

Consent for the Use or Disclosure of Protected Health Information

400 Blankenbaker Parkway, Suite 200 - Louisville, KY 40243

As required by the Health Insurance Portability and Accountability Act of 1996 this practice may not use your personal health information for the purposes of treatment, payment or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Information Practices. You have the right to review the Notice of Information Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the notice of information practices by describing the requested restrictions in the "restriction request" section of this form. You may revoke this consent at any time by signing and dating the revocation section on your copy of the form and returning it to this office.

CONSENT SECTION

Patient Name: _____ Date of Birth: _____

I, _____ (print name) hereby consent to the use and disclosure of my child's personal health information for the purposes of treatment, payment and health care operations. My signature below indicates that I have received and been given an opportunity to read the Notice of Information Privacy Practices and to have any questions answered before signing.

I understand that I may request restrictions on the uses and disclosures of my child's health information at any time by completing and signing the restriction request section of this form. I further understand that the practice is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to the practice. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

Signature Date

RESTRICTION REQUEST SECTION

I hereby request the following restrictions on the uses and disclosures of my child's health information (please describe the requested restrictions in detail):

Signature Date

All Children Pediatrics, PLLC

REVIEWER SECTION

The terms of this request are / are not (circle one) acceptable.

Signature Date

Jeffrey Burton, MD, Patti Bingham, CMM, Deanna Sutton, Aimee Ivers
Privacy/Security Committee Members
Print Name Title

Reviewer's comments:

REVOCATION SECTION

I hereby revoke this consent.

Signature Date

All Children Pediatrics, PLLC

II. When the practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, the practice will not use or disclose your health information without your written authorization. If you do authorize the practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. Your Health Information Rights

1. You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstance, a decision to deny access may be reviewable. In some circumstance, you may have a right to have this decision reviewed. Please contact our Privacy Contact/Officer if you have questions about access to your medical record.

2. You have the right to request a notification of your protected health information. This means that you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restrictions you wish to request with your physician. You may request a restriction by submitting in writing your restriction request to our Privacy Contact/Officer.

3. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact/Officer.

4. You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact/Officer to determine if you have questions about amending your medical record.

5. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices, as well as disclosures made pursuant to your authorization. It also excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

6. You have a right to a paper copy of this Notice of Privacy Practices, upon request, even if you have agreed to accept this notice electronically.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact:

Patti Bingham, CMM, Privacy Officer

IV. Changes to this Notice of Privacy Practices

The practice reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, the practice is required by law to comply with this Notice.

V. Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy right have been violated by us. You may file a complaint with us by notifying our privacy contact/officer of your complaint. We will not retaliate against you for filing a complaint.

Complaints about this Notice of Privacy Practices or how the practice handles your health information should be directed to:

Jeffrey Burton, MD or Patti Bingham, CMM, Privacy Officer

This notice was published and becomes effective on April 14, 2003.

All Children Pediatrics, PLLC

I acknowledge All Children Pediatrics, PLLC has provided me a copy its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information.

Signature of Patient or Parent/Guardian/Personal Representative

Name of Patient or Parent/Guardian/Personal Representative

Date

Description of Parent/Guardian/Personal Representative's Authority

Patient Copy

All Children Pediatrics, PLLC

7. **Disaster Relief** We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.
8. **Required by law** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
9. **Public health** As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.
10. **Communicable Diseases** We may disclose your protected health information, as authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
11. **Health oversight activities** We may disclose your health information to health oversight agency for activities authorized by law, such as audits, investigations, inspections, licensure and other proceedings. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
12. **Abuse or Neglect** We may disclose protected health information to public officials who are authorized by law to receive reports of abuse, neglect or domestic violence.
13. **Food and Drug Administration** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.
14. **Judicial and administrative proceedings** We may disclose your health information in the course of any administrative or judicial proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discover request or other lawful process.
15. **Law enforcement** We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes. In addition, your protected health information may be disclosed for the following purposes: (1) legal processes and otherwise required by law, (2) requests for limited information for identification and location purposes, (3) requests pertaining to victims of a crime, and (4) alerting law enforcement officials when (a) there is suspicion that death has occurred as a result of criminal conduct, (b) in the event that a crime occurs on the Practice's premises, or (c) a medical emergency exists (not on the Practice's premises) and it is likely that a crime has occurred.
16. **Deceased person information** We may disclose your health information to coroners, medical examiners and funeral directors for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may also disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
17. **Organ donation** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
18. **Research** We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board or the privacy board that has been reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
19. **Public safety** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
20. **Specialized government functions** We may disclose your health information for military, national security, prisoner and government benefits (only for health plans) purposes.
21. **Worker's compensation** We may disclose your health information as necessary to comply with worker's compensation laws and other similar legally established programs.
22. **Marketing** We may contact you to provide appointment reminders or to give you information about other treatments or health-related benefits and services that may be of interest to you.
23. **Fund-raising** We may contact you to participate in fund-raising activities for All Children Pediatrics, PLLC.
24. **Change of Ownership** In the event that the practice is sold or merged with another organization, your health information/record will become the property of the new owner.
25. **Required Uses and Disclosures** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the privacy standards applicable to your protected health information.

All Children Pediatrics, PLLC

Notice of Privacy Practices

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.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices please contact:

Patti Bingham, CMM
All Children Pediatrics, PLLC
400 Blankenbaker Parkway, Suite 200 - Louisville, KY 40243

Effective Date of This Notice: April 14th 2003

References to "you" or "your" refers to all pediatric patients at All Children Pediatrics, PLLC, however the Parent, Guardian or Personal Representative will be responsible for acknowledging receipt of the following Notice of Privacy Practices.

I. How the practice may Use or Disclose Your Health Information

This practice collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of the practice, but the information in the medical record belongs to you. The practice protects the privacy of your health information. The law permits the practice to use or disclose your health information for the following purposes:

1. **Treatment** We will use and disclose our protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician. Finally we may use and disclose protected health information for the treatment activities of another health care entity or provider.

2. **Payment** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. We may also use and disclose protected health information for the payment activities of another health care entity or provider.

3. **Regular Health Care Operations** We may use or disclose, as needed, your protected health information in order to support the business activities of this practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. In addition, we may use or disclose your protected health information to another entity in order for that entity to conduct specific health care operations, which include quality assessment activities and reviewing the competence of health care professionals.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

4. **Information provided to you** We may disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Contact/Officer to request that these materials not be sent to you.

5. **Directory** We may list your name, where you are located in our facilities, your general medical condition and your religious affiliation in the event we create such a directory. This information may be provided to members of the clergy. This information, except your religious affiliation, may be provided to other people who ask for you by name. If you do not want us to list this information in our directory and provide it to clergy and others, you must tell us that you object.

6. **Notification and communication with family** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.