REVISED 7-17-17

PEDIATRIC CARE OF KENTUCKY, P.S.C.

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.

PURPOSE

The purpose of this Notice is to advise you of your rights and how we may use and disclose medical information about you. We are required by law to:

- Protect the privacy of medical information which identifies you;
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice currently in effect.
- Notify you if there is a breach of your medical information.

If you have any questions about this Notice, please contact the Pediatric Care of Kentucky, P.S.C. Privacy Officer.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

We will not use or disclose your medical information without your authorization except as described in this Notice. We will not use or disclosure your genetic medical information for underwriting purposes. If you provide us written authorization, you may revoke your authorization at any time in writing. However, that revocation will not be effective as to any medical information we disclosed prior to your revocation. We reserve the right to change the terms of this Notice and our privacy policies at any time. We reserve the right to make the revised or changed Notice effective for health information that we already have about you as well as any medical information we receive in the future. We will promptly change the copy before we make an important change to our privacy policies. A current copy of the Notice will be posted in the office. The Notice will have the effective date on the first page.

Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other healthcare providers who provide medical services to you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process.

Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to, and payment may be collected from you, an insurance company or a third party. In order to bill and collect payment from the proper party, we may provide your medical information to our business associates such as, billing companies, claims processing companies, and others that process our health care claims. For example, we may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

Health Care Operations. We may use and disclose medical information about you in the course of the operation of our medical practice. These uses and disclosures are necessary to run the practice and make sure that all of our patients receive quality care. We may record or monitor telephone calls for customer service reasons as part of our operations; however such information will not be used to make health care decisions about you and will not be recorded into your medical record. For example, we may use or disclose your medical information:

- In order to review our services and to evaluate our staff's performance;

- To legal and other consultants who assist us in complying with laws and meeting quality and accreditation standards;

Appointment Reminders. We may use and disclose your medical information to contact you to as a reminder that you have an appointment.

Treatment Alternatives. We may use and disclose your medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for that medical care.

As Required by Law. We will disclose medical information about you when required to do so by federal, state or local law.

At Your Request. We will disclose your medical information to you at your request.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Health-Related Benefits and Services. We may use and disclose medical information about you to tell you about health-related benefits or services that may be of interest to you.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. If you were injured on the job and you have filed a claim under workers' compensation or a similar program, we may release medial information about you to facilitate your claim.

Public Health Risks. We may disclose medical information about you for public health purposes to public health authorities in order to prevent or control disease, injury, or disability; or to report deaths, suspected abuse or neglect of a child or adult, reactions to medications, or problems with healthcare products.

Health Oversight Activities. We may disclose medical information about you to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process to someone else involved in the dispute, but only if efforts have been made to tell you about the request or obtain an order protecting the information requested.

Law Enforcement. We may release medical information about you if asked to do so by law enforcement officials in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; or to facilitate the investigation of criminal conduct at our practice; and

Coroners, Medical Examiners and Funeral Directors. We may release medical information about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Agencies. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may release medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or otherwise under the custody of a law enforcement official, we may release medical 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 or the health and safety of others; or (3) for the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Except as identified above, we will not otherwise use or disclose your medical information without an authorization. For example, we will obtain your authorization to use or disclose your medical information for any of the following purposes:

Psychotherapy Notes. Except under limited circumstances, we must obtain your authorization in order to use or disclose your psychotherapy notes.

Marketing. We must obtain your authorization for any use or disclosure of your medical information for the purpose of marketing, except if the marketing is in the form of a face-to-face communication or a promotional gift of nominal value.

Sale of your medical information. We must obtain your authorization in order to sell your medical information to another party.

We will not condition your treatment on whether you sign an authorization to disclosure your medical information. However, we may condition any research-related treatment on your signing an authorization to use or disclose your medical information for research purposes.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding your health information:

1. RIGHT TO INSPECT AND COPY. You have the right to inspect and receive copies of your medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

We will respond to your request within thirty (30) days of the request or sixty (60) days if your medical information is not available on site. We shall be granted a thirty (30) day extension upon written notice to you providing the reason for the extension of time.

Fees. There may be a fee for copies of your record; you will be notified before any charges are applied.

Denials. We may deny your request to inspect and/or receive copies of your medical information if it is not in writing and in other, very limited circumstances. You will receive a written notice of denial containing the reason for denial and the procedure for review. In some circumstances, another licensed health care professional chosen by Pediatric Care of Kentucky, P.S.C. may 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. However, in some circumstances, our denial of a request by you to inspect and/or receive copies of your information is not subject to review.

2. RIGHT TO AMEND. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, Pediatric Care of Kentucky, P.S.C.

In your written request, you must provide a reason that supports your request for amendment. If we approve your request, we shall make the amendment to your medical information, inform you that we have made the amendment, and make a reasonable effort to tell others that need to know about the change to your medical information.

Denials. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept for, or Pediatric Care of Kentucky, P.S.C.;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

If your request for amendment is denied, we will provide you with a written statement of the basis for the denial and a description of how you may file a written statement of disagreement. If you do not file a statement of disagreement, you may request that your request for amendment and our written denial be provided with any future disclosures of your medical information.

3. RIGHT TO AN ACCOUNTING OF DISCLOSURES. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made regarding medical information about you.

Exclusions. The list will not include: disclosures made for treatment, payment, or health care operations; disclosures made directly to you; disclosures authorized by you pursuant to a signed authorization; disclosures made for national security or intelligence purposes; and disclosures to correctional institutions and for other law enforcement purposes. The list also will not include disclosures made before April 14, 2003.

Your request must include a time period, which may not exceed six (6) years prior to the date of the request and may not include any dates prior to April 14, 2003. Your request should also indicate in what form, i.e., electronic or paper, you would like your request to be processed. We will provide the first list to you at no charge, however if you make more than one request in the same year, we may charge you up to $1.00 per page for each additional request. We will notify you of the cost involved and you may choose to withdraw or modify you request at that time before any costs are incurred.

4. RIGHT TO REQUEST RESTRICTIONS. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. ***However, we are not required to grant your request.*** If we do grant your request, we will comply with your request unless the information is needed to provide you emergency medical treatment.

In your request, tell us, (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

We are required to grant your restriction request only if the disclosure is: (1) to a health plan; (2) for payment or health care operations purposes; (3) not required by law; and (4) the disclosure pertains only to information about an item or service for which you've paid in full.

5. RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may request that we only contact you at work or by mail.

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

6. RIGHT TO PAPER COPY OF THIS NOTICE. You have the right to request a paper copy of this notice.

PROCEDURE

If you would like to inspect, amend or copy your medical information, request an accounting of disclosures of your medical information, or to request a restriction on your medical information, please submit your request in writing to:

Pediatric Care of Kentucky, P.S.C.
Attn: Privacy Officer
20 Medical Village Dr. #102
Edgewood, KY 41017

REPORTING VIOLATIONS OF YOUR PRIVACY RIGHTS

If you believe your privacy rights have been violated, you may file a complaint with our company or the Department of Health and Human Services. To file a complaint with our company, please contact the Privacy Officer. All complaints must be submitted in writing to:

Pediatric Care of Kentucky, P.S.C.
Attn: Privacy Officer
20 Medical Village Dr. #102
Edgewood, KY 41017

You will not be penalized for submitting a complaint.

PEDIATRIC CARE OF KENTUCKY, P.S.C.
PATIENT ACKNOWLEDGMENT

By signing my name below, I acknowledge that I have been provided with a Notice of Privacy Practices that provides a description of how my medical information will be used or disclosed.

I understand that Pediatric Care of Kentucky, P.S.C. reserves the right to change its Notice of Privacy Practices. I further understand that Pediatric Care of Kentucky, P.S.C. will not implement any changes in its privacy practices prior to posting a revised notice in the practice.

_____ _____

Signature of Patient or
Patient's Legally Authorized Representative

Witness

_____

If signed by the Patient's Legal Representative,
please provide a description of Legal Representative's
authority to act on behalf of the Patient

_____ _____

Date

Notice Effective Date or Version

Patient Name:

DOB:

_____ _____

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