SOUTH MIAMI CHILDREN'S CLINIC
HIPPA 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.

OUR COMMITMENT TO YOUR PRIVACY:
We understand that information about you and your health is very personal and we are committed to protecting the privacy of this information. Each time you visit South Miami Children's Clinic, we create a record of the care and service. This record is necessary to provide you with high quality care and to ensure we are in compliance with certain legal requirements. This notice applies to all of your health information in our custody.

This Notice will describe the ways in which we may use and disclose your medical information. We reserve the right to change the terms of this notice at any time. Any revisions to this Notice will be applicable to all medical information we already have about you, as well as any of your medical information that we may receive, create, or maintain in the future. We will post a copy of our current Notice in prominent locations. A copy of the Notice in effect will be available from the clinic's receptionist.

HOW WE MAY USE & DISCLOSE HEALTH INFORMATION ABOUT YOU:
The following categories describe way that we use your health information within South Miami Children's Clinic and disclose your health information to persons or entities outside of South Miami Children's Clinic. Each description is a category of uses or disclosures. We have not listed every use or disclosure within the categories, but all permitted uses and disclosures will fall within one of the following categories.

Treatment: We may use health information about you to provide you with medical treatment and services. We may use health information about you to doctors, nurses, technicians, medical students, interns or other personnel who are involved in taking care of you during your visit with us.

Payment: We may use and disclose health information about you so that the treatment and services you receive at South Miami Children's Clinic may be billed to and payment collected from you, an insurance company or a third party. This may also include the disclosure of health information to obtain prior authorization for treatment and procedures from your insurance plan.

Health care operations: We may use and disclose health information about your for operations, including quality assurance activities, administrative activities, financial and business planning and development, customer service activities, including investigations of complaints. These uses and disclosures are necessary for South Miami Children's Clinic to ensure all of our patients receive quality care.

Appointment reminders: We may use your health information to contact you as a reminder that you have an appointment for treatment of medical care.

Family members and friends: We may disclose your health information to individuals, such as family members and friends who are involved in your care or who help pay for your care. We may take such disclosures when: a) we have your verbal agreement to do so; b) we make such disclosure and you do not object; or c) we can infer from the circumstances that you would not object to such disclosures. For example, if family members are in the exam room with you, we will assume that you agree to our disclosure of your information in their presence.

We also may disclose your health information to family members or friends in instances when you are unable to agree or object to such disclosures and the disclosures relate to the family member or friend's involvement in your care. For example, if you present to the clinic with an emergency medical condition, we may share information with a family member or friend that comes with you to the clinic. We also may share your health information with a family member who calls us to request a prescription refill for you

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) 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 access and control your protected health information. "Protected health information" is information about you including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health services

SPECIAL SITUATIONS THAT DO NOT REQUIRE YOUR AUTHORIZATION:
The following disclosures of your health information are permitted by law without any oral or written permission from you.

Averting a serious threat to health or safety: We may use and/or disclose health information about you when necessary to prevent a serious threat to your health or safety or the health and safety of another person or the public. These disclosures would be made only to someone able to help prevent the threat.

Public health activities: We may disclose health information about you for public health activities. These generally include the following:

a. to prevent or control disease, injury or disability
b. to report child abuse or neglect
c. to report reactions to medications, problems with products or other adverse events
d. to notify people of recalls of products they may be using
e. to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition

Health oversight activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include audit, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care systems, government programs and compliance with civil rights laws.

Lawsuits and disputes: If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. We may disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute

Law enforcement: We may disclose health information if asked to do so by law enforcement officials for the following reasons:

a. in response to a court order, subpoena, warrant summons or similar process
b. about the victim of a crime if under certain circumstances, we are unable to obtain the person's agreement
c. about criminal conduct at our clinic
d. in emergency circumstances to report a crime, the location of the crime or victim, or the identity, description or location of the person who committed the crime.

Coroners, medical examiners and funeral home directors: We may disclose health information to a coroner or medical examiner This may be necessary to identify a decease person or determine the cause of death of a person We may also release health information about patients at our clinic to funeral home directors as necessary to carry out their duties.
National security and intelligence activities: We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Legal requirements: We will disclose health information about you without your permission when required to do so by federal, state, or local law.

PATIENT CONSENT FORM

Addition to HIPPA Notice of Privacy Practices

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy When it is appropriate and necessary, we provide the minimum necessary information to only those we feel and in the need of your health care information and information about treatment, payment or health care operation in order to provide health care that is in your best interest.

There are times you may wish other family members or friends to inquire about your appointments or have access to your medical information. We will not release any information unless you have listed them below If you wish to allow messages other than just to return our calls on your message recorder, please indicate this also

Recorded Messages: No_____ (do not leave messages other than to return call)

Yes_____ May leave messages

List any family member(s) or others you wish to have access to your records, for example, who may call in regarding your condition or call for you. **We will not release any information to spouses or your children unless they are listed below.** (we will require signed releases by you from anyone wanting access to your records other than the insurance companies you have listed, healthcare provider necessary to your care, or persons listed below)

List names and how related:

1 _____

2. _____

3. _____

Signature below is acknowledgement that you have received the HIPPA Notices of Privacy Practices.

Printed Name:_____

Signature:_____

Date:_____

With your specific written authorization: Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission (called authorization). If you authorize us to use or disclose health information by you, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have made with your permission and that we are required to retain our records of the care that we provided to you.

Your Rights: following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of or used in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information

You have the right to request to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members of friends who maybe involved in your care.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional

You have the right to request to receive confidential communications from us by alternative means or alternative location You have the right to obtain a copy of this notice from us. Upon request, even if you have agreed to accept this notice alternatively (i.e., electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Complaints: you may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with use by notifying us of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information If you have any objections to this form, please call us at our main phone number

Signature below is only acknowledgement that you have received this notice of our privacy practices.

Print Name_____

Signature_____

Date: _____