

MONTCLAIR PEDIATRIC GROUP, LLC

73 Park Street, Montclair, NJ 07042 973 746-7375

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.

At our practice, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR HEALTH RECORD

Each time you visit our practice, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- Tool in educating health professionals,
- Source of data for medical research,
- Source of information for public health officials charged to improve the health of the state and nation,
- Source of data for our planning and marketing, and
- Tool by which we can assess and continually work to improve the care we render and outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of our practice, the information belongs you. You have the right to:

- Obtain a paper copy of this notice of privacy policies upon request,
- Inspect and copy your health record as provided by 45 CFR 164.524,
- Amend your health record as provided by 45 CFR 164.526,
- Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528,
- Request confidential communications of your health information as provided by 45 CFR 164.522, and
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522 (our practice, however, is not required by law to agree to a requested restriction).

OUR RESPONSIBILITIES

Our practice is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate your health information.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top, right-hand corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request.

We will not use or disclose your health information in a manner other than described in the section regarding Examples Of Disclosures For Treatment, Payment, And Health Operations, without your written authorization, which you may revoke as provided by 45 CFR 164.508(b)(5), except to the extent that action has already been taken.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact our practice's Privacy Officer at (973-746-7375).

If you believe your privacy rights have been violated, you can either file a complaint with our Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our Privacy Officer or the OCR. The address for the OCR is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

We will use your health information for treatment.

For example:

Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care 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 will also provide your other physician(s) or subsequent health care provider(s) (when applicable) with copies of various reports that should assist them in treating you.

We will use your health information for payment.

For example:

A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example:

Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

- **Business Associates**
There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a transcription service we use to transfer dictated patient care into the medical record. Due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do. To protect your health information, however, when these services are contracted we require the business associate to appropriately safeguard your information.
- **Research**
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 Directors**
We may disclose health information to funeral directors to carry out their duties consistent with applicable law.
- **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 contact you as part of a fundraising effort.
- **Food And Drug Administration (FDA)**
We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
- **Workers Compensation**
We may disclose health information to the extent authorized by and necessary to comply with laws relating to workers compensation or other similar programs established by law.
- **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.
- **Appointment Reminders**
We may contact you or a family member at the phone number you have provided to us as a reminder that you have an appointment.
- **Marketing**
We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **Directory**
Unless you notify us that you object, we will use your name, location in the facility, and general condition for our directory purposes. This information may be provided to members of your family and to other people who ask for you by name.
- **Notification**
We may use or disclose information to notify or assist in notifying a family member or personal representative (or other person responsible for your care) of your location and general condition.
- **Communication With Family**
Health professionals, using their best judgment, may disclose to a family member, other relative, or close personal friend (or any other person you identify) health information relevant to that person's involvement in your care or payment related to your care.
- **Law Enforcement**
We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Montclair Pediatrics Group, LLC **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice.

Signed: _____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed by: _____

Internal Use Only:

If patient or patient’s representative refuses to sign acknowledgement of receipt of Notice, please document the date and time the Notice was presented to patient and sign below.

Presented on (date and time): _____ By: (Name & Title) _____

Disclosure of Protected Health Information Log

<u>Date</u>	<u>Name of Requestor</u>	<u>Info Requested*(be specific)</u>	<u>Sent Bill (if applicable)</u>	<u>Recv’d Check</u>	<u>Date Sent</u>

If more space needed, continue information log on the reverse side.

*** Note: If the request is for a patient’s entire medical record, you must document a reason why.**

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, Montclair Pediatrics Group, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operation.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that Montclair Pediatrics Group, LLC reserves the right to change their Notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should RDA change their Notice, they will send a copy of any revised Notice to the address I’ve provided (whether U.S. mail or, if I agree, email).

I understand that as part of this organization’s treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand that as part of this organization’s treatment, payment, or healthcare operations, it may become necessary for Montclair Pediatrics Group, LLC to leave a message on an answering machine or with a family member at the phone number you have provided to us.

Patient Comments or restrictions (if any) are: _____

I fully understand and accept the terms of this consent.

Patient Signature

Print-Patient’s Name

Date: _____

Disclosed as permitted under federal and state law. I understand the contents of the Notice.