Morris County Primary Care
2839 Route 10 East
Morris Plains, NJ 07950
(973) 292-5600

H. Patrick Burns, MD

To Whom It May Concern:

You have the right to request a copy of our Notice of Privacy Practices, effective April 14, 2003. This is being provided to you as a requirement of the Health Insurance Portability & Accountability Act of 1996 (HIPAA). The Privacy Rule ("HIPAA Standards for Privacy of Individually Identifiable Health Information") establishes national protections for the privacy of individually identifiable health information.

The Privacy Rule, for the first time, creates national standards for the confidentiality of medical records and other personal health information. For patients, it means being able to make choices when seeking care based on how personal health information is used.

- It enables patients to find out how their information may be used and disclosed.
- It generally limits release of information to the minimum reasonably needed for the intended purpose.
- It generally gives patients the right to examine and obtain a copy of their own health records and request corrections.
- It encourages individuals to think about controlling certain uses and disclosures of their health information.

We have traditionally taken many of the kinds of steps required by the Privacy Rule to protect the privacy of our patients' medical records. The Privacy Rule requires, however, that we put certain policies and procedures in writing. As allowed by the Privacy Rule, our Privacy Policies and Procedures have been reasonably designed to account for the size and resources of our Practice, and the type of activities we conduct related to our patients' private health information, while still complying with the minimum requirements of the Rule.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I may request a copy of the Notice of Privacy Practices with the effective date of April 14, 2003 for **Morris County Primary Care**.

Print Patient Name:_________________________________

*Signature of Patient: _________________________________

Date:_________________________________

*If person signing is not the patient, please print your name and relationship to patient:
Name _________________________________

Relationship _________________________________

I [patient or representative] request a copy of the Notice of Privacy Practices: Yes _____ No _____

For Office Use:

If patient/representative requested copy of Notice, date copy was provided: _________________________.

If no acknowledgment could be obtained, state the reasons why and the efforts taken to try to obtain the acknowledgment: _________________________________
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