All About Kids Pediatrics, S.C.
Notice of Privacy Practices "HIPAA"

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.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other identifiable health information used or disclosed by use in any form, whether electronically, on paper, or orally are kept confidential. This act gives you, the patient, significant new rights to understand and control how you health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing continuity or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality management and improvement activities, auditing functions, and cost management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You agree that all telephone numbers and email addresses you provide may be used by All About Kids Pediatrics and those acting on its behalf to communicate with me by telephone (including cell phone), text, or any automated or prerecorded messages.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications for protected health information from us by alternative means or at alternative locations.
- The right to inspect or copy your protected health information
- The right to amend your protected health information
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice upon request

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy policies with respect to protected health information.

This notice is effective April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practice currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provision effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provision of this notice or the policies and procedures of this office. We will not retaliate against you for filing a complaint.

For more information regarding HIPAA or to file a complaint contact the Privacy Officer or our office in writing or you may contact:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, D.C. 20201
(202)619-0257
Toll Free: 1-877-696-6775

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers, who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice to Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain the current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

Child's Full Name Date of Birth

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_____

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_____ _____

Your Name:_____

Relationship to Patient(s):_____

Signature:_____

Date:_____

****For patients of All About Kids Pediatrics to fill out **and keep for their own files**. Do not return back to our office.