



ENGLEWOOD HEALTH

PHYSICIAN NETWORK

Patient Information Form

TODAYS DATE

/ /

LAST NAME		FIRST NAME		MI	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	GENDER IDENTITY (optional) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Transgender Male (FTM) <input type="checkbox"/> Transgender Female (MTF)
ADDRESS		CITY		STATE	ZIP CODE	
MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed	DATE OF BIRTH / /	EMAIL		SSN # - - -		
HOME PHONE () <input type="checkbox"/> Preferred?	CELL PHONE () <input type="checkbox"/> Preferred?	WORK PHONE () <input type="checkbox"/> Preferred?				
May we leave you a message on this number? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Brief <input type="checkbox"/> Extended	May we leave you a message on this number? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Brief <input type="checkbox"/> Extended	May we leave you a message on this number? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Brief <input type="checkbox"/> Extended				
Are you part of the Bloodless Medicine Program? <input type="checkbox"/> YES <input type="checkbox"/> NO			Do you have a Living Will/Advance Directive? <input type="checkbox"/> YES <input type="checkbox"/> NO			
RACE <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other Race <input type="checkbox"/> White	ETHNICITY <input type="checkbox"/> Hispanic or Latin <input type="checkbox"/> Non Hispanic or Latin <input type="checkbox"/> Prefer not to answer					
PRIMARY LANGUAGE <input type="checkbox"/> Chinese <input type="checkbox"/> English <input type="checkbox"/> Farsi <input type="checkbox"/> French <input type="checkbox"/> Greek <input type="checkbox"/> Hindi <input type="checkbox"/> Italian <input type="checkbox"/> Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Other						
DO YOU NEED A TRANSLATOR? <input type="checkbox"/> YES <input type="checkbox"/> NO						

PHARMACY NAME	PHONE ()
PHARMACY ADDRESS	CITY STATE ZIP CODE

EMERGENCY CONTACT #1	RELATIONSHIP	EMERGENCY CONTACT PHONE ()
EMERGENCY CONTACT #2	RELATIONSHIP	EMERGENCY CONTACT PHONE ()

Which provider do you see to meet most of your healthcare needs?

PRIMARY CARE PROVIDER	PHONE ()
PRIMARY CARE PROVIDER ADDRESS	CITY STATE ZIP CODE

REFERRING CARE PROVIDER	PHONE ()
REFERRING CARE PROVIDER ADDRESS	CITY STATE ZIP CODE

OTHER CARE PROVIDER	PHONE ()
OTHER CARE PROVIDER ADDRESS	CITY STATE ZIP CODE

OTHER CARE PROVIDER	PHONE ()
OTHER CARE PROVIDER ADDRESS	CITY STATE ZIP CODE

(continued on next side)



EMPLOYMENT INFORMATION

EMPLOYER NAME	OCCUPATION/POSITION
EMPLOYMENT STATUS <input type="checkbox"/> Employed Full-time <input type="checkbox"/> Self-employed <input type="checkbox"/> On active military duty <input type="checkbox"/> Other <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> Reserves	

INSURANCE/PAYMENT INFORMATION

PRIMARY INSURANCE *Which insurance should be billed first?*

SUBSCRIBER NAME	IN WHOSE NAME IS YOUR HEALTH INSURANCE POLICY?		
SUBSCRIBER SSN #	SUBSCRIBER DATE OF BIRTH	RELATIONSHIP TO SUBSCRIBER	
- -	/ /		

SUBSCRIBER EMPLOYER			
SUBSCRIBER EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
SUBSCRIBER GENDER <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Female <input type="checkbox"/> Other			

PRIMARY INSURANCE COMPANY	POLICY #	GROUP #	
INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE
EMERGENCY CONTACT PHONE # ()			

ADDITIONAL INSURANCE *Which insurance should be billed second? This may not apply to you.*

SUBSCRIBER NAME	IN WHOSE NAME IS YOUR HEALTH INSURANCE POLICY?		
SUBSCRIBER SSN #	SUBSCRIBER DATE OF BIRTH	RELATIONSHIP TO SUBSCRIBER	
- -	/ /		

SUBSCRIBER EMPLOYER			
SUBSCRIBER EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
SUBSCRIBER GENDER <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Female <input type="checkbox"/> Other			

OTHER INSURANCE COMPANY	POLICY #	GROUP #	
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ACKNOWLEDGEMENT/AUTHORIZATION

I CERTIFY THAT ALL INFORMATION I PROVIDED ABOVE IS ACCURATE AND TRUE. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS FOR ANY SERVICES FURNISHED TO ME BY THIS PHYSICIAN GROUP. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. I AUTHORIZE THE RELEASE OF MY INFORMATION CONCERNING MY HEALTHCARE TO MY INSURANCE COMPANY FOR THE PURPOSE OF REVIEWING AND PROCESSING MEDICAL CLAIMS FOR PAYMENT.		
SIGNATURE	RELATIONSHIP TO PATIENT	DATE / /



ENGLEWOOD HEALTH PHYSICIAN NETWORK

DESIGNATION OF RELATIVES, FRIENDS, AND CAREGIVERS TO RECEIVE NECESSARY TREATMENT-RELATED INFORMATION

Patient Name: _____

Date: _____

Patient DOB: _____

I agree that Englewood Health Physician Network may disclose certain portions of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care.

Englewood Health Physician Network will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Signature of Patient/Guardian: _____

Date: _____

I choose not to designate any individual at this time.

I designate the following contacts listed below as persons involved with my health care or payment relating to my health care for Englewood Health Physician Network to make the limited disclosures described above.

I understand that I am not required to list anyone, and can change this list at any time in writing.

Contact Name: _____	Contact's DOB (required): _____
Relationship: _____	

Contact Name: _____	Contact's DOB (required): _____
Relationship: _____	

Contact Name: _____	Contact's DOB (required): _____
Relationship: _____	

New Jersey Department of Health
 Vaccine Preventable Disease Program
 P.O. Box 369, Trenton, NJ 08625-0369
 609-826-4860 (Fax 609-826-4866)
 www.njiis.nj.gov

**NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
 CONSENT TO PARTICIPATE**

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

<i>REGISTRANT INFORMATION</i>	<i>PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)</i>		
Registrant Name (<i>Print</i>)	Name (<i>Print</i>)		
Date of Birth	Address		
Country of Birth	City, State, Zip Code		
Name of Primary Health Care Provider	Relationship to Registrant		
<p>I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.</p> <p>I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.</p> <p>I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above.</p> <p>There is no cost to participate in this program.</p> <p><input type="checkbox"/> Yes, I would like to participate in this program.</p> <p><input type="checkbox"/> No, I do not want to participate in this program.</p>			
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)</td> <td style="width: 30%;">Date</td> </tr> </table>		Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date
Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date		

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number
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- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -



ENGLEWOOD HEALTH PHYSICIAN NETWORK

CONSENT FOR TREATMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF INFORMATION AND FINANCIAL AGREEMENT

1. CONSENT FOR TREATMENT

The undersigned consents to any x-rays, laboratory or other medical procedures or examination rendered to me under the general and specific instructions of my physician(s). I acknowledge that no guarantees have been made to me as to the result of treatment/ examination in Englewood Health Physician Network. I also consent to the testing of my blood for Human Immunodeficiency Viruses (HIV) and/or other blood borne pathogens, in the event that any individual at an Englewood Health Physician Network practice is accidentally exposed to my blood or body fluids, or my physician believes such testing is medically indicated. Results of such testing will be reported to me, noted on my medical record and reported to the State Department of Health as required by law.

2. RELEASE OF INFORMATION

Englewood Health Physician Network is hereby authorized to release any/all of my medical records to the person(s) liable for my financial obligations resulting from services and to use data from my medical record for quality, epidemiology and education studies to which no identifying information will be made public. I authorize Englewood Health Physician Network to download my historical medication information from Sure Scripts.

3. ASSIGNMENT OF INSURANCE BENEFITS

In the event the patient is entitled to physician benefits of any type arising out of any policy of insurance coverage from the patient or any other party liable for the patient, said benefits are hereby assigned to Englewood Health Physician Network and/or treating physician. In the event the patient's insurer denies medical benefits, coverage, or payment, consent is hereby authorized to allow Englewood Health Physician Network and/or treating physician to appeal such decisions on the patient's behalf.

4. MEDICARE BENEFITS (IF APPLICABLE)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I assign the benefits payable for services to Englewood Health Physician Network or the physician furnishing the services and authorize Englewood Health Physician Network or the treating physician to submit a claim to Medicare for payment.

5. MEDICAID

I certify that services covered by this claim have been received and I request that payment for these services be made on my behalf. I assign the benefits payable for practice services to Englewood Health Physician Network and/or treating physician. I authorize Englewood Health Physician Network or the physician to submit a claim to Medicaid for payment on my behalf. I authorize the release of my medical information necessary to process this claim in accordance with program policy.

6. OTHER PHYSICIAN SERVICES (OUTSIDE OF OUR PRACTICE)

In the event the patient is entitled to benefits of any type arising out of any policy of insurance covering the patient, that said benefits are also hereby assigned to any other physicians (outside of our practice) providing services to you at our request. I understand that it is the responsibility of the patient to obtain information from his/her insurance company to determine if the above mentioned physicians are participating in the patient's insurance plan. Participation by Englewood Health Physician Network in any given insurance plan does not indicate participation by the other physicians outside of this Practice. I understand that I am responsible to the other physicians' practices for any charges not covered by my insurance plan.

7. FINANCIAL AGREEMENT

I agree, whether signing as agent or patient, that in consideration of the services rendered to the patient, I am hereby individually obligated to make payment to Englewood Health Physician Network in accordance with the regular rates and terms of Englewood Health Physician Network. I understand that I am responsible to Englewood Health Physician Network for any amounts billed to and not covered by any insurance carrier(s), including any amounts denied by the insurance carrier for no pre-certification or referral. Should the account be referred for collection after a default, I agree to pay costs of collection, including reasonable attorney's fee. All delinquent accounts bear interest at legal rates.

The undersigned certifies that he/she has read and understands the foregoing, receiving a copy thereof and as a patient or the patient's agent, authorized to execute the above, accepts its terms.

Patient Signature/Authorized Agent

Date

Print Name Patient Signature/Authorized Agent

I acknowledge that I have been provided with a copy of Englewood Health Physician Network Privacy Notice.

Patient Signature/Authorized Agent

Date

DOB: _____



ENGLEWOOD HEALTH PHYSICIAN NETWORK

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Englewood Health is dedicated to protecting your privacy, including the protected health information about you that we generate and maintain. This Notice describes how we may use and share protected health information, our legal obligations related to the use and sharing of this information, and your rights related to the protected health information about you. As required by law, we must maintain the privacy of protected health information, provide you with this Notice of our legal duties and privacy practices with respect to such information, and abide by the terms of this Notice.

WHO FOLLOWS THIS NOTICE

The notice describes the practices of the following entities:

- Englewood Health, Englewood, NJ
- Englewood Health Off-Campus Diagnostic Imaging Centers- Emerson, Fair Lawn, Glen Ridge, Pompton Plains, and Woodland Park, NJ
- Physician Network Office Locations in Northern NJ and Rockland County, NY

These entities, sites, and locations may share health care information with each other for treatment, payment, or operational purposes described in this notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment: We may use and disclose your health information to provide you with treatment and health care services. For example, we may disclose information about you to doctors, nurses, technicians, students, or other personnel involved in your care. We may also share this information about you with other agencies or facilities in order to provide the different things you need, such as prescriptions, lab work, and/or continuing medical care after you leave our facility. Sharing your information for this purpose gives your providers the information they need to provide you with appropriate care.

Payment: We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care, such as an ambulance company. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send an invoice disclosing your health information to your insurance company or to a benefit payer that is responsible for all or part of your medical bill. If federal or state law requires us to obtain a written release from you prior to disclosing health information for payment purposes, we will ask you to sign a release.

Health Care Operations: We may use and disclose your health information for our health care operations. For example, your health information may be used by the members of the medical staff to evaluate the performance of our health care professionals, assess patients' quality of care and case outcomes, and seek areas of improvement within our facility. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.

Appointment Reminders: We may contact you to remind you of an upcoming appointment.

Treatment Alternatives: We may contact you to tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Patient Directory: If you do not object, we may include certain limited information about you in our patient directory while you are a patient within our facility. This information may include your name, location in the hospital, your general condition (e.g., fair, stable, etc.), and your religious affiliation. The directory information, except for your religious affiliation, may be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. This will allow your family, friends, and clergy to visit you in the hospital and to know how you are doing. **If you object to any or all of this information being included in the directory, communicate this to us so that this information may be removed from the directory.**

Research: We may use or disclose your health information for research purposes, subject to the requirements of applicable law. All research projects are subject to a special approval process, which establishes protocols to ensure that your health information will continue to be protected. When required, we will obtain a written authorization from you prior to using your health information for research.

Fundraising Activities: We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Marketing Activities: We may contact you as part of our marketing activities, as permitted by applicable law.

Required by Law: We may use and disclose your health information as required by law. For example, we may disclose health information for mandated patient registries, communicable disease reporting, and for judicial and administrative proceedings, including disclosures in response to a court order.

Law Enforcement: We may release your health information to assist law enforcement officials with their law enforcement duties. Examples include responding to a court order, subpoena, warrant, summons, or similar process; identifying or locating a suspect, fugitive, or missing person; and reporting criminal conduct on our premises.

To Avert a Serious Threat to Health or Safety: As permitted by applicable law and standards of ethical conduct, we may use and disclose health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Disaster-Relief Efforts: When permitted by law, we may coordinate our uses and disclosures of health information with public or private entities assisting in a disaster-relief effort. If you do not want us to disclose your health information for this purpose, you must communicate this to your caregiver so that we do not disclose this information unless done so in order to properly respond to the emergency.

Organ and Tissue Donation: If you are an organ donor, we may release your health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the Armed Forces, domestic or foreign, we may release your health information to military command authorities as authorized or required by law.

Worker's Compensation: We may release your health information for programs that provide benefits for work-related injuries or illnesses.

Public Health Activities: We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report births and deaths;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Health Oversight Activities: We may disclose health information to federal or state agencies that oversee our activities, including licensing, auditing, and accrediting agencies.

Coroners, Medical Examiners, and Funeral Directors: We may disclose health information to coroners, medical examiners, and funeral directors as necessary for them to carry out their duties.

National Security and Intelligence Activities: We may release your health information to authorized federal officials for intelligence, counterintelligence, or other national security activities that are authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so that they may provide protection to the President or other authorized persons or foreign heads of state or to conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your health information to the correctional institution or to law enforcement officials so that duties can be carried out under the law.

Other Uses of Your Health Information: Other uses and disclosures of health information not covered by this Notice or by the laws that apply to us will be made only with your permission in a written authorization, including certain marketing activities, sale of health information, and disclosure of psychotherapy notes with some exceptions. You have the right to revoke your authorization at any time, provided that the revocation is in writing, except to the extent that we have already taken action in reliance on your authorization.

EXCHANGE OF HEALTH INFORMATION WITH OTHER PROVIDERS

We participate in electronic exchanges of health information with other health care providers in order to facilitate health care, to avoid duplication of services (such as lab tests), and to reduce the likelihood that medical errors will occur. These exchanges include Epic Care Everywhere and Jersey Health Connect. These Health Information Exchanges (HIEs) allow patient information to be shared among participating providers through a secure network, giving your participating providers immediate electronic access to your pertinent health information that is necessary for treatment, payment, and health care operations.

You can obtain additional information about Epic Care Everywhere by visiting <https://www.epic.com/careeverywhere/>.

You can obtain additional information about the Jersey Health Connect HIE by visiting <http://www.jerseyhealthconnect.org/>.

If you do not wish to have your information included in Epic Care Everywhere or Jersey Health Connect, you may opt out. Please see the instructions below to opt out. Unless you opt out, your information will be available through the Epic Care Everywhere and Jersey Health Connect HIE networks to authorized participating providers in accordance with this Notice and applicable law.

How to Opt Out of Epic Care Everywhere and/or Jersey Health Connect:

Epic Care Everywhere and Jersey Health Connect are separate health information exchanges with different opt out instructions. Opting out of one of these exchanges will NOT automatically remove you from the other.

Epic Care Everywhere:

The *Care Everywhere Consent/ Opt Out Form*, can be obtained from your Englewood Health caregiver, or you can download the form from <http://englewoodhealth.org/privacy>. Return the completed form to the Englewood Health Health Information Management Department as noted on the form.

Jersey Health Connect:

The *Jersey Health Connect Opt-Out Form* can be obtained directly from any of your providers participating in Jersey Health Connect, or you can download the form from <http://www.jerseyhealthconnect.org/patients/opt-out/>. Return the completed form to Jersey Health Connect as noted on the form.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy: With certain exceptions, you have the right to inspect and to receive a copy of your health records. You have the right to obtain, upon request, a copy of your health information in an electronic format if we maintain your health information electronically (in our computers). You may also request that we transmit a copy of your health information to another company or person you have designated. However, this right is subject to a few exceptions, including psychotherapy notes, information collected for certain legal proceedings, and any medical information restricted by law.

In order to inspect and copy your health information, you must submit your request in writing to Englewood Health's Privacy Officer. If you request a copy of your health information, we may charge you a fee for the cost of copying and mailing your records, as well as for other costs associated with your request. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Right to Request a Restriction: You have the right to request a restriction or limitation on the health information we use and disclose about you for treatment, payment, and health care operations. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which the health care provider has been paid out of pocket in full. To request a restriction, you must make your request in writing to Englewood Health's Privacy Officer.

Right to Request Confidential Communications: You have the right to request that we communicate with you about your health matters by alternative means or at alternative locations. To make such a request, you must submit your request in writing to Englewood Health's Privacy Officer.

Right to Request an Amendment: You have the right to request an amendment to your health information. In order to request an amendment to your health information, you must submit your request in writing to Englewood Health's Privacy Officer, along with a description of the reason for your request. If we agree to your request, we will amend your record(s) and notify you of such. We have the right to deny your request for amendment. If we deny your request for an amendment, we will provide you with a written explanation of why we denied the request and to explain your rights.

Right to an Accounting of Disclosures: You have the right to receive an accounting of disclosures of your health information made by us to individuals or entities other than you, in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to Englewood Health's Privacy Officer. 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 cost 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.

Right to Notification of a Breach: You will receive notifications of breaches of your unsecured protected health information as required by law.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you have previously agreed to electronically receive this Notice. You can always request a written copy of our most current version of this Notice from Englewood Health's Privacy Officer.

CHANGE TO THIS NOTICE

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 health information we maintain. This Notice will contain the effective date on the last page. If we amend this Notice, we will provide the revised version on our website, and we will provide you with a copy of the Notice that is currently in effect, upon your request.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of Health & Human Services. You may contact Englewood Health at (201) 894-3000 and ask for the Privacy Officer for additional information pertaining to a complaint. We will not take any retaliatory action against you for filing a complaint.

CONTACT PERSON

If you have any questions or would like further information about this Notice, please contact Englewood Health at (201) 894-3000 and ask for the Privacy Officer.

This Notice is effective March 3, 2018, and replaces all earlier versions.