Golden Gate Pediatrics - A Medical Corporation Notice of Privacy Practices

To our patients: This notice describes how health information about you may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We will use your protected health information for treatment, payment (health plans) & operations (quality assessment, training medical students, messaging via our answering service & other operations) & other purposes permitted by law. We reserve the right to revise this Notice. Any revision will be effective for all past, present & future health information.

Our commitment to your privacy: Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information. We will notify you if a breach of your unsecured protected health information occurs. Please contact our Privacy Officer for any questions regarding these policies.

Use and disclosure of your health information in certain special circumstances: The following circumstances may require us to use or disclose your health information without your authorization or opportunity to agree or object:

- To public health authorities and health oversight agencies that are authorized by law to collect information, including communicable disease and child abuse or neglect.
- As required by law for lawsuits and similar proceedings in response to a court or administrative order.
- If required to do so by a law enforcement official, consistent with federal & state laws, including criminal activity.
- When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization permitted by law to collect & receive the information.
- To federal officials for intelligence and national security activities authorized by law, as well as disclosure to Armed Forces personnel under military command, the Dept. of Veteran Affairs and foreign military command.
- To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- For Workers Compensation and similar programs.
- To researchers when approved by the institutional review board and protocols ensure the privacy of your protected health info.
- To the Food & Drug Administration for quality, safety and effectiveness of FDA regulated products or activities.
- To Coroners, Funeral Directors and Organ Donation for identification, cause of death and to carry out duties including organ donation, as authorized by law.

Your rights regarding your health information

Communications: You can request that our practice communicate with you about your health and related issues in a particular matter or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.

You can request a **restriction in our use or disclosure** of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and 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 you. With certain limitations, you may request an accounting of non-routine disclosures. We may use demographic information to contact you regarding fundraising activities supported by our office, provided you do not opt out. Please request restrictions through the Privacy Officer.

You have the right to **inspect and obtain a copy** of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes, information complied for use in criminal, civil or administrative proceedings or laboratory results when access is prohibited by law. Decisions to deny access may be reviewable. Please contact the Privacy Officer. To obtain record copies you must submit a request in writing to: Medical Records -Golden Gate Pediatrics, A Medical Corporation, 3641 California Street, San Francisco. CA 94118.

You may ask us to **amend your health information** if you believe it is incorrect or incomplete, 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 your primary care physician. You must provide us with reason that supports your request for amendment. We may deny the request, in which case you may submit a statement of disagreement. If we do not agree, we will provide you with a copy of our rebuttal. Please contact the Privacy Officer.

Right to a copy of this notice: You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

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 our office administrator, Mike Gangel, at (415)668-0888. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to provide an authorization for other uses and disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law, which you may also revoke in writing.

If you have any questions regarding this notice or our health information privacy policies, please contact: Mike Gangel, Office Administrator-
Golden Gate Pediatrics. A Medical Corporation, 3641 California Street, San Francisco, CA 94118

I hereby acknowledge that I have been presented with a copy of Golden Gate Pediatrics "Notice of Privacy Practices."

If the patient is a minor:

Print Patient Name _____ **Date** _____

Parent or Guardian Signature _____ **Print Parent or Guardian Name** _____

(Please complete both sides of this form)

Effective Date: April 14, 2003

Golden Gate Pediatrics – A Medical Corporation

Patient Authorization for Use and Disclosure of Protected Health Information

By signing this authorization, I authorize Golden Gate Pediatrics – A Medical Corporation to use and/or disclose certain protected health information (PHI) about my child or myself to:

(Initials)

- o _____ **School, Camps, Sports** – any form that we submit to the office for completion
- o _____ **Insurance companies** – for underwriting purposes to obtain healthcare coverage, provided signed release is attached
- o _____ **Other,** as specified: _____

This authorization permits Golden Gate Pediatrics to use and or disclose the following individually identifiable health information about my child or myself to schools & camps; for sport participation; to insurance companies to obtain healthcare coverage, and for other purposes I specify. If "other," please describe the information to be used or disclosed, such as date(s) of service, type of services, level of detail to be released, origin of information, etc.

(Initials)

- o _____ Health information from chart notes to complete the form as indicated above
- o _____ Immunization records only, to be faxed, mailed, or picked up – upon verbal request with proper ID.
- o _____ As per my request, with proper identification
- o _____ Other _____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. The Practice may receive payment or other remuneration from a third party in exchange for using or disclosing the PHI, such as record copying fees from insurance companies. This authorization will expire:

- ◎ Until revoked
- ◎ Other _____

I do not have to sign this authorization in order to receive treatment from Golden Gate Pediatrics. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 3641 California Street, San Francisco, CA 94118

Signed by: _____ _____ _____

Signature of Patient, Parent or Legal Guardian | Relationship to Patient | Date

_____ _____

Patient's Name | Print Name of Patient, Parent or Legal Guardian

Patient/Guardian to Be Provided With a Signed Copy of Authorization Upon Request

(Please complete both sides of this form)