Garden State Rheumatology Consultants

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NOTICE OF PRIVACY PRACTICES

Effective Date: 09/23/2025

Your Rights

- Get a copy of your medical record in paper or electronic form.
- Ask us to correct your record if you believe it is incorrect or incomplete.
- Request confidential communications (e.g., by phone or at a different address).
- Ask us to limit what we share, though we may not always be able to agree.
- Receive a list of those with whom we've shared your information.
- Get a copy of this notice at any time.
- Choose someone to act for you if you have a medical power of attorney.
- File a complaint if you believe your privacy rights have been violated.

Our Uses and Disclosures

We typically use or share your health information in the following ways:

- Treatment: Share with other providers involved in your care.
- Payment: Bill and receive payment from your insurance plan.
- Healthcare Operations: Improve quality, safety, and efficiency of care.

We may also share your information:

- With public health authorities (for disease reporting, recalls, safety).
- For health research (with safeguards in place).
- To comply with law or respond to legal/government requests.
- To address workers' compensation, law enforcement, and national security needs.
- To organ and tissue donation programs, coroners, and medical examiners.

Our Responsibilities

- We are required by law to maintain the privacy and security of your health information.
- We will notify you if a breach occurs that may have compromised your privacy.
- We will follow the duties and practices described in this notice.
- We will not use or share your information other than as described here unless you give written permission.

Questions or Complaints

If you have questions or concerns, please contact:
Privacy Officer: Johana Ramirez
Phone: 908-977-1677
Address: 2333 Morris Ave, STE B-111, Union, NJ 07083

You may also file a complaint with the U.S. Department of Health and Human Services at www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Acknowledgment of Receipt

Patient/Representative Signature: _____ Date: _____