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Notice of Privacy Practices

As required by HIPAA: The Health Insurance Portability and Accountability Act of 1996

This notice describes how your medical information as a patient of this practice may be used and disclosed and how you can get access to this information. Please review it carefully.

The privacy of your medical information is important to us. You may be aware the U.S government regulators established a privacy rule, the Health Insurance Portability and Accountability Act (HIPAA) governing protected health information (PHI). PHI includes individually protected health information including demographic information and relates to your past, present and future physical and mental health or condition and related health care services. This notice tells you about how your PHI may be used, and about certain rights that you have.

Use and disclosure of protected health information

- Federal law provides that we may use your PHI for your treatment, without further specific notice to you, or written authorization by you. For example, we may provide laboratory or test data to a specialist.

- Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you. For example, under a health plan, we are required to provide the health insurance company with a diagnosis code for your visit and a description of the service rendered.

- Federal law provides that we may use your medical information for health care operations without further specific notice to you, or written authorization by you. For example, we may use the information to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

- We may use or disclose your medical information, without further notice to you, or specific authorization by you where:

1. Required for public health purposes
2. Required by law to report child abuse
3. Required by a health oversight agency to oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct.
4. Required by law in judicial or administrative proceedings
5. Required for law enforcement purposes by a law enforcement official.
6. Required by a coroner or medical examiner
7. Permitted by law to a funeral director
8. Permitted by law for organ donation purposed
9. Permitted by law to avert a serious threat to health or safety
10. Permitted by law and required by military authorities if you a member of the armed forces of U.S.
11. Required for national security, as authorized by law.
12. Required by correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official
13. Otherwise required or permitted by law
14. Certain types of uses and disclosures of protected health information require authorization, these include:
    - uses and disclosures of psychotherapy notes
    - uses and disclosures of PHI for marketing purposes; and
    - disclosures that constitute the sale of PHI
15. Other uses and disclosures not described in this Notice of Privacy Practices will be made only with an individual's authorization

Minors

- For divorced or separated parent: each parent has equal access to health information about their unemancipated child(ren), unless there is a court order to the contrary that is known to us or unless it is a type of treatment or service where parental rights are restricted.
- We can release your medical information to a friend or family member that is involved in your medical care. For example, a babysitter or relative who is asked by a parent or guardian to take their child to the pediatrician's office may have access to this child's medical information. We prefer to have written authorization from the parent or guardian for someone else to accompany the child and may make reasonable attempts to obtain this authorization.
- You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner.
- Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights you have

- You have the right to request restrictions on certain uses or disclosures described above. Except as states below, we are not required to agree to such restrictions.
- You have the right to request confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location e.g. at home and not at work. Such requests must be made in writing to your physician. Our office will accommodate reasonable requests.
- You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged)
- You have the right to request amendments to your medial information. Such requests must be in writing and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.
- You have the right to request an accounting of any disclosure we make of your medical information. This is a list of certain

non-routine disclosures our practice has made of your health information for non-treatment, payment or health care operation purposes. An accounting does not have to be made for disclosures we make to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required un 45 CFR 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law, or disclosures made before April 14, 2003.

- You have the right to restrict certain disclosures of Protected Health Information to a health plan, for carrying out payment or health care operations, where you pay out of pocket in full for the healthcare item or service.
- You have the right to, or will receive, notifications of breaches of your unsecured patient health information.
- All requests must state a time which may not be longer than six (6) years from the date of disclosure.
- You have a right to receive a paper copy of our notice of privacy policies.
- You have the right to receive electronic copies of health information.

Obligations that we have

- We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices. We are required to abide by the terms of this notice if it is currently in effect.
- We reserve the right to revise this notice, and to make a new notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office and copies available there.
- We will inform you of our intentions to raise funds and your right to opt out of receiving such communications.
- If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer or the U.S. Department of Health Services' Office of Civil Rights. We will provide the address of the OCR Regional Office upon your request. No retaliation will occur against you for filing a complaint.

Organization contact information

- **If you have any questions about this notice, please contact our Practice Manager at 978-465-0322.**

Your acknowledgement

- The purpose of this notice is to inform you, the patient, of your PHI is used and / or disclosed by this provider or organization. We want you to be fully aware of how we use your PHI so that you can provide us with your Acknowledgement for us to treat your care needs, receive payment for services rendered, and allow administrative and other activities necessary to operate the practice and carry out our mission.

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis/ es and other health information to by bill(s)
- A means by which my health plan or health insurance company can verify that services billed were actually provided
- A tool for routine health care operations in this organization, such as ensuring that we have quality processes and programs in place and making sure that the professionals who provide your care are competent to do so.
- An important part of studies that may be conducted to further research efforts and the development of new knowledge.

I understand that:

- I have been provided with a Notice of Information Practices that provides specific examples and descriptions of how my personal health information is used and disclosed by Riverside Pediatrics
- I have the right to review the Notice of Information Practices prior to signing this Acknowledgement.
- Riverside Pediatrics will revise and distribute its Notice of Information whenever changes are made to any of its privacy practices.
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations and Riverside Pediatrics is not required to agree to those restrictions.
- I may revoke this Acknowledgement in writing at any time. Further, I am aware that Riverside Pediatrics can proceed with uses and disclosures that pertain to treatment, payment or healthcare issues that took place before the Acknowledgement was revoked.

Restrictions on the use and disclosure of your HPI

To request a restriction on the use and disclosure of your personal health information related to your treatment, payment for service, or for the health care operations of Riverside Pediatrics, please do so after reading the Notice of Information Practices.

I request the following restrictions to the use of disclosure of my personal health information:

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_____

Please provide your signature below to indicate that you have read the above Acknowledgement and have reviewed the Notice of Information Practices.

Patient Name: _____

Parent/Guardian signature (or patient if 18 yr or older):

_____

Date: _____