NOTICE OF PRIVACY PRACTICES FOR CARMEL PEDIATRICS, PA

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.

WE UNDERSTAND THAT YOUR HEALTH INFORMATION IS PERSONAL TO YOU, AND WE ARE COMMITTED TO PROTECTING THE INFORMATION ABOUT YOU. THIS NOTICE OF PRIVACY PRACTICES (OR "NOTICE") DESCRIBES HOW WE WILL USE AND DISCLOSE PROTECTED INFORMATION AND DATA THAT WE RECEIVE OR CREATE RELATED TO YOUR HEALTH CARE.

OUR DUTIES. WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION, AND TO GIVE YOU THIS NOTICE DESCRIBING OUR LEGAL DUTIES AND PRIVACY PRACTICES. WE ARE ALSO REQUIRED TO FOLLOW THE TERMS OF THE NOTICE CURRENTLY IN EFFECT.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU. WE WILL NOT USE OR DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION, EXCEPT IN THE FOLLOWING SITUATIONS:

TREATMENT: WE WILL USE AND DISCLOSE YOUR HEALTH INFORMATION WHILE PROVIDING, COORDINATION OR MANAGING YOUR HEALTH CARE. FOR EXAMPLE, INFORMATION OBTAINED BY A NURSE, PHYSICIAN, OR OTHER MEMBER OF YOUR HEALTHCARE TEAM WILL BE RECORDED AND USED TO DETERMINE THE COURSE OF TREATMENT THAT SHOULD WORK BEST FOR YOU. YOUR PHYSICIAN WILL PUT IN YOUR RECORD HIS OR HER EXPECTATIONS OF THE MEMBERS OF YOUR HEALTHCARE TEAM. MEMBERS OF YOUR HEALTHCARE TEAM WILL THEN RECORD THE ACTIONS THEY TOOK AND THEIR OBSERVATIONS. IN THAT WAY, THE PHYSICIAN WILL KNOW HOW YOU ARE RESPONDING TO TREATMENT. WE MAY ALSO PROVIDE OTHER HEALTHCARE PROVIDERS WITH YOUR INFORMATION TO ASSIST THEM IN TREATING YOU.

PAYMENT: WE WILL USE AND DISCLOSE YOUR MEDICAL INFORMATION TO OBTAIN OR PROVIDE COMPENSATION OR REIMBURSEMENT FOR PROVIDING YOUR HEALTH CARE. FOR EXAMPLE, WE MAY SEND A BILL TO YOU OR YOUR HEALTH INSURNACE PLAN. THE INFORMATION ON OR ACCOMPANYING THE BILL MAY INCLUDE INFORMATION THAT IDENTIFIES YOU, AS WELL AS YOUR DIAGNOSIS, PROCEDURES, AND SUPPLIES USED. AS ANOTHER EXAMPLE, WE MAY DISCLOSE INFORMATION ABOUT YOU TO YOUR HEALTH PLAN SO THAT THE HEALTH PLAN MAY DETERMINE YOUR ELIGIBILITY FOR PAYMENT FOR CERTAIN BENEFITS.

HEALTH CARE OPERATIONS: WE WILL DISCLOSE YOUR HEALTH INFORMATION TO DEAL WITH CERTAIN ADMINISTRATIVE ASPECTS OF YOUR HEALTH CARE, AND TO MANAGE OUR BUSINESS MORE EFFICIENTLY. FOR EXAMPLE, MEMBERS OF OUR MEDICAL STAFF MAY USE INFORMATION IN YOUR HEALTH RECORD TO ASSESS THE QUALITY OF CARE AND OUTCOMES IN YOUR CASE AND OTHERS LIKE IT. THIS INFORMATION WILL THEN BE USED IN AN EFFORT TO IMPROVE THE QUALITY AND EFFECTIVENESS OF THE HEALTHCARE AND SERVICES WE PROVIDE.

BUSINESS ASSOCIATES: THERE ARE SOME SERVICES PROVIDED IN OUR ORGANIZATION THROUGH CONTRACTS WITH BUSINESS ASSOCIATES. WE MAY DISCLOSE YOUR HEALTH INFORMATION TO OUR BUSINESS ASSOCIATES SO THEY CAN PERFORM THE JOB WE'VE ASKED THEM TO DO. HOWEVER, WE REQUIRE ASSOCIATES TO TAKE PRECAUTIONS TO PROTECT YOUR HEALTH INFORMATION.

NOTIFICATION OF FAMILY: WE MAY USE OR DISCLOSE INFORMATION TO RELAY OR ASSIST IN RELAYING YOUR LOCATION AND GENERAL CONDITION TO A FAMILY MEMBER, PERSONAL REPRESENTATIVE, OR OTHER PERSON RESPONSIBLE FOR YOUR CARE.

COMMUNICATION WITH FAMILY: WE MAY DISCLOSE TO A FAMILY MEMBER, OTHER RELATIVE, CLOSE PERSONAL FRIEND OR ANY OTHER PERSON YOU IDENTIFY, HEALTH INFORMATION RELEVANT TO THAT PERSON'S INVOLVEMENT IN YOUR CARE.

RESEARCH: CONSISTENT WITH APPLICABLE LAW WE MAY DISCLOSE INFORMATION TO RESEARCHERS WHEN THEIR RESEARCH HAS BEEN APPROVED BY AN INSTITUTIONAL REVIEW BOARD THAT HAS REVIEWED THE RESEARCH PROPOSAL AND ESTABLISHED PROTOCOLS TO ENSURE THE PRIVACY OF YOUR HEALTH INFORMATION.

FUNERAL DIRECTOR, CORONER, AND MEDICAL EXAMINER: CONSISTENT WITH APPLICABLE LAW WE MAY DISCLOSE HEALTH INFORMATION TO FUNERAL DIRECTORS, CORONERS, AND MEDICAL EXAMINERS TO HELP THEM CARRY OUT THEIR DUTIES.

ORGAN PROCUREMENT ORGANIZATIONS: CONSISTENT WITH APPLICABLE LAW, WE MAY DISCLOSE HEALTH INFORMATION TO ORGAN PROCUREMENT ORGANIZATIONS OR OTHER ENTITIES ENGAGED IN THE PROCUREMENT, BANKING, OR TRANSPLANTATION OF ORGANS FOR THE PURPOSE OF TISSUE DONATION AND TRANSPLANT.

FUNDRAISING: WE MAY USE CERTAIN INFORMATION FOR PURPOSES OF RAISING FUNDS.

FOOD AND DRUG ADMINISTRATION (FDA): WE MAY DISCLOSE TO THE FDA HEALTH INFORMATION RELATIVE TO ADVERSE EVENTS, PRODUCT DEFECTS, OR POST-MARKETING SURVEILLANCE INFORMATION TO ENABLE PRODUCT RECALLS, REPAIRS, OR REPLACEMENT.

PUBLIC HEALTH: AS REQUIRED BY LAW, WE MAY DISCLOSE YOUR HEALTH INFORMATION TO PUBLIC HEALTH OR LEGAL AUTHORITIES CHARGED WITH PREVENTING OR CONTROLLING DISEASE, INJURY, OR DISABILITY, INCLUDING CHILD ABUSE AND NEGLECT.

VICTIMS OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE: WE MAY DISCLOSE YOUR HEALTH INFORMATION TO APPROPRIATE GOVERNMENTAL AGENCIES, SUCH AS ADULT PROTECTIVE OR SOCIAL SERVICES AGENCIES, IF WE REASONABLY BELIEVE YOU ARE A VICTIM OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE.

HEALTH OVERSIGHT: IN ORDER TO OVERSEE THE HEALTH CARE SYSTEM, GOVERNMENT BENEFITS PROGRAMS, ENTITIES SUBJECT TO GOVERNMENTAL REGULATION AND CIVIL RIGHTS LAWS FOR WHICH INFORMATION IS NECESSARY TO DETERMINE COMPLIANCE, WE MAY DISCLOSE TO YOUR HEALTH INFORMATION FOR OVERSIGHT ACTIVITIES AUTHORIZED BY LAW, SUCH AS AUDITS AND CIVIL, ADMINISTRATIVE, OR CRIMINAL INVESTIGATIONS.

COURT PROCEEDING: WE MAY DISCLOSE YOUR HEALTH INFORMATION IN RESPONSE TO REQUESTS MADE DURING JUDICIAL AND ADMINISTRATIVE PROCEEDINGS, SUCH AS COURT ORDERS OR SUBPOENAS.

LAW ENFORCEMENT: UNDER CERTAIN CIRCUMSTANCES, WE MAY DISCLOSE YOUR HEALTH INFORMATION TO LAW ENFORCEMENT OFFICIALS. THESE CIRCUMSTANCES INCLUDE REPORTING REQUIRED BY CERTAIN LAWS (SUCH AS THE REPORTING OF CERTAIN TYPES OF WOUNDS), PURSUANT TO CERTAIN SUBPOENAS OR COURT ORDERS, REPORTING LIMITED INFORMATION CONCERNING IDENTIFICATION AND LOCATION AT THE REQUEST OF A LAW ENFORCEMENT OFFICIAL, REPORTING DEATH, CRIMES ON OUR PREMISES, AND CRIMES IN EMERGENCIES.

INMATES: IF YOU ARE AN INMATE OF A CORRECTIONAL INSTITUTION OR UNDER THE CUSTODY OF A LAW ENFORCEMENT OFFICIAL, WE MAY RELEASE HEALTH INFORMATION ABOUT YOU TO THE CORRECTIONAL INSTITUTION OR LAW ENFORCEMENT OFFICIAL. THIS RELEASE WOULD BE NECESSARY (1) FOR THE INSTITUTION TO PROVIDE YOU WITH HEALTH CARE; (2) TO PROTECT YOUR HEALTH AND SAFETY OF OTHERS; OR (3) FOR THE SAFETY AND SECURITY OF THE CORRECTIONAL INSTITUTION.

THREATS TO PUBLIC HEALTH OR SAFETY: WE MAY DISCLOSE OR USE HEALTH INFORMATION WHEN IT IS OUR GOOD FAITH BELIEF, CONSISTENT WITH ETHICAL AND LEGAL STANDARDS, THAT IT IS NECESSARY TO PREVENT OR LESSEN A SERIOUS AND IMMINENT THREAT OR IS NECESSARY TO IDENTIFY OR APPREHEND AN INDIVIDUAL.

SPECIALIZED GOVERNMENT FUNCTIONS: SUBJECT TO CERTAIN REQUIREMENTS, WE MAY DISCLOSE OR USE HEALTH INFORMATION FOR MILITARY PERSONNEL AND VETERANS, FOR NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES, FOR PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS, FOR MEDICAL SUITABILITY DETERMINATIONS FOR THE DEPARTMENT OF STATE, FOR CORRECTIONAL INSTITUTIONS AND OTHER LAW ENFORCEMENT CUSTODIAL SITUATIONS, AND FOR GOVERNMENT PROGRAMS PROVIDING PUBLIC BENEFITS.

WORKERS COMPENSATION: WE MAY DISCLOSE HEALTH INFORMATION WHEN AUTHORIZED AND NECESSARY TO COMPLY WITH LAWS RELATING TO WORKERS COMPENSATION OR OTHER SIMILAR PROGRAMS.

OTHER USES: WE MAY ALSO USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION FOR THE FOLLOWING PURPOSES:

TO CONTACT YOU TO REMIND YOU OF AN APPOINTMENT FOR TREATMENT;

TO DESCRIBE OR RECOMMEND TREATMENT ALTERNATIVES TO YOU;

TO FURNISH INFORMATION ABOUT HEALTH-RELATED BENEFITS AND SERVICES THAT MAY BE OF INTEREST TO YOU; OR

FOR CERTAIN CHARITABLE FUNDRAISING PURPOSES.

PROHIBITION ON OTHER USES OR DISCLOSURES. WE MAY NOT MAKE ANY OTHER USE OR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION. ONCE GIVEN, YOU MAY REVOKE THE AUTHORIZATION BY WRITING TO THE CONTACT PERSON LISTED BELOW. UNDERSTANDABLY, WE ARE UNABLE TO TAKE BACK ANY DISCLOSURE WE HAVE ALREADY MADE WITH YOUR PERMISSION.

INDIVIDUAL RIGHTS. YOU HAVE MANY RIGHTS CONCERNING THE CONFIDENTIALITY OF YOUR HEALTH INFORMATION.
YOU HAVE THE RIGHT TO:

REQUEST RESTRICTIONS ON THE HEALTH INFORMATION WE MAY USE AND DISCLOSE FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. WE ARE NOT REQUIRED TO AGREE TO THESE REQUESTS. TO REQUEST RESTRICTIONS, PLEASE SEND A WRITTEN REQUEST TO THE CONTACT PERSON INDICATED ON PAGE 3.

RECEIVE CONFIDENTIAL COMMUNICATIONS OF HEALTH INFORMATION ABOUT YOU IN A MANNER OR AT A CERTAIN LOCATION. FOR INSTANCE, YOU MAY REQUEST THAT WE ONLY CONTACT YOU AT WORK OR BY MAIL. TO MAKE SUCH A REQUEST, YOU MUST WRITE TO THE CONTACT PERSON INDICATED ON PAGE 3, AND TELL US HOW OR WHERE YOU WISH TO BE CONTACTED.

INSPECT OR COPY YOUR HEALTH INFORMATION. YOU MUST SUBMIT YOUR REQUEST IN WRITING TO THE CONTACT PERSON INDICATED ON PAGE 3. IF YOU REQUEST A COPY OF YOUR HEALTH INFORMATION WE MAY CHARGE YOU A FEE FOR THE COST OF COPYING, MAILING OR OTHER SUPPLIES. IN CERTAIN CIRCUMSTANCES WE MAY DENY YOUR REQUEST TO INSPECT OR COPY YOUR HEALTH INFORMATION. IF YOU ARE DENIED ACCESS TO YOUR HEALTH INFORMATION, YOU MAY REQUEST THAT THE DENIAL BE REVIEWED. ANOTHER LICENSED HEALTH CARE PROFESSIONAL WILL THEN REVIEW YOUR REQUEST AND THE DENIAL. THE PERSON CONDUCTING THE REVIEW WILL NOT BE THE PERSON WHO DENIED YOUR REQUEST. WE WILL COMPLY WITH THE OUTCOME OF THE REVIEW.

AMEND HEALTH INFORMATION. IF YOU FEEL THAT HEALTH INFORMATION WE HAVE ABOUT YOU IS INCORRECT OR INCOMPLETE, YOU MAY ASK US TO AMEND THE INFORMATION. TO REQUEST AN AMENDMENT, YOU MUST WRITE TO THE CONTACT PERSON INDICATED ON PAGE 3. YOU MUST ALSO GIVE US A REASON TO SUPPORT YOUR REQUEST. WE MAY DENY YOUR REQUEST TO AMEND YOUR HEALTH INFORMATION IF IT IS NOT IN WRITING OR DOES NOT PROVIDE A REASON TO SUPPORT YOUR REQUEST.

WE MAY ALSO DENY YOUR REQUEST IF THE HEALTH INFORMATION:

- WAS NOT CREATED BY US, UNLESS THE PERSON THAT CREATED THE INFORMATION IS NO LONGER AVAILABLE TO MAKE THE AMENDMENT,
- IS NOT PART OF THE HEALTH INFORMATION KEPT BY OR FOR US,
- IS NOT PART OF THE INFORMATION YOU WOULD BE PERMITTED TO INSPECT OR COPY, OR
- IS ACCURATE AND COMPLETE.

RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION. YOU MUST SUBMIT A REQUEST IN WRITING TO THE CONTACT PERSON INDICATED BELOW. NOT ALL HEALTH INFORMATION IS SUBJECT TO THIS REQUEST. YOUR REQUEST MUST STATE A TIME PERIOD, NO LONGER THAN 6 YEARS AND MAY NOT INCLUDE DATES BEFORE JUNE 1, 2010. YOUR REQUEST MUST STATE HOW YOU WOULD LIKE TO RECEIVE THE REPORT (PAPER, ELECTRONICALLY). THE FIRST ACCOUNTING YOU REQUEST WITHIN A 12-MONTH PERIOD IS FREE. FOR ADDITIONAL ACCOUNTINGS, WE MAY CHARGE YOU THE COST OF PROVIDING THE ACCOUNTING. WE WILL NOTIFY YOU OF THIS COST AND YOU MAY CHOOSE TO WITHDRAW OR MODIFY YOUR REQUEST BEFORE CHARGES ARE INCURRED.

RECEIVE A PAPER COPY OF THIS NOTICE UPON REQUEST, EVEN IF YOU HAVE AGREED TO RECEIVE THE NOTICE ELECTRONICALLY. YOU MUST SUBMIT A REQUEST FOR A PAPER NOTICE IN WRITING TO THE PRIVACY OFFICER AT 7825 BALLANTYNE COMMONS PARKWAY, SUITE 100, CHARLOTTE, NC 28277.

ALL REQUESTS TO RESTRICT USE OF YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, TO INSPECT AND COPY HEALTH INFORMATION, TO AMEND YOUR HEALTH INFORMATION, OR TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF HEALTH INFORMATION MUST BE MADE IN WRITING TO THE PRIVACY OFFICER AT CARMEL PEDIATRICS, PA. THERE MAY BE A FEE FOR THE COST OF COPYING YOUR MEDICAL RECORD.

CONTACT PERSON. IF YOU BELIEVE THAT YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED, A COMPLAINT MAY BE MADE IN WRITING TO OUR PRIVACY OFFICER AT 7825 BALLANTYNE COMMONS PARKWAY, SUITE 100, CHARLOTTE, NC 28277 OR BY CALLING 704-752-2000. YOU MAY ALSO SUBMIT A COMPLAINT TO THE OFFICE OF CIVIL RIGHTS, THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ATLANTA FEDERAL CENTER, SUITE 3B70, 61 FORSYTH STREET, S.W., ATLANTA, GA. 30303-8909 OR CALL (404) 562-7886. WE WILL NOT RETALIATE AGAINST YOU FOR FILING ANY SUCH COMPLAINT.

CHANGES TO THIS NOTICE. WE RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES AND TO APPLY THE REVISED PRACTICES TO HEALTH INFORMATION ABOUT YOU THAT WE ALREADY HAVE. ANY REVISION TO OUR PRIVACY PRACTICES WILL BE DESCRIBED IN A REVISED NOTICE THAT WILL BE DISPLAYED IN OUR FACILITY.

PLEASE SIGN AND DATE BELOW STATING YOU HAVE RECEIVED AND READ THIS INFORMATION.

Patient Name: _____ DOB: _____

Responsible Party Signature: _____ DATE: _____