HIPAA Privacy Policy Statement Notice (Revised 9/29/15)

Paul Wexler, M.D./GENASSIST™, Inc.
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At GENASSIST™, Inc./Paul Wexler, M.D.'s office we understand that privacy is important to you and we are committed to protecting the confidentiality of your medical and/or financial information. The trust and confidence of our patients has always been our goal and that is why we have always taken steps to respect and protect your privacy.

Restricted Disclosure of Information:

GENASSIST™, Inc./Paul Wexler, M.D. does **NOT** reveal information about your medical and/or financial history to parties outside our office unless:

- Your request or authorize us in writing
- The disclosure is required or permitted by law (e.g. subpoena, investigation of fraudulent activity to comply with federal, state or local laws).

Under HIPAA enacted 10/16/02 (Revised 9/23/13) we are unable to discuss any medical and/or financial issues with anyone other than the patient without the patient's written authorization ahead of time.

Employee Obligations Regarding Confidentiality:

We restrict access to medical or financial information about you to those employees who have a business reason to know such information in order to provided medical and/or financial services to you. The employees at GENASSIST™, Inc./Paul Wexler, M.D.'s office have been educated on the importance of privacy and confidentiality and are required to conform to our ***Privacy Policy requirements.***

Security Procedures:

GENASSIST™, Inc./Paul Wexler, M.D.'s office uses established security procedures to conform to federal standards. We maintain physical, electronic and protocol safeguards to protect your medical and/or financial information. We test and audit these procedures to ensure their integrity.

*****Please certify that you have read this and understand the Medical Information/Financial Information Privacy Policy Statement by signing and dating below:***

****As of 9/23/13 I understand that if I request medical and/or financial information via email the information WILL NOT be encrypted. I agree by signing below.***

_____ _____
Patient Printed Name Date of Birth

_____ _____
Patient Signature Date

I authorize the following person(s) listed below to be able to ask about my medical and/or financial information on my behalf:

_____ _____
Name(s) Date