East Side Medical Radiology, PLLC
Steven D. Wolff M.D. Ph.D.
170 E 77th St., New York, NY 10075 ([redacted])

HIPAA PRIVACY NOTICE

- I acknowledge that I have been given a copy of the Practice's "HIPAA Privacy Notice" which describes the Practice's obligations to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how the Practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the Practice's HIPAA Privacy Notice and to ask questions about it. I understand the Practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice.
- I further acknowledge that the Practice can change its HIPAA Privacy Notice in the future, and that I can receive a copy of the Practice's current Privacy Notice at any time by contacting the Privacy Officer.
- I understand that I have a right to request that the Practice restrict its uses and disclosures of my health information for treatment, payment, or health care operations. If my restrictions are accepted by the Practice, these restrictions will be binding on the Practice. I also understand that the Practice is not required to agree to my requested restrictions.
- I do not request any restrictions on the Practice's use or disclosures of my health information for treatment, payment or health care operations. _____(initial).
- I do request specific restrictions, as listed below, on the Practice's use or disclosures of my health information for treatment, payment or health care operations. _____(initial).
- By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment and healthcare operations. I understand that I have the right to revoke this consent at any time in writing, but if I do, my revocation will not influence any actions the Practice has already taken in reliance on this consent.

Authorization to Obtain or Release Medical Records from Medical Providers

I hereby authorize East Side Medical Radiology PLLC to obtain any and all medical records specifically related to my current condition from any physician, hospital, or other health care professional that has provided medical care to me in relation to my current condition in the past. _____(initial).

I also authorize the Practice to release any and all medical records, physically or verbally, concerning my care to the following specified parties:

Referring Physician DR BERNARD KRUGER	Consent Required
Insurance Company, Medicare, Medicaid, Third Party Administrator, Managed Care Company	Consent Required
Additional Party Name	**Relationship to Patient**
1.	
2.	
3.	
4.	
5.	

Authorization to Obtain or Release Medical Information to Individual/Family Members

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical conditions, the law stipulates that these rules may be waived.

_____ (initial) I authorize the Practice to release any or all information, in any form of communication, concerning my medical care as set forth above.

Patient's Signature:_____ Print Patient's Name JEFFREY EPSTEIN

Date: JAN. 18, 2018