

Effective Date of this Notice: _____

GROSSMONT PEDIATRICS
NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR CHILD'S INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR CHILD'S PRIVACY

Our practice maintains the privacy of your child's individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you.

We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your child's IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your child's IIHI
- Your child's privacy rights in regard to your child's IIHI
- Our obligations concerning the use and disclosure of your child's IIHI

The terms of this notice apply to all records containing your child's IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your child's records that our practice has created or maintained in the past, and for any of your child's records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

**B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:
Venk Adigopula, Practice Manager at 619-698-2184 ext. 109 for further information.**

C. WE MAY USE AND DISCLOSE YOUR CHILD'S INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

1. Treatment. Our practice will use your child's IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we will use the results to help us reach a diagnosis. We will use your child's IIHI in order to write a prescription for you, or we may disclose your child's IIHI to a pharmacy when we order a prescription for you. Our practice staff – including, our doctors, nurses, medical assistants, front office, billing and referrals – will use or may disclose your child's IIHI in order to treat you or to assist others in your child's treatment. Additionally, we may disclose your child's IIHI to others who may assist in your child's care, such as your spouse, children, parents or caretakers.

2. Payment. Our practice will use and may disclose your child's IIHI to bill and collect payment for the services and items you may receive from us. For example, we will contact your child's health insurer to certify that you are eligible for certain benefits, and we may provide your child's insurer with details regarding your child's treatment to determine if your child's insurer will cover or pay for your child's treatment. We will also use and may disclose your child's IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we will use your child's IIHI to bill you directly for services and items.

3. Health Care Operations. Our practice will use and may disclose your child's IIHI to operate our business. For example, our practice may use your child's IIHI to evaluate the quality of care you received from us, or to conduct diagnoses and procedure analyses, healthcare scheduling and business planning activities for our practice.

4. Appointment Reminders. Our practice may use and disclose your child's IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your child's IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your child's IIHI to inform you of health-related benefits or services that may be of interest or available or not available to you.

7. Release of Information to other caretakers. Our practice may release your child's IIHI to other caretakers who are involved in your child's care, or who assists in taking care of your child. For example, a grandparent, relative or sitter, who brings your child for care to our practice, may gain access to your child's medical information.

8. Disclosures Required By Law. Our practice will use and may disclose your child's IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR CHILD'S IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your child's identifiable health information:

1. Public Health Risks. Our practice may disclose your child's IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency/ies and authority/ies regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your child's IIHI to a health oversight agency for activities authorized by law. Oversight activities may include investigations, inspections, audits, surveys, licensure and disciplinary actions, civil, administrative, and criminal procedures or actions, or activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your child's IIHI in response to a court or administrative order, if your child is involved in a lawsuit or similar proceeding. We also may disclose your child's IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, only after we have made an effort to inform you of the request, and to allow you to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Research. Our practice may use and disclose your child's IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your child's IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your child's IIHI is being used only for the research and (iii) the researcher will not remove any of your child's IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

7. Serious Threats to Health or Safety. Our practice may use and disclose your child's IIHI when necessary to reduce or prevent a serious threat to your child's health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

8. Military. Our practice may disclose your child's IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

9. National Security. Our practice may disclose your child's IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your child's IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

10. Inmates. Our practice may disclose your child's IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to your child, (b) for the safety and security of the institution, and/or (c) to protect your child's health and safety or the health and safety of other individuals.

E. YOUR RIGHTS REGARDING YOUR CHILD'S IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your child's health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Venk Adigopula, Practice Manager at 619-698-2184 ext. 109** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your child's IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your child's IIHI to only certain individuals involved in your child's care or the payment for your child's care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your child's IIHI, you must make your request in writing to **Venk Adigopula, Practice Manager at 619-698-2184 ext. 109**. Your request must describe in a clear and concise fashion:

- (a) the information you wish restricted;
- (b) whether you are requesting to limit our practice's use, disclosure or both; and
- (c) whom you want the limits to apply to.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Venk Adigopula, Practice Manager at 619-698-2184 ext. 109** in order to inspect and/or obtain a copy of your child's IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

Effective Date of this Notice: _____

4. Amendment. You may ask us to amend your child's health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Venk Adigopula, Practice Manager at 619-698-2184 ext. 109.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your child's IIHI for non-treatment or operations purposes. Use of your child's IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your child's information to file your child's insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Venk Adigopula, Practice Manager at 619-698-2184 ext. 109.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Venk Adigopula, Practice Manager at 619-698-2184 ext. 109.**

7. Right to File a Complaint. If you believe your child's privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Venk Adigopula, Practice Manager at 619-698-2184 ext. 109.** All complaints must be submitted in writing. **You will not be penalized by our practice for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your child's IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your child's IIHI for the reasons described in the authorization. Please note that we are required to retain records of your child's care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Venk Adigopula, Practice Manager at 619-698-2184 ext. 109.**

GROSSMONT PEDIATRICS
PRIVACY POLICIES

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not fear about providing information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). Our practice and its physicians and staff will:

- ☞ Adhere to the standards set forth in the Notice of Privacy Practices (NPP).
- ☞ Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, without an authorization from the patient.
- ☞ Use and disclose PHI to remind patients of their appointments only within their consent.
- ☞ Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will
 - Implement reasonable measures to protect the integrity of all PHI of patients.
- ☞ Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- ☞ Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:
 - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
 - Not disclose PHI data unless the patient (or his or her authorized representative) has properly consented to or authorized the release, or the release is authorized by law.
- ☞ Recognize that, the patient has a right to inspect and obtain a copy of his/her child's PHI. Caretakers also have rights to request amendments to his/her child's medical record if he/she believes his/her child's information is inaccurate or incomplete. Our practice and its physicians and staff will:
 - Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.
 - Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- ☞ All physicians and staff of our practice will maintain a list of all disclosures of PHI for purposes other than TPO for each patient. We will provide this list to patients upon request, so long as their requests are in writing.
- ☞ All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- ☞ All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
- ☞ Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

GROSSMONT PEDIATRICS
YOUR RIGHT TO RECEIVE A COPY OF YOUR CHILD'S PHI

Privacy Procedures to accomplish this Privacy Policy

- Front office staff will have an original form for authorized caretakers to complete when he/she desires to inspect and copy his/her child's PHI. A photocopy of this form will be given to caretakers. After the caretaker has submitted his/her request in writing, the front office staff will verify that the caretaker's signature matches his/her signature on file.
- Once the caretaker completes the form, the front office staff will forward the form to the Privacy Officer for review. The Privacy Officer will review the caretaker's request and respond to the caretaker within 30 days from the date of the request. The Privacy Officer can request an additional 30-day extension as long as the request is made to the caretaker in writing with the reason for the delay clearly explained.
- The Privacy Officer will agree to all reasonable requests. If access is denied, the Privacy Officer will provide the caretaker with an explanation for the denial and a description of the caretaker's review appeal.
- When the caretaker has requested to inspect their PHI and his/her request has been accepted, the Privacy Officer or other authorized practice representative will accompany the caretaker to a private area to inspect his/her child's records. After the caretaker inspects the record, the Privacy Officer will note in the record the date and time of the inspection, and whether the caretaker made any requests for amendments or changes to the record.
- When the caretaker's request to copy his/her child's PHI has been accepted, the front office staff will copy his/her child's record within 5 working days at a charge of 25 cents per page.

GROSSMONT PEDIATRICS
**CARETAKER CONSENT FOR USE AND DISCLOSURE
OF CHILD'S PROTECTED HEALTH INFORMATION**

With my consent, Grossmont Pediatrics may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Grossmont Pediatrics' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Grossmont Pediatrics reserves the right to revise its Notice of Privacy Practices any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Venk Adigopula, Privacy Officer at 6942 University Avenue #A, La Mesa, CA 91942.

With my consent, Grossmont Pediatrics may call my home or other designated location, and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my child's clinical care, including laboratory results among others.

With my consent, Grossmont Pediatrics may mail to my home or other designated location any item, that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that Grossmont Pediatrics, restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, and if it does, it is bound by this agreement.

By signing this form, I am consenting to Grossmont Pediatrics' use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Grossmont Pediatrics may decline to provide treatment to me.

I CONFIRM I HAVE RECEIVED A COPY OF THE HIPAA DECLARATION TODAY

Signature of Caretaker or Legal Guardian

Child's Name

Caretaker's Name

Date

Print Name of Caretaker or Legal Guardian

GROSSMONT PEDIATRICS
**CARETAKER AUTHORIZATION FOR PRACTICE TO RELEASE
PROTECTED HEALTH INFORMATION TO THIRD PARTIES**

By signing this authorization, I authorize Grossmont Pediatrics to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Grossmont Pediatrics to use or disclose to _____

_____ the following individually identifiable health information:

Person or Entity to receive the information

specifically (date(s) of service, level of detail to be released, origin of information, etc.).

This authorization will expire on _____.
{Expiration Date or Defined Event}.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Grossmont Pediatrics, has acted in reliance upon this authorization. My written revocation must be submitted to Grossmont Pediatrics' Privacy Officer at 6942 University Avenue #A, La Mesa, CA 91942.

Signed by: _____
Signature of Caretaker or Legal Guardian Relationship to Patient

Caretaker's Name Date

Print Name of Patient or Legal Guardian Child's Name

GROSSMONT PEDIATRICS

**CARETAKER AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION FOR PURPOSES REQUESTED BY THE PRACTICE**

By signing this authorization, I authorize Grossmont Pediatrics, to use and/or disclose certain protected health information (PHI) about me to _____ . This
Name of entity to receive this information
authorization permits Grossmont Pediatrics to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____.

The information will be used or disclosed for the following purpose:

_____.

The Practice may or may not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____
{Expiration Date or Defined Event}.

I do not have to sign this authorization in order to receive treatment from Grossmont Pediatrics. In fact, I have the right to refuse to sign this authorization. I also have the right to inspect or copy the information to be used or disclosed. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at 6942 University Avenue #A, La Mesa, CA 91942.

Signature of Caretaker or Legal Guardian

Relationship to Patient

Caretaker's Name

Date

Print Name of Caretaker or Legal Guardian

Child's Name

CARETAKER/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

SITUATIONS REQUIRING/NOT REQUIRING AUTHORIZATION

Under the HIPAA Privacy Rule, your practice **does not have to obtain** caretaker authorization or consent to disclose PHI

- To a provider who has an indirect treatment relationship with the patient;
- To a health oversight agency with respect to audits, civil, administrative, and/or criminal investigations, proceedings or actions, inspections, licensure or disciplinary actions;
- In response to a court order, court-ordered warrant, subpoena or summons;
- To law enforcement for the purpose of identifying or locating a suspect, fugitive, material witness or missing person, (e.g., disclosing a deceased individual's PHI if suspicion persists that death may have resulted from criminal conduct);
- To organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes or tissue for donation and transplantation;
- As required by law for public health activities and the prevention or control of disease, injury or disability, including but not limited to communicable diseases and product defects or problems (e.g., with food and dietary supplements and product labeling issues);
- As required by law to social or protective services with respect to victims of abuse, neglect or domestic violence;
- Of Armed Forces personnel for activities deemed to assure proper execution of military mission;
- To authorized federal officials for the conduct of lawful intelligence or counter-intelligence as authorized by the National Security Act;
- To authorized federal officials as it relates to protecting the President of the United States, to foreign heads of state or other authorized persons;
- To the United States Department of State as it relates to obtaining security clearance, service abroad and other provisions of the Foreign Service Act;
- To correctional institutions or law enforcement as it relates to inmates' healthcare or the health and safety of individuals treating and transferring inmates;
- To a person who may have been exposed to a communicable disease, if the practice is authorized by law to notify such persons in the conduct of a public health intervention or investigation;
- To an employer, if the practice is a covered provider who is a member of the workforce of the employer or who provides healthcare to the patient at the request of the employer: to conduct an evaluation relating to medical surveillance of the workplace; or to evaluate whether the individual has a work-related illness or injury;
- To an auto insurance company or workman's compensation when they are responsible for payment of the practice's services;

Under the HIPAA Privacy Rule, your practice **must obtain caretaker authorization** beyond the consent form if it wants to use PHI

- To disclose PHI about a patient to a third party (i.e., a life insurance underwriter).
- To market a product or service;
- To raise funds for any entity other than your practice;
- For research unless your practice has a signed waiver approved by the Institutional Review Board (IRB) for the use and disclosure of PHI or has de-identified PHI;
- To use psychotherapy notes for TPO, unless use or disclosure is required for:
 - ◆ law enforcement purposes or legal mandates
 - ◆ oversight of the provider who created the notes
 - ◆ a coroner or medical examiner
 - ◆ aversion of a serious and imminent threat to health or safety;

GROSSMONT PEDIATRICS
REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PHI

CARETAKERS PLEASE NOTE: THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street

Apartment #

City, State & Zip

Type of PHI to be restricted or limited: (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Home phone # | <input type="checkbox"/> Patient history |
| <input type="checkbox"/> Home address | <input type="checkbox"/> Office address |
| <input type="checkbox"/> Occupation | <input type="checkbox"/> Office phone # |
| <input type="checkbox"/> Name of employer | <input type="checkbox"/> Spouse's name |
| <input type="checkbox"/> Visit notes | <input type="checkbox"/> Spouse's office phone # |
| <input type="checkbox"/> Hospital notes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Prescription information | |

How would you like your child's PHI restricted?

Signature of Caretaker or Legal Guardian

Date

FOR INTERNAL PURPOSES ONLY:

Date Request Received: _____

GROSSMONT PEDIATRICS
REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street

Apartment #

City, State & Zip

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is \$0.25 per page, with a minimum charge of \$ 5.00.

Signature of Caretaker or Legal Guardian

Date

Print Name of Caretaker or Legal Guardian

FOR INTERNAL PURPOSES ONLY:

Date Request Received: _____

GROSSMONT PEDIATRICS
CARETAKER DENIAL LETTER

Date _____

Patient's Name
Address
City, State, Zip

Dear _____:

In accordance with the Final Rule for the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) issued by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Grossmont Pediatrics is unable to honor your request to inspect and obtain a copy of your child's protected health information (PHI) for the following reason(s):

- Grossmont Pediatrics does not possess the information requested.
- You have requested psychotherapy notes, as defined in the Privacy Rule, and we are not required to allow you to inspect and obtain a copy of your child's psychotherapy notes.
- The Privacy Rule does not require the practice to permit you to inspect and obtain a copy of the requested information because it has been compiled in anticipation of, or for use in a civil, criminal or administrative action or proceeding.
- The Privacy Rule does not require the practice to permit you to inspect and obtain a copy of the requested information because it is subject to or exempted by the Clinical Laboratory Improvements Amendments (CLIA) of 1988.
- The Privacy Rule does not require the practice to permit you to inspect and obtain a copy of the requested information because the information was obtained from someone other than a healthcare provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.
- The Privacy Rule does not require the practice to permit you to inspect and obtain a copy of the requested information because the information was/is being created or obtained in the course of on-going research that includes treatment and you agreed to the denial of access when you consented to participate in the research. Your right of access will be reinstated upon the completion of the research.
- The requested information is contained in records subject to the federal Privacy Act, 5 U.S.C. §552a, and this denial meets the requirements of that law.
- A licensed healthcare professional has determined in his/her professional judgment that access to the requested information is reasonably likely to endanger your child's life or physical safety or the life or physical safety of another person.
- The requested information makes reference to another person and a licensed healthcare professional has determined, in the exercise of reasonable judgment, that the requested access is reasonably likely to cause substantial harm to such other person.
- You are the personal representative of the subject of the requested information, and a licensed healthcare professional has determined, in the exercise of professional judgment, that the requested information should not be provided to you.

If access to requested information has been denied for any of the last three reasons listed above, you have the right to have the denial reviewed by another licensed healthcare professional who did not participate in this denial. If you choose to have this denial reviewed, please submit a written request to our Privacy Officer, Venk Adigopula at 6942 University Avenue #A, La Mesa, CA 91942.

Our Privacy Officer will respond with a written decision within a reasonable period of time whether or not to ultimately grant or deny access to your child's PHI as originally requested. You may file a complaint regarding this denial with the Privacy Officer, Venk Adigopula at 619-698-2184 ext. 109, or with the Secretary of the U.S. Department of Health and Human Services.

Complaints to the Secretary must be in writing, name the Practice, describe the acts/omissions believed to violate the Privacy Rule, and be filed within 180 days of the alleged violation.

Very truly yours,

Venk Adigopula

Manager

GROSSMONT PEDIATRICS

REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Street

Apartment #

City, State & Zip

Type of Entry to be amended: _____

- Visit note
- Nurse note
- Hospital note
- Prescription information
- Patient history

Please explain how the entry is inaccurate or incomplete.

Please specify what the entry should say to be more accurate or complete.

Signature of Caretaker or Legal Guardian

Date

FOR INTERNAL PURPOSES ONLY:

Date Request Received: _____

- Amendment has been: Accepted
 Denied
 Denied in part, Accepted in part

If denied (in whole or in part)*, check reason for denial:

- PHI was not created by this organization.
- PHI is not available to the caretaker for inspection in accordance with the law.
- PHI is not a part of patient's designated record set.
- PHI is accurate and complete.

Comments from healthcare provider who provided service:

Name of Staff Member Completing Form: _____

Title: _____

Signature of Grossmont Pediatrics

Date

*If your request has been denied, in whole or in part, you have the right to submit a written statement disagreeing with the denial to the practice, *Attn: {Name of Privacy Officer {practice address}}*. If you do not provide us with a statement of disagreement, you may request that we provide your original request for amendment and our denial with any future disclosures of the protected health information that is the subject of the requested amendment. Additionally, you may file a complaint with our Privacy Officer *[insert name or title, and telephone number]* or the Secretary of the U.S. Department of Health & Human Services.

***PRACTICE MUST INFORM CARETAKER THAT A WRITTEN REQUEST IS REQUIRED, AND THAT THE CARETAKER IS REQUIRED TO PROVIDE A REASON TO SUPPORT THE REQUESTED CHANGE.**

GROSSMONT PEDIATRICS
**REQUEST FOR AN ACCOUNTING OF CERTAIN DISCLOSURES OF
PROTECTED HEALTH INFORMATION FOR NON-TPO PURPOSES**

As a caretaker, you have the right to receive an accounting of certain non-routine disclosures of your child's identifiable health information made by our practice. Your request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be provided free of charge. For additional lists during the same 12-month period, you may be charged for the costs of providing the list; however the practice will notify you of the cost involved and you may choose to withdraw or modify your request.

To request an accounting of disclosures made by the practice, you must submit your request in writing to Venk Adigopula, 6942 University Avenue #A, La Mesa, CA 91942.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Street

Apartment #

City, State & Zip

Signature of Caretaker or Legal Guardian

Date

FOR INTERNAL PURPOSES ONLY:

Date Request Received: _____