

## **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 READ THIS NOTICE CAREFULLY**

In the material below, "you" and "your" are also used to mean and pertain to "you" or to "your child," or "your children" where appropriate. This notice is being given to you because federal law gives you a right to receive adequate notice of how our Practice handles medical information, our legal duties with regard to your medical information, and your rights with regard to your medical information.

### **A. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

When you need health care, you give information about yourself to doctors, nurses, and other health care workers. This information, along with the record of the care you receive, is "protected health information." Our Practice uses your health information within the Practice and shares (or discloses) your health information outside the Practice in order to provide you with essential medical care and for other purposes. This Notice of Privacy Practices describes how we use and disclose your health information and when we will ask for specific permission to do so.

#### **1. Treatment, Payment and Health Care Operations**

Our Practice may legally use and disclose your health care information for treatment, payment and health care operations, and need not ask for your specific permission to do these things, as explained below.

##### **Treatment**

Our Practice may legally use and disclose your health information to provide, coordinate or manage your health care and related services by one or more health care providers. We will also share information with other third parties, such as home health agencies, visiting nurses, schools (immunization records, as required by education laws), and others who are involved in the care of your children. This helps to make certain that everyone caring for your child has the information needed.

##### **Payment**

Our Practice will use and disclose health information to bill and collect payment for health care services we provide. If you have health insurance, our providers bill those payers and will disclose information that the insurance companies or government agencies need in order to determine your child's eligibility for services or the medical necessity of the services you received. In those cases, we will provide the minimum health information necessary for payment. In most cases, this information consists of the diagnosis (medical reason for the visit or service) and the procedure(s) performed, such as an office visit, laboratory tests, or immunizations.

##### **Health Care Operations**

Our Practice may use and disclose your health information for activities that are necessary to operate the Practice and carry out its mission. Some disclosures are to outside parties, who must agree to protect the confidentiality of all health information they receive from us. Examples of "health care operations" include, but are not limited to, the following: Quality assessment; Auditing activities and Compliance programs; Using outside Legal, Auditing, or other Consulting services; Electronic data storage; and Medical information management and analysis.

#### **2. Uses and Disclosures for other purposes**

Federal privacy law also permits uses and/or disclosures of your child's health information in the following areas without your specific permission:

- As required by law
- For public health activities, including reports to the state public health and child protection authorities, and to the Food and Drug Administration
- For health oversight activities
- For legal and administrative proceedings
- For law enforcement purposes
- With regard to patients who have died, to coroners, medical examiners and funeral directors
- To avert a serious threat to health or safety

### **3. Uses and Disclosures That You May Limit or Request Not Be Made**

Our Practice may disclose to a family member or other person close to you, or identified by you, the health information that is necessary for that person's involvement with your care.

### **4. Uses and Disclosures Requiring Your Written Authorization**

- Disclosure of sensitive information to administrative and judicial proceedings (counseling, confidential communications between a parent and/or child and social worker or therapist, and the like)
- Disclosure of genetic testing (as defined by state law) or test results
- Disclosure of HIV testing or test results
- Disclosure of substance abuse treatment
- Disclosure of treatment for sexually transmitted diseases
- Research conducted by entities outside our Practice
- Marketing/Communication to you about products and services you might purchase
- Other uses not covered above that our Practice may describe when asking for your permission

Note: If you have given authorization, you may revoke it at any time, provided that the revocation is in writing, except to the extent that a use or disclosure has been made in reliance upon your prior authorization.

## **B. YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION AND HOW TO EXERCISE THEM**

### **The Right to Request Limits on Uses and Disclosures of Your Health Information**

You have the right to request limitations on the uses and disclosures of your child's health information for treatment, payment or health care operations or for notification purposes. Our Practice is not obligated to agree to your request. If we agree, we must put the restriction in writing and abide by it, except if necessary to treat you in an emergency. You may not ask us to restrict uses and disclosures that we are legally required to make.

If you restrict disclosing information to your health insurance company for payment, we will ask you to sign an agreement indicating that you are originating the request, that you will be liable for payment for all such services requested at our full charge rate, and that you will not ask your insurance carrier to pay for such services or to appeal to our Practice. In the event that you contact your insurance carrier about such services, either to ask the carrier to pay or to complain that the Practice has asked for payment for a covered service (such as an office visit), we may disclose to the carrier the fact that you had agreed to a waiver to pay for services, that you had requested us not to bill or otherwise contact your carrier, and may have to disclose the reason for the visit, such as the diagnosis or procedure.

### **The Right to Receive Confidential Communication of Your Child's Health Information**

You have the right to request to receive your child's health information by alternative means. For example, you might ask our Practice to send mail to an alternative address, or to contact you by telephone only at work. Your request must be in writing. Our Practice must agree with any reasonable request and cannot ask you to explain the basis for your request. We can require you to provide information as to how payment, if any, will be handled, and to specify an alternative address or other method of contact.

### **The Right to Look at and Get a Copy of Your or Your Child's Health Information**

With very few exceptions, you have the right to look at and obtain a copy of you or your child's health information that our Practice maintains related to your treatment and bills. You must make your request in writing. We will respond within thirty (30) days from receipt of your request. If you ask for a copy, you will be charged a reasonable fee. If your request is denied, you will be given a written explanation of the reasons for the denial and the rights, if any, to a review of the denial. Instead of providing you with the information you requested, we may offer to provide a summary or explanation as long as you agree in advance to this and to any fees for such summary or explanation. If you ask for information we do not have, but we know where it is, we must tell you where to direct your request.

### **The Right to Amend Your Health Information**

You have the right to ask us to amend your health information related to your treatment and bills if you believe there are errors or missing information. You must make your request in writing and provide the reason. We have sixty (60) days to respond. If we have not been able to act on the request within sixty (60) days, we may notify you that we are extending the response time by thirty (30) days. If we do that, we will send you an explanation for the delay and state a date by which you will receive our decision. We may deny your request if we determine that the information you want amended is accurate and complete, is not part of our records or created by us, or is information to which you have no right of access. If we deny your request, we must give you a written statement with the reasons why and what other steps are available to you. If we grant the request, we will ask you to identify the persons you want to receive the amendment and agree to have us notify them along with any others who received the information before correction and who might rely on the incorrect information in providing treatment to you/your child.

### **The Right to Receive An Accounting of Disclosures to Your/Your Child's Health Information**

You have the right to receive a record of disclosures of your health information. You may request this for the six (6) years prior to the date of your request (but not prior to April 1, 2003) or for a shorter period. The listing you receive will include the date of each disclosure, the name (and address, if known) of the entity or person who received it, a brief description of the information disclosed, and a brief statement of the purpose of the disclosure or a copy of the written request for information. The following exceptions apply:

- Disclosures made for purposes of treatment, payment or health care operations
- Disclosures made to you pursuant to your written authorization
- Disclosures to persons involved in your care or for notification purposes
- Disclosures for national security or intelligence purposes
- Disclosures to correctional institutions or law enforcement officials who have custody of you/your child
- Disclosures that occurred prior to the effective date shown on this Notice of Privacy Practices

We will respond to your request for an accounting within sixty (60) days, unless we need an extension of no more than thirty (30) days, in which case we will explain the reason for the delay and tell you the date by which you will receive the listing. Your first request for accounting in any twelve (12) month period is free, but we will make a reasonable charge for any other requests in that period. We will notify you of the charge before we carry out the accounting so that you have the chance to withdraw or modify the request to avoid or reduce the fee.

### **The Right to Receive a Copy of this Notice of Privacy Practices Upon Request**

*You may request a paper or email (if available) copy of this Notice of Privacy Practices from our Practice.*

### **C. OUR DUTIES WITH RESPECT TO YOUR HEALTH INFORMATION**

Our Practice is required by law to maintain the privacy of your/your child's health information and to provide individuals with notice of our legal duties and privacy practices with respect to your/your child's health information. Our Practice must abide by the terms of the Notice of privacy practices currently in effect. We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time and to make the new Notice of Privacy Practices effective for all protected health information that we maintain. If we do so, the updated Notice of Privacy Practices will be available in the registration area for public viewing. You may request a copy of the current Notice of Privacy Practices at any time from our Practice.

### **D. HOW TO COMPLAIN IF YOU BELIEVE THAT YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED**

If you think that we may have violated your privacy rights or you disagree with any action we have taken with regard to your health information, you may file a complaint with our Practice. You may also send a written complaint to the Secretary of the Department of Health and Human Services, 200 Independence Avenue, SW, Washington, DC 20201, or via e-mail to [HHS.Mail@hhs.gov](mailto:HHS.Mail@hhs.gov). We will take no retaliatory action against you if you file a complaint about our privacy practices.

### **E. PERSON TO CONTACT FOR INFORMATION OR WITH A COMPLAINT**

If you have any questions about this Notice of Privacy Practices or any complaints, please contact our Practice's Privacy Officer, or ask to speak to the Practice Administrator/Office Manager.

### **F. EFFECTIVE DATE**

This Notice of Privacy Practices is effective as of April 1, 2003.

**ACKNOWLEDGMENT OF  
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

---

In this notice, “you” and “your” are also used to mean and pertain to “you” or to “your child” or “your children” where appropriate.

---

The providers (physician, nurse practitioners), nursing and administrative staff at our Practice, at the Directions of the physicians, may share your health information for treatment, payment and health care operations.

I understand that my health information may be used for treatment payment or healthcare operations purposes, such as:

1. Sharing my health information among providers (both inside and outside the practice), on a need-to-know basis, to give me treatment.
2. Using my health information for billing purposes, including giving referrals to specialists, when necessary and appropriate.
3. Sharing my health information with health insurance companies, government agencies, or other payers that request information related to benefits determinations, claims file for visits or admission, and other billing matters.
4. Using my health information for healthcare operations, including monitoring the quality of care, audits and surveys, and carrying out other business and administrative activities.

I understand that all reasonable efforts will be made to protect the privacy of my health information, whether maintained on paper or electronically, and regardless of how it is communicated (paper, email, and fax mail).

I have been given the opportunity to read the Notice of Privacy Practices that outlines in more detail how my health care information is used and shared with others. The Notice of Privacy Practices explains (1) When I need to give further approval for the providers to use my health information or share it outside the practice and (2) when my permission is not needed for the providers to use my health information or share it outside the practice (e.g. required by law, public health activities, etc.).

I understand that this Practice has reserved the right to change the Notice of Privacy Practices at any time. I may obtain a current copy of the Notice of Privacy Practices by contacting the Privacy Officer or from the Practice’s website.

My signature below constitutes my acknowledgment that I have been provided a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Signature of patient (if age 18 or older) or parent/guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Print)