Douglas R. Birns M.D.
George Klein M.D.
Klein And Birns, P.L.L.C.
Eastside Urologic Associates, P.L.L.C.
157 East 72nd Street
New York, N.Y.
(212) 744-8700

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.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our physician private practice ("practice" or "office") and its staff. A copy of our current notice will always be posted in our reception area. You will also be able to obtain your own copy by calling our office at (212) 744-7700 or by asking for one at the time of your next visit.

If you have any questions about this notice or would like further information, please contact our Privacy Officer Dr. Birns at (212) 744-8700 .

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing you with health care. Some examples of protected health information are:

" information indicating that you are a patient of our practice or receiving treatment or other health-related services from us;
" information about your health condition (such as a disease you may have);
" information about health care products or services you have received or may receive in the future (such as an operation or a CT scan); or
" information about your health care benefits under an insurance plan (such as whether a prescription is covered);

when combined with:

" demographic information (such as your name, address, or insurance status);
" unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number); or
" other types of information that may identify who you are.

REQUIRED PERMISSIONS TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We will obtain a one-time general written consent to use and disclose your health information in order to treat you, obtain payment for that treatment, and conduct our business operations. This general written consent will be obtained the first time we provide you with treatment or services. This general written consent is a broad permission that does not have to be repeated each time we provide treatment or services to you.

We will generally obtain your written authorization before using your health information or sharing it with others outside of our practice. You may also ask that we transfer your records to another person by completing a written authorization form. If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it or taken action to do what you asked us to do. To revoke a written authorization, please write to our Privacy Officer at New York Urological Associates, P.C. , 880 Fifth Ave., New York, N.Y. 10021.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

1. Treatment, Payment And Business Operations

With your general written consent, we may use your health information or share it with others in order to treat your condition, obtain payment for that treatment, and run our business operations. In some cases, we may also disclose your health information for payment activities and certain business operations of another health care provider or payor. Below are further examples of how your information may be used and disclosed for these purposes.

Treatment. The doctors, nurses and other staff of our practice may share your health information with each other for the purpose of treating you. A doctor from our practice may also share your health information with a doctor outside of our practice to determine how best to diagnose or treat you. Your doctor may also share your health information with another doctor to whom you have been referred for further health care.

Payment. We may use your health information or share it with others so that we can get payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after we have treated you, or to determine whether it will cover your treatment. We might also need to inform your health insurance company about your health condition in order to obtain pre-approval for your treatment, such as admitting you to a hospital for a particular type of surgery. Finally, we may share your information with other health care providers who have treated you so that they also can have accurate information to seek payment from your health insurance company or managed care plan.

Business Operations. We may use your health information or share it with others in order to conduct our office's business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve

the care they provide for you. Finally, we may share your health information with other health care providers and with your health insurance company or managed care plan for certain of their business operations if the information is related to a relationship the provider or payor currently has or previously had with you, and if the provider or payor is required by federal law to protect the privacy of your health information.

Appointment Reminders, Treatment Alternatives, Benefits And Services. In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment or services at our facility. We may also use your health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

HIPAA DISCLOSURE FOR TELEPHONE NOTIFICATION

In our ongoing efforts to improve the quality of the patient care we deliver, we are notifying patients of their appointments telephonically a day or two prior to their scheduled appointment.

We need your written permission to call you at home and/or leave a message with whomever answers your home telephone or leave a message on your answering machine, if you have one.

The patient must be made aware that Klein and Birns P.L.L.C. and Eastside Urology Associates pre-confirms appointments via an automated telephone system. My signature below authorizes you to include me in the appointment process. I understand that I can revoke this in writing at any time.

Business Associates. We may disclose your health information to our contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company. Another example is that we may share your health information with an accounting firm or law firm that provides professional advice to us about how to improve our health care services and comply with the law. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information.

We can do all of these things if you have signed a general written consent form. Once you sign this general written consent form, it will be in effect indefinitely until you revoke your general written consent. You may revoke your general written consent at any time, except to the extent that we have already relied upon it. For example, if we provide you with treatment before you revoke your general written consent, we may still share your health information with your insurance company in order to obtain payment for that treatment. To revoke your general written consent, please write to Dr. Douglas Birns, 157 East 72nd Street, New York, N.Y. 10021.

2. Emergencies Or Public Need

We may use your health information, and share it with others, in order to treat you in an emergency or to meet important public needs. We will not be required to obtain your general

written consent before using or disclosing your information for these reasons. We will, however, obtain your written authorization for, or provide you with an opportunity to object to, the use and disclosure of your health information in these situations when state law specifically requires that we do so.

Emergencies. We may use or disclose your health information in order to treat you, to obtain payment for that treatment, and to conduct our business operations if you need emergency treatment or if we are required by law to treat you but are unable to obtain your general written consent. If this happens, we will try to obtain your general written consent as soon as we reasonably can after we treat you.

Communication Barriers. We may use and disclose your health information in order to treat you, to obtain payment for that treatment, and to conduct our business operations if we are unable to obtain your general written consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

As Required By Law. We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if notice is required by law.

Public Health Activities. We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury or disability. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits us to do so.

Victims Of Abuse, Neglect Or Domestic Violence. We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence. For example, we may report your information to government officials if we reasonably believe that you have been a victim of such abuse, neglect or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

Health Oversight Activities. We may release your health information to government agencies authorized to conduct audits, investigations and inspections of office and its staff. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Product Monitoring, Repair And Recall. We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

Lawsuits And Disputes. We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute.

Law Enforcement. We may disclose your health information to law enforcement officials for the following reasons:

" To comply with court orders or laws that we are required to follow;
" To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;
" If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your agreement because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
" If we suspect that your death resulted from criminal conduct;
" If necessary to report a crime that occurred on our property; or
" If necessary to report a crime discovered during an offsite medical emergency (for example, by emergency medical technicians at the scene of a crime).

To Avert A Serious And Imminent Threat To Health Or Safety. We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

National Security And Intelligence Activities Or Protective Services. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

Military And Veterans. If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

Coroners, Medical Examiners, And Funeral Directors. In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

Organ And Tissue Donation. In the unfortunate event of your death, we may disclose your health information to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

Research. In most cases, we will ask for your written authorization before using your health information or sharing it with others in order to conduct research. However, under some circumstances, we may use and disclose your health information for research without your written authorization if we obtain approval through a special process to ensure that research without your written authorization poses minimal risk to your privacy. Under no circumstances, however, would we allow researchers to use your name or identity publicly. We may also release your health information without your written authorization to people who are preparing a future research project, so long as any information identifying you does not leave our office. In the unfortunate event of your death, we may share your health information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.

3. Incidental Disclosures

While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information. These rights are important because they will help you make sure that the health information we have about you is accurate. They may also help you control the way we use your information and share it with others, or the way we communicate with you about your medical matters.

1. Right To Inspect And Copy Records

You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to Dr.Birns. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. The standard fee is $0.75 per page and must generally be paid before or at the time we give the copies to you.

We will respond to your request for inspection of records within 10 days. We ordinarily will respond to requests for copies within 30 days if the information is located at our office, and within 60 days if it is located off-site at another facility. If we need additional time to respond to a request for copies, we will notify you in writing within the timeframe above to explain the reason for the delay and when you can expect to have a final answer to your request.

Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide you with a summary of the information instead.

We will also provide a written notice that explains our reasons for providing only a summary, and a complete description of your rights to have that decision reviewed and how you can exercise those rights. The notice will also include information on how to file a complaint about these issues with us or with the Secretary of the Department of Health and Human Services. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect or copy.

2. Right To Amend Records

If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept in our records. To request an amendment, please write to Ms. Bernstein. Your request should include the reason(s) why you think we should make the amendment. Ordinarily we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.

If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement which we will include in your records. We will also include information on how to file a complaint with us or with the Secretary of the Department of Health and Human Services. These procedures will be explained in more detail in any written denial notice we send you.

3. Right To An Accounting Of Disclosures

After April 14, 2003, you have a right to request an "accounting of disclosures" which identifies certain other persons or organizations to whom we have disclosed your health information in accordance with applicable law and the protections afforded in this Notice of Privacy Practices. An accounting of disclosures does not describe the ways that your health information has been shared between health care providers at our office or with other health care providers outside our practice, as long as all other protections described in this Notice of Privacy Practices have been followed (such as obtaining the required approvals before sharing your health information with our doctors for research purposes).

An accounting of disclosures also does not include information about the following disclosures:

" Disclosures we made to you or your personal representative;
" Disclosures we made pursuant to your written authorization;
" Disclosures we made for treatment, payment or business operations;
" Disclosures made to your friends and family involved in your care or payment for your care;
" Disclosures that were incidental to permissible uses and disclosures of your health information (for example, when information is overheard by another patient passing by);
" Disclosures for purposes of research, public health or our business operations of limited portions of your health information that do not directly identify you;
" Disclosures made to federal officials for national security and intelligence activities;

“ Disclosures about inmates to correctional institutions or law enforcement officers; and
“ Disclosures made before April 14, 2003.

To request an accounting of disclosures, please write to Dr.Birns. Your request must state a time period., but after April 14, 2003 for the disclosures you want us to include. For example, you may request a list of the disclosures that we made between January 1, 2004 and January 1, 2005. You have a right to receive one accounting within every 12 month period for free. However, we may charge you for the cost of providing any additional accounting in that same 12 month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred.

Ordinarily we will respond to your request for an accounting within 60 days. If we need additional time to prepare the accounting you have requested, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting. In rare cases, we may have to delay providing you with the accounting without notifying you because a law enforcement official or government agency has asked us to do so.

4. Right To Request Additional Privacy Protections

You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, or run our business operations. You may also request that we limit how we disclose information about you to family or friends involved in your care or payment for your care. For example, you could request that we not disclose information about a surgery you had. To request restrictions, please write to Ms. Bernstein. Your request should include (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others, or both; and (3) to whom you want the limits to apply.

We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law. Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction.

5. Right To Request Confidential Communications

You have the right to request that we communicate with you about your medical matters in a more confidential way by requesting that we communicate with you by alternative means or at alternative locations. For example, you may ask that we contact you at home instead of at work. To request more confidential communications, please write to Ms. Bernstein. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests. Please specify in your request how or where you wish to be contacted, and how payment for your health care will be handled if we communicate with you through this alternative method or location.

6. Right To Have Someone Act On Your Behalf

You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

7. Right To Obtain A Copy Of Notices

If this notice is provided electronically, you have the right to a paper copy of this notice, which you may request at any time. To do so, please call our office at 212-744-8700. We may change our privacy practices from time to time. If we do, we will revise this notice so you will have an accurate summary of our practices. We will post any revised notice in our office reception area. You will also be able to obtain your own copy of the revised notice. The effective date of the notice will always be noted in the top right corner of the first page. We are required to abide by the terms of the notice that is currently in effect.

8. Right To File A Complaint

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact our Privacy Officer at 157 East 72nd Street, New York, N.Y. 10021. No one will retaliate or take action against you for filing a complaint.

9. How To Learn About Special Protections For HIV, Alcohol and Substance Abuse, Mental Health, And Genetic Information

Special privacy protections apply to HIV/AIDS-related information, mental health information and psychotherapy notes. Some parts of this general Notice of Privacy Practices may not apply to these types of information. To request a Notice of Privacy Practices that pertains to those types of health information, please contact our Privacy Officer at (212) 744-8700.

ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the physician private practice listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians, and staff.

Signed: _____ Date:_____