

# **Notice of Privacy Practices**

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD AS A PATIENT OF PEDIATRIC HEALTHCARE ASSOCIATES, P.A. MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR CHILD'S PERSONAL HEALTH INFORMATION**

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

**FOR CONVENIENCE, THIS DOCUMENT WILL MAKE REFERENCE (“YOU OR YOUR”) PERSONAL HEALTH INFORMATION (PHI) AS THAT INFORMATION REGARDING THE CHILD’S OR CHILDREN’S INFORMATION AND ANY OTHER INFORMATION THAT MAY BE DIRECTLY APPLICABLE TO YOU AS THE PARENT OR GUARDIAN OF THE CHILD OR CHILDREN**

## **A. OUR COMMITMENT TO YOUR PRIVACY**

Our practice is dedicated to maintaining the privacy of your child’s **personal health information (PHI)**. In conducting business, we will create records regarding you, your child and the treatment and services we provide to your child. We are required by law to maintain the confidentiality of health information that identifies you and your child. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your child’s PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at that time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your child’s PHI
- Your privacy rights in regard to your PHI
- Our obligations concerning the use and disclosure of your PHI

**The terms of this notice apply to all records containing your child’s PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.**

**B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:**

**Karon Hocutt, Privacy Officer  
Pediatric Healthcare Associates, P.A.  
3701 Eldorado Parkway, Suite A  
McKinney, Texas 75070  
(972) 562-5437 / (972) 548-7888**

**C. WE MAY USE AND DISCLOSE YOUR CHILD'S PERSONAL HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:**

**1. Treatment.** Our practice may use your child's PHI facilitate medical treatment. For example, we may ask your child to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your child's PHI in order to write a prescription, or we might disclose your child's PHI to a pharmacy when we order a prescription. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your child's PHI in order to facilitate your child's treatment or assist others in the treatment. Additionally, we may disclose your child's PHI to others who may assist in your child's case, such as your spouse, other children, or grandparents.

**2. Payment.** Our practice may use and disclose your child's PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items.

**3. Health Care Operations.** Our practice may use and disclose you PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you have received from us, or to conduct cost-management and business planning activities for our practice.

**4. Appointment Reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment.

**5. Health-Related Benefits and Services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

**6. Release of Information to Family/Friends.** Our practice may release your PHI to a friend or family member that involved in the care of your child. For example, a parent may ask a relative or babysitter to take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

**7. Disclosures Required by Law.** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

**D. YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding the PHI that we maintain about your child:

- 1. Confidential Communications.** You have the right to request that our practice communicate with you about your child's health and related issues in a particular manner or to a certain location. In order to request a type of confidential communication, you must make a written request to **Karon Hocutt, PHA Privacy Officer, (972-562-5437)**, specifying the requested method of contact, or the location where you

wish to be contacted. Our office will accommodate reasonable requests. You need not give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your child's PHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your child's PHI to only certain individuals involved in your child's care or the payment for your child's care, such as family members or friends. **We are not required to agree to your request;** however if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat your child. In order to request a restriction in our use of disclosure of your child's PHI, you must make a request in writing to the **PHA Privacy Officer noted above**. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both; and (c) to whom you want the limits to apply.
3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about your child, including patient medical records and billing records. You must submit your request in writing to the **PHA Privacy Officer noted above** in order to inspect and/or obtain a copy of your child's PHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment.** You may ask us to amend your child's health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the **PHA Privacy Officer noted above**.
5. **Accounting of Disclosures.** All of our patients have a right to request a list of certain non-routine disclosures PHA has made of your child's PHI for non-treatment or operations purposes. Use of your child's PHI as part of the routine patient care in PHA is not required to be documented. To request an accounting of the disclosures, your request must be made in writing and submitted to the **PHA Privacy Officer noted above**. All requests must state a time period, which may be no longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge. Our practice will charge for additional requests during the 12 month period. PHA will notify you of the costs involved with additional requests and you may withdraw your request before incurring any costs.
6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the **PHA Privacy Officer noted above**.
7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the **PHA Privacy Officer noted above**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**
8. **Right to Provide an Authorization for Other Use and Disclosures.** Our practice will obtain your written authorization for use and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your child's PHI may be revoked at any time in writing. Please note, we are required to retain records of your care

## **PEDIATRIC HEALTHCARE ASSOCIATES P.A**

### **PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

With my consent, Pediatric Healthcare Associates may use and disclose protected health information about me and my child to carry out treatment, payment, and healthcare operations. Please refer to Pediatric Healthcare Associate's, P.A. Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pediatric Healthcare Associates, P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, Pediatric Healthcare Associates, P.A., 3701 Eldorado Parkway, Suite A, McKinney, Texas, 75070.

With my consent, Pediatric Healthcare Associates may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items, and any call pertaining to my child's clinical care, including laboratory results among others.

With my consent, Pediatric Healthcare Associates may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Pediatric Healthcare Associates may e-mail my appointment reminder cards and patient statements.

I have the right to request that Pediatric Healthcare Associates, P.A. restrict how it discloses my or my child's protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Pediatric Healthcare Associate's, P.A. use and disclosure of my or my child protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Pediatric Healthcare Associates, P.A. may decline to provide treatment to me.

Date\_\_\_\_\_

Signature of Parent or Guardian\_\_\_\_\_

Name of Child\_\_\_\_\_ DOB\_\_\_\_\_

Printed Name of Parent or Guardian\_\_\_\_\_

