

Date: _____

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Privacy Practices Acknowledgement

Your Rights. Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this NOTICE OF PRIVACY PRACTICES. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You have the right to another Healthcare Professional.

You have the right to request confidential communications from us by alternative means or at an alternative location.

You have a right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to your protected health information. If you have any objections to this form, please ask to speak with our Patient Care Coordinator either in person or by phone.

Date: _____

Signature below is only to acknowledge that you have received this notice of our privacy practices:

Patient's Name: _____ Signature: _____ Date: _____
Please Print

Parent or Guardian if patient under 18:
_____ Signature: _____ Date: _____
Please Print

I hereby give my permission for Marlene J. Mash MD & Assoc. to disclose information regarding my treatment to:

Spouse: _____

Son(s)/Daughter(s):

Parents: _____

Other: _____

Physician: _____

Patient Fees for Medical Record Retrieval

Medical record copying fees:

Patients will be charged a flat fee of .25 per page (twenty five cents). Actual cost of postage will be charged unless patient receives documents in-office. All requests will be processed within 48 hours.

Note: Some health insurance contracts may require the physician to forward patient records to another physician within a network at no charge. (The charges listed in this notice do not apply to an X-ray film or any other portion of a medical record which is not susceptible to photostatic reproduction.)

PLEASE NOTE: Fees for Subpoena, Attorney, or Insurance Company Requests available upon request.