**PRIVACY NOTICE TO PATIENTS**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY Pediatric Group Associates (***PGA)*** AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

*PLEASE READ CAREFULLY*

Effective Date: April 14, 2003

Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations, ***PGA*** and all similar health care providers are required by federal law to maintain the privacy of your protected health information (“PHI”) and will abide by the terms in this Privacy Notice.

Please be advised that ***PGA*** may use your PHI in rendering treatment to you. For example, we are permitted to use your PHI in providing you with medical care/treatment when you visit our office or we treat you in a hospital or nursing facility. Under federal law, we may disclose your PHI to you or we can disclose your PHI to third parties for treatment. For example, if we refer you to a specialist, we will forward your medical information to such specialist. We can disclose your PHI for payment purposes. For example, we will disclose your PHI to your insurance provider, employer, Medicare, Medicaid or other party responsible for providing you with health insurance coverage in order for ***PGA*** to be reimbursed for our services rendered to you. We will also use or disclose your PHI for health care operations. For example, we may use your PHI when we engage in quality assurance and medical chart reviews, which are part of our health care operations. We may also disclose your PHI when required by the secretary of Health & Human Services.

Unless disclosure is required under federal, state law, or certain other exceptions, including law enforcement, we are prohibited from disclosing your PHI without your authorization. Our practice may use or disclose your PHI in accordance with the specific requirements of the HIPAA rules without ***PGA*** needing to obtain your authorization if any of the following instances occur:

1. Required by law
2. Required for public health purposes
3. Required disclosures about victims of abuse, neglect or domestic violence,
4. Required by health oversight agency for oversight activities authorized by law,
5. Required in the course of any judicial or administrative proceeding,
6. If disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public,
7. Required for a law enforcement purpose to a law enforcement official,
8. Required by a coroner or medical examiner,
9. Required by an organ procurement organization, for research, or

Additionally, if you are a member of the armed forces, ***PGA*** is permitted to disclose your PHI without your consent if deemed necessary by appropriate military command authorities to assure an appropriate military mission.

We may also context you via mail or phone to remind you of appointments with our office or to discuss treatment alternatives.

In the event our practice wishes to disclose your PHI to another entity besides those referenced above, we are required to obtain your authorization. We would seek to obtain your authorization if ***PGA*** desired to release your PHI for reasons other than treatment, payment or for our practice’s operations. For example, if we desired to participate in outside research or a drug study, we would need your written authorization prior to being permitted to release your PHI to such outside research facility or drug manufacturer. If you provide us with an authorization, you have the ability to revoke such authorization at any time by sending PGA a written revocation. However, if we have already released such information pursuant to your prior authorization, the revocation will be effective for all future disclosures only.

Please be further advised that you have the ability to access, copy, inspect and amend your medical information that we maintain. Additionally, if you desire, PGA can provide you with an accounting of all disclosures that we have made of your PHI to third parties, except disclosures for treatment, payment, or health care operations and pursuant to authorization.

If you have a dispute with our practice regarding our use of your PHI or disclosure by ***PGA*** and believe that your primary rights have been violated, please contact our Practice Privacy Officer to file a complaint or you may contact the Secretary of Health and Human Services. Alternatively, dispute forms are available from our practice. P lease understand that PGA will not retaliate against your in any way for filing a complaint.

Lastly, please be advised that you have the right to request restrictions on certain use and disclosures of your PHI to carry out treatment, payment or health care operations or disclosures by ***PGA*** of your PHI to a family member, relative or a close personal friend. However, we are not required by federal law to agree to your requested restriction. If you request a copy of your PHI, you also have the ability to request that we send it to an alternative location (different address) and by alternative means.

Additionally, if you have received this notice in an electronic form and you would like a paper copy, please contact the Practice Privacy Officer. ***PGA*** reserves the right to amend this Notice as revised. Notices will be posted in our office and provided to you upon your visit.

Please sign below acknowledging a receipt of the ***PGA*** Privacy Notice. Thank you and if you have any questions, please direct them to the Practice Privacy Officer.

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Patient or Patient Representative Date

HIPAA Notice of Privacy Practices

Pediatric Group Associates

*Effective Date*: *September 6, 2013*

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

**OUR OBLIGATIONS:**

We are required by law to:

Maintain the privacy of protected health information

Give you this notice of our legal duties and privacy practices regarding health information about you

Follow the terms of our notice that is currently in effect

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:**

The following describes the ways we may use and disclose health information that identifies you (“Health Information”). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our Practice Manager/Privacy Officer.

***For Treatment***. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

***For Payment***. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

***For Health Care Operations***. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

***Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services***. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

***Individuals Involved in Your Care or Payment for Your Care***. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

**SPECIAL SITUATIONS:**

***As Required by Law***. We will disclose Health Information when required to do so by international, federal, state or local law.

***To Avert a Serious Threat to Health or Safety***. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

***Business Associates***. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

***Organ and Tissue Donation***. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

***Public Health Risks***. We may disclose Health Information for public health activities. These activities generally include 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; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

***Health Oversight Activities***. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

***Data Breach Notification Purposes.*** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

***Lawsuits and Disputes***. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

***Law Enforcement***. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person’s agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

***Coroners, Medical Examiners and Funeral Directors***. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

**USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT**

***Individuals Involved in Your Care or Payment for Your Care.*** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person’s involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

***Disaster Relief.*** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

**YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES**

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Practice Manager/Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

**YOUR RIGHTS**:

You have the following rights regarding Health Information we have about you:

***Right to Inspect and Copy***. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our Privacy Officer. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

***Right to an Electronic Copy of Electronic Medical Records.*** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

***Right to Get Notice of a Breach.*** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

***Right to Amend***. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Practice Manager/Privacy Officer.

***Right to an Accounting of Disclosures***. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Practice Manager/Privacy Officer.

***Right to Request Restrictions***. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. To request a restriction, you must make your request, in writing, to our Privacy Officer. We are not required to agree to your requestunless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

***Out-of-Pocket-Payments.*** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

***Right to Request Confidential Communications***. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Practice Manager. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

***Right to a Paper Copy of This Notice***. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, [www.pediatricgroupqc.com](http://www.pediatricgroupqc.com). To obtain a paper copy of this notice, contact our Practice Manager/Privacy Officer.

**CHANGES TO THIS NOTICE:**

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

**COMPLAINTS:**

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Practice Manager/Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit AMA’s web site, [www.ama-assn.org](http://www.ama-assn.org).

Print Patient Name

Patient/Legal Guardian Signature Date

HIPAA Notice of Privacy Practices

Pediatric Group Associates

*Effective Date*: *September 6, 2013*

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. I HAVE READ AND MY SIGNATURE ON THIS PAGE CONFIRMS RECEIPT OF THE HIPAA/NPP FOR PGA.**

**CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Pediatric Group Associates (PGA) will obtain and maintain protected health information (“PHI”) pertaining to you as a patient of PGA. Please be advised that we will use and disclose your PHI as necessary, in order to treat you, receive payment for services and facilities provided to you, and for administration of our health care operations. PGA’s ability to use and disclose a patient’s PHI is more fully discussed in our Privacy Notice, which was provided to you upon commencement of your treatment, and which is posted in our office. Prior to signing this consent, you have the right to review that Notice. Please note that we have reserved the right to amend the Notice and we will provide you with a copy of such Notice or make copies of such Notice available to you if it is materially amended in the future. We reserve the right to change our privacy practices.

As a patient of PGA, you have the right to restrict PGA use or disclosure of your PHI for carrying out treatment, payment or health care operations; however, PGA does not have to agree with such restrictions. Nevertheless, if we agree to your restrictions, we agree to be bound by such restrictions.

Unless PGA has relied and acted upon your consent to use or disclose your PHI, you have the right to revoke this consent by providing PGA with a written revocation of consent.

If you agree to consent to our use and disclosure of your PHI for treatment, payment and for purposes of health care operations, please execute where noted below.

**ACKNOWLEDGED AND AGREED TO:**

**CHILDS NAME AND DATE OF BIRTH**

*\*\* Please Print \*\**

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Patient or Patient Representative

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Name Date of Birth

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* I give ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ permission to access   
   
 my medical records at PGA. Please circle: YES NO

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
 Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_