy certain special confidentiality protections under applicable state and federal law. Any disclosures of these type of records will be subject to these special protections.
OTHER USES OF YOUR HEALTH INFORMATION

Certain uses and disclosures of PHI will be made only with your written authorization, including uses and/or disclosures: (a) of psychotherapy notes (where appropriate); (b) for marketing purposes; and (c) that constitute a sale of PHI under the Privacy Rule. Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of PHI for treatment, payment, and health care operations. However, we are not required to agree to your request. We are, however, required to comply with your request if it relates to a disclosure to your health plan regarding health care items or services for which you have paid the bill in full. To request a restriction, you may make your request in writing to the Privacy Officer at North Shore Hematology/Oncology Associates.

2. You have the right to reasonably request to receive confidential communications of your PHI by alternative means or at alternative locations. To make such a request, you may submit your request in writing to the Privacy Officer at North Shore Hematology/Oncology Associates.

3. You have the right to inspect and copy the PHI contained in your medical/billing records, except:
   (i) for psychotherapy notes, (i.e., notes that have been recorded by a mental health professional documenting counseling sessions and have been separated from the rest of your medical record);
   (ii) for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
   (iii) for PHI involving laboratory tests when your access is restricted by law;
   (iv) if you are a prison inmate, and access would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, any officer, employee, or other person at the correctional institution or person responsible for transporting you;
   (v) if we obtained or created PHI as part of a research study, your access to the PHI may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;
   (vi) for PHI contained in records kept by a federal agency or contractor when your access is restricted by law; and
   (vii) for PHI obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.

In order to inspect or obtain a copy of your PHI, you may submit your request in writing to the Medical Records Section at North Shore Hematology/Oncology Associates. If you request a copy, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

We may also deny a request for access to PHI under certain circumstances if there is a potential for harm to yourself or others. If we deny a request for access for this purpose, you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. You have the right to request an amendment to your PHI but we may deny your request for amendment if we determine that the PHI or record that is the subject of the request:
   (i) was not created by us, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
   (ii) is not part of your medical or billing records or other records used to make decisions about you;
   (iii) is not available for inspection as set forth above; or
   (iv) is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. In order to request an amendment to your PHI, you must submit your request in writing to the Medical Records Section at our office along with a description of the reason for your request.

5. You have the right to receive an accounting of disclosures of PHI made by us to individuals or entities other than you for the six years prior to your request, except for disclosures:
   (i) to carry out treatment, payment, and health care operations as provided above;
   (ii) incidental to a use or disclosure otherwise permitted or required by applicable law;
   (iii) pursuant to your written authorization;
   (iv) to persons involved in your care or for other notification purposes as provided by law;
   (v) for national security or intelligence purposes as provided by law;
   (vi) to correctional institutions or law enforcement officials as provided by law;
   (vii) as part of a limited data set as provided by law.

To request an accounting of disclosures of your PHI, you must submit your request in writing to the Privacy Officer at our office. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

6. You have the right to receive a notification, in the event that there is a breach of your unsecured PHI, which requires notification under the Privacy Rule.

COMPLAINTS

If you believe that your HIPAA privacy rights have been violated, you should immediately contact the Privacy Officer at (631) 751-3000. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Region II Office for Civil Rights, 26 Federal Plaza, New York, NY 10278.

CONTACT PERSON

If you have any questions or would like further information about this HIPAA notice, please contact the Privacy Officer at (631) 751-3000.

This notice is effective as of September 17, 2013.