Alliance Pediatrics, PA

Patient Name: _____

Receipt of Notice of Privacy Practices Written Acknowledgement Form

DOB: _____

Today's Date:

I, _____, have received a copy of Alliance Pediatrics ' Notice of Privacy Practices in the form as attached hereto.

Printed Name: _____ Signature: _____

Updated Notice of Privacy Practices (9/23/13 Revisions) *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 & Accountability Act ("HIPAA") governing protected health information ("PHI"). PHI includes individually identifiable health information including demographic information and relates to your past, present or 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 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 that 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 services 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:

Required for public health purposes, or for law enforcement by a law enforcement official; **Required by** law to report child abuse, or by a health oversight agency for oversight activities authorized by law, or by law in judicial or administrative proceedings, or by correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official or by a coroner/medical examiner; **Permitted by law** to a funeral director, or for organ donation purposes, or to avert a serious threat to health or safety; **Permitted by law and required by** military authorities if you are a member of the armed forced of the U.S. ; Permitted by law and required for national security, as authorized by law; or otherwise required or permitted by law.

Certain types of uses and disclosures of protected health information require authorization, these include:

- Uses and disclosures of psychotherapy notes and disclosures of PHI for marketing and disclosures that constitute the sale of PHI. Other uses and disclosures not described in this Notice of Privacy Practices will be made only with an individual's authorization.

State Specific Laws

The State of Florida states the right to privacy in its constitution. FL law is more stringent and will override HIPAA regulations. FL provides additional protection for information regarding HIV/AIDS, mental health, substance abuse and sexually transmitted diseases.

We will also continue to follow considerations of confidentiality under state law for minors when treated for certain conditions (for example, minors do not need parental permission to consent to treatment for sexually transmitted diseases, pregnancy, drug abuse and others. The minor's personal health information is not allowed to be released, except as outlined in this notice, without the written authorization of the minor).

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us

otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

Minors

For divorced or separated parents: 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. A separate form is available for this purpose. 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 That You Have

- You have the right to request restrictions on certain uses or disclosures described above. Except as stated 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 practice will accommodate reasonable requests.
- You have the right to inspect & obtain copies of your medical information (a reasonable fee will be charged).
- You have the right to request amendments to your medical 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 disclosures we make of your medical information 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 under 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 PHI 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 are required to notify Business Associates of Health Info Exchange of the restriction
    - A family member or other third party may make the payment on your behalf and the restriction will still be triggered
- You have a right to, or will receive, notifications of breaches of your unsecured patient health information.
- All requests must state a time period, 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 a right to receive electronic copies of health information.

Obligations That We Have

- We are required by law to maintain the privacy of PHI and to provide individuals with notice of our legal duties and privacy practices. We are required to abide by the terms of this notice as long as it is currently in effect.
- We reserve the right to revise this notice, and to make a new notice effective for all PHI we maintain. Revised notices will be posted in our office, and copies will be 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 with the U.S. Department of Health and Human Services' Office for Civil Rights (OCR). 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 Alliance Pediatrics, PA*4627 NW 53rd Ave Gainesville FL* (352)335-8888*Contact Person: Carol Ellis, Privacy Officer