CHESTER PEDIATRICS

NOTICE AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Please review this notice carefully and sign at the bottom

The Health Insurance Portability Accountability Act of 1996 (HIPPA) is a federal program that requires all medical records and other individually identified heath information used or disclosed by practices in any form are kept confidential. Chester Pediatrics designates that all information, including demographic information, related to the care of any patient, or payment for that care is **confidential.** The following explains how we, Chester Pediatrics are going to maintain the privacy of your health information and how we may use and disclose that information.

USES AND DISCLOSURES: Chester Pediatrics may use and disclose your medical records for each of the following purposes: treatment, payment and health care operations.

- **Treatment** is defined as providing, coordinating, or managing health care and related services by one or more health care providers. This means we will collect information about your child and their family as part of our registration and evaluation processes. Such information includes names, addresses, phone numbers, birth dates, social security numbers and health and personal histories. *For example:* Information obtained by a nurse, physician or other member of Chester Pediatrics will be recorded in your record and used to determine the course of treatment that should work best for your child. The providers who are treating your child will then record their expectations and the actions they took and their observations. In that way the provider will know how your child is responding to treatment.
- **Payment** is defined as obtaining compensation for services, confirming insurance coverage, billing or collection activities, and utilization review. *For example:* A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies your child, as well as their diagnosis, procedures and supplies used.
- **Health Care operations** include the management aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

USES AND DISCLOSURES WITHOUT SPECIFIC AUTHORIZATION: Chester Pediatrics may also disclose your protected health Information without your specific authorization (permitted by law) for the following reasons.

- To a **family, friend or other person** when the situation indicates that disclosure would be in your child's best interest if you were unavailable. This would include a medical emergency or disaster relief.
- To a **coroner, medical examiner,** funeral director, or organ procurement organization for certain purposes. This may be necessary, for example, to determine the cause of death.
- To the **public health authority** that is authorized by law to collect and receive information related to the prevention of disease, disability, or injury.
- To prevent a **serious and imminent threat** to your child's health or safety or the health or safety of others.
- To **appropriate authorities** if we reasonably believe your child is a possible victim of abuse, neglect, domestic violence or other crime.
- To a **business associate** so that they can perform the job we've asked them to do and bill you and your third party payer for services rendered. Examples of business associates include our electronic claims billing vendor and our electronic statements billing vendor. We require the business associate to appropriately safeguard your information.
- To a **government authority** responsible for cases of child abuse.
- To **the FDA** as it relates to adverse events, product defects, or problems.
- For the purpose of investigating or prosecuting the **violation of a government healthcare benefits** program (e.g., Medicare, Medicaid).
- In response to a **court order or subpoena.**
- For **law enforcement,** as it relates to the prevention, reporting, or investigation of a crime.
- To the **department of Health and Human Services** as may be needed to investigate compliance with or a violation of HIPPA.
- To contact you to provide **appointment reminders** or information about **treatment options** or other health-related benefits and services that may be of interest to you.

ANY OTHER USES OR DISCLOSURES will be made only with your written authorization. You may terminate such authorization in writing and we are required to honor and abide by that written request, except if we have already taken actions relying on your authorization.

PATIENT RIGHTS: The following are your 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 your 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 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 of protected health information from us by alternative means (e.g., by phone, in person, fax) or at an alternative address.
- The right to inspect and receive a copy of your protected health information. You will be charged a $10.00 administrative fee and .25

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per page for the cost of copying the records. In only the following situations can you be **denied access** to your medical record:

- If the records were prepared for a legal occurrence.
- If the disclosure might result in physical or emotional harm to the patient.
- If the record is protected by the Clinical Laboratory Improvements Act of 1988 (CLIA).
- If the records are part of an investigational study and the patient granted the denial of access when he or she enrolled in the study.

- The right to request that we amend your protected health information.
- The right to receive an accounting of disclosures of protected health information. We are not required under HIPPA privacy regulation to provide you with an accounting of any disclosure prior to April 14, 2003, disclosures for treatment, payment, or healthcare operations and disclosure to persons involved in your care.
- The right to obtain a paper copy of this notice from us upon request.

OUR RESPONSIBILITIES: Chester Pediatrics is 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.

Chester Pediatrics is required to abide by the terms of this notice which is **effective April 14, 2003** and Chester Pediatrics reserves the right to change the terms of this Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. You may request and we will post a written copy of a revised Notice of Privacy Practices from Chester Pediatrics.

COMPLAINTS: If you feel that your privacy protections have been violated, you can file a written complaint with our office privacy Officer or with the Department of Health and Human Services or Office of Civil Rights. The complaint in no way influences your treatment at Chester Pediatrics.

ACKNOWELDGEMENT OF PRIVACY PRACTICES

I have received, read and understand Chester Pediatrics Notice of Privacy Practices and that Chester Pediatrics has the right to change it's Notice of Privacy Practices from time to time and that I may contact Chester Pediatrics **privacy Officer, Kerry Dryden** at 804-748-9090 at 4707 Buckingham Ct. Chester, VA 23831 to obtain a current copy of the notice of privacy practices or if you have any questions regarding these policies.

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 you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____

Patient name Relationship to patient

_____ _____ _____

Signature of Patient or Guardian Date Chart Number and Patient DOB