

**HIPAA Notice of Privacy Practices**  
**PLATTE COUNTY PEDIATRICS**  
**1104 PLATTE FALLS ROAD**  
**PLATTE CITY MO 64079**  
**(816) 858-5253**

**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.**

**Uses and Disclosures of Protected Health Information:**

Your protected health information may be used and disclosed by your physician, our office staff and others outside for our office that are involved in the care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to the medical school students that see patients at our office. We may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, when contacting you for appointment reminders. We may use or disclose your protected health information in the following situation without your authorization. These situations include, as Required By Law: Public Health issues, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Under the Law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization or opportunity to object unless required by law.

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights:**

**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 use 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 a restriction of you protected health information.** This means you may ask us not to use or disclose any part of you protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of you protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

**Your physician is not required to agree to a restriction that you may request.** If a 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 at an alternative location. You will have the right to obtain a paper 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.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**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 us in writing. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **February 21, 2006.**

We are required by law to maintain the privacy of individuals and provide this notice of our legal duties and privacy practices, with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or phone at (816) 232-6601.

**Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:**

**Patients Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Parent/Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_