



## Pediatric Associates of Hampden County, Inc.

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### NOTICE OF PRIVACY PRACTICES

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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.

*If you have any questions about this Notice, please contact your Privacy Officer, at the number listed at the end of this notice.*

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This Notice applies to all of the records of your care generated by your health care provider.

#### Our Responsibilities

Pediatric Associates of Hampden County, Inc. (PAHC) is required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. The current Notice will be posted in the waiting room and includes the effective date. In addition, we will make our best effort to provide you with a copy of this notice and we request you acknowledge with your signature.

We are required by law to abide by the terms of this Notice and notify you if we make changes to this Notice, which may be at any time. Changes to the Notice will apply to your medical information that we already maintain as well as new information received after the change occurs. If we change our Notice, it will be posted in the waiting area. You may also request that a revised Notice be sent to you in the mail or you may ask for one at your next appointment or appropriate visit. This Notice will also serve to advise you as to your rights with regard to your medical information.

#### How We May Use and Disclose Medical Information About You.

The following categories describe examples of the way we use and disclose medical information:

1. **For Treatment:** We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other doctors, nurses, technicians, medical students, or other personnel who are involved in your care. For example, a laboratory or medical specialist may need to know information about you to run tests or to provide treatment. For example, information may be shared with Bay State Reference Laboratories, Noble Hospital or Bay State Medical Center when you are referred for laboratory tests or imaging services.

We may also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you. For example, your medical information may be provided to a physician to whom you have been referred so as to ensure that the physician has appropriate information regarding your previous treatment and diagnosis.

2. **For Payment:** We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information before it approves or pays for the health care services we recommend for you. The insurance company may use that information in connection with making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example,



obtaining 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. We may sometimes provide PHI to Credit Bureau Collections, our collection agency, or accountant for billing purposes or our law firm for legal advice and services.

3. **For Health Care Operations:** We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to, quality assessment activities, employee review activities, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. In addition, we use a sign-in sheet at the registration desk where you will be asked to sign your child's name when coming in for sick child visits. We may also call you by name or your child in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment or to conduct certain mailings such as flu vaccine reminders and discharge letters when your child reaches age of maturity.
4. **Business Associates:** There are some services provided in our organization through contracts with business associates. Examples include billing collection services. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information through a written contract.

**Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object**

We also may use and disclose your health information as set forth below. You have the opportunity to agree or object to the use or disclosure of all or part of your health information in these instances. If you are not present or able to agree or object to the use or disclosure of the health information (such as in an emergency situation), then your clinician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

1. **Individuals Involved in Your Care or Payment for Your Care:** Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
2. **Future Communications:** We may communicate to you via newsletters, mailings or other means regarding treatment options; information on health-related benefits or services, disease- management programs, wellness programs; to assess your satisfaction with our services; to remind you that you have an appointment for medical care; as part of fund raising efforts; for population based activities relating to improving health or reducing health care costs; for conducting training programs or reviewing competence of health care professionals; or other community based initiatives or activities in which our facility is participating. If you are not interested in receiving these materials, please contact our Privacy Officer [or designated person].

**Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object**

We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

1. As required by law. We may use and disclose health information to the following types of entities, including but not limited to:



- a. Food and Drug Administration
  - b. Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
  - c. Correctional Institutions
  - d. Workers Compensation Agents
  - e. Organ and Tissue Donation Organizations
  - f. Military Command Authorities
  - g. Health Oversight Agencies
  - h. National Security and Intelligence Agencies
  - i. Protective Services for the President and Others
  - j. Authority that receives reports on abuse and neglect
2. Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
  3. State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs.

#### Your Health Information Rights

Although your health record is the physical property of the PAHC, you have the right to:

1. **Inspect and Copy**: You have the right to inspect and copy 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 or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Requests for access to and copies of your medical information must be submitted to the practice in writing. The practice charges a reasonable fee for labor and copying of this information.
2. **Amend**: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting a request in writing. You have the right to request an amendment for as long as we keep the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.
3. **An Accounting of Disclosures**: You have the right to request an accounting of our disclosures of medical information about you except for certain circumstances, including disclosures for treatment, payment, health care operations or where you specifically authorized a disclosure. The practice will provide the first accounting to you in any 12 month period without charge. The practice will impose a fee of \$10.00 each subsequent request for an accounting within the 12 month period.
4. **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 or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure that you had.



We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

5. **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. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes.
6. **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To exercise any of your rights, please obtain the required forms from the Privacy Officer, Mary Brzoska and submit your request in writing.

### Complaints

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer by calling (413) 562-5256 in our Westfield office, or (413) 734-1001 in our West Springfield office. In either case, select the option to speak to the practice manager or ask for the Privacy Officer or by contacting the Secretary of the Federal Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

### Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

### **PRIVACY OFFICER**

Name: **Mary Brzoska**

Telephone Number: (413) 562-5256 Westfield; (413) 734-1001 West Springfield

Patient Acknowledgment: I acknowledge that I have received Pediatric Associates of Hampden Counties Notice of Privacy Practices

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date