NOTICE OF PRIVACY PRACTICES

Family Time Pediatrics 733 W 40TH ST, BALTIMORE, MD 21211

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

Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This act gives you, the patient significant new rights to understand and control how your health information is used. "HIPPA" 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 information.

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

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be referral to a specialist.

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 the insurance company for payment.

Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal assessment review.

We may contact you to provide appointment reminders or information about treatment. Any other uses and disclosures will be made only with your ·written authorization. You may revoke such authorization in writing and we will abide by that 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 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 not 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 of protected health

information from us by alternative means or at alternative locations.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected heal ·information.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be notified of any breach of medical records.
- The right to restrict disclosure of medical information to your insurance plan for those visits paid for out of pocket.

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 practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices in effect. We reserve the right to change the terms of Notice of Privacy Practices and to make the new notice effective for all protected health information we maintain.

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

I have received a copy of the Privacy Practices/HIPAA forms. I understand the above information regarding protected health information (PHI).

DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

Parent/Guardian Signature _____ Date _____