HIPAA Notice of Information 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 Notice of Information Practices describes how Lake Area Pediatrics (LAP) may use and share your medical information with others to carry out Treatment, Payment or health care Operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to see and amend your Protected Health Information (PHI). Protected Health Information (PHI) is information about you and services you have received. This would include information such as your name, address, date of birth, diagnosis, treatment, or other information that may identify you and your past, present or future physical or mental health or treatment you receive.

1. Uses and Disclosures of Your Medical Information

Uses and Disclosures of Your Medical Information

Your PHI may be used and shared by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of Lake Area Pediatrics, and any other use permitted or required by law.

Treatment: We will use and share your PHI 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 (for example, sending PHI about you to a specialist as part of a referral).

Payment: Your PHI will be used, as needed, to receive payment for your health care services. For example, getting approval for a hospital stay may require that your PHI be shared with the health plan to obtain approval for the hospital admission. Or for example, sending billing information to your insurance company or Medicaid.

Health Care Operations: We may use or disclose, as needed, your PHI in order to support the business activities of Lake Area Pediatrics. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, health oversight audits or inspections, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students who 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 contact you to remind you of your appointment by phone or email.
We may use or disclose your PHI in several other situations **without** your authorization. We may give out PHI about you for public health purposes, abuse or neglect reporting, research studies, funeral arrangements and organ donation, workers' compensation purposes, Food and Drug Administration requirements, and emergencies. We also disclose PHI when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders.

Other Permitted and Required Uses and Disclosures will be made only with your authorization or opportunity to object unless required by law. You may take back any authorization you agreed to, at any time, in writing.

2. Your Rights Following is a statement of your rights about Protected Health Information. (PHI)

- **You have the right to inspect and request a copy of your PHI.** Federal law, however, does create some exceptions to this right and exempts the following records: psychotherapy notes; information gathered to be used in a civil, criminal, or administrative action or proceeding.
- **You have the right to request a restriction of your PHI.** This means you may ask us not to use or share any part of your PHI for the purposes of Treatment, Payment or health care Operations. You may also request that any part of your PHI not be disclosed to family members, friends or other individuals who may be involved in your care. While Lake Area Pediatrics will consider any reasonable request for restrictions, we are not required to agree to your request.
- **You have the right to request that PHI about you be communicated to you in a confidential manner,** such as sending mail to an address other than your home or by other means.
- **You have the right to obtain a paper copy of this notice from us upon request at any time.**
- **You may have the right to request that LAP amend your PHI**. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare an answer to your statement and will provide you with a copy of any such answer.
- **You have the right to receive an accounting of certain disclosures, if any, of your PHI.**
- **You have the right to complain to LAP or to the Secretary of Health and Human Services** if you believe your privacy rights have been violated by Lake Area Pediatrics. You may file a complaint with us by notifying our HIPAA Privacy Officer at the address or phone number below. Filing a complaint will not affect your health care services in any way.

In order to exercise any of the above rights, you may ask any staff member in the Lake Area Pediatrics office for the proper forms and instructions.

We reserve the right to change the terms of this notice for all records and will inform you by posting the revised notice in the waiting area and on our website, www.LakeAreaPediatrics.com . We are required by law to protect the privacy of your information, provide this notice about our information practices and follow the information practices that are described in this notice. If you have any questions or complaints, please contact our LAP Privacy Officer.

By signing below, you only acknowledge that you have received a copy of this Notice of Information Practices.

________________________________ ________________________

Patient's Name Date of Birth

________________________________ ________________________

Parent of Guardian Signature Date

For Office Use Only

Patient was given a copy of this notice: ______ Patient refused to sign acknowledgement _____

_____________________________________ ____________ _____________

Staff Signature Date Account Number