HIPAA Privacy Notice – Patient Acknowledgement
"Health Insurance Portability and Accountability Act"

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.

The Federal Government has required that your medical records remain private, confidential, and unavailable to anyone without your expressed written consent. Our medical records of your care remain the physical property of Castle Rock Pediatrics. The State of Colorado supports this law. Forms are used for you to authorize, in writing, the release of a copy of your specific medical records to another entity such as physician, medical practice, or to an insurance company for treatment, payment, and operations of Castle Rock Pediatrics.

Castle Rock Pediatrics endorses, supports, and participates in electronic Health Information Exchange (HIE). Making your health information available to your health care providers and other qualified medical professionals through the HIE provides better quality care and helps reduce your costs by eliminating unnecessary duplication of tests and procedures. You may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time.

Health Care Operations

There remain certain operational activities, where, in the process of delivering medical care to our patients, specific disclosure of information becomes necessary and will be conducted by medical and administrative professionals within this practice, without expressed written permission of each specific occurrence by you. Some examples include, but are not limited to:

- Requesting Photo ID at your visit
- Taking and saving a photograph of the patient for the chart to be used for identification and medical treatment
- Calling / faxing / electronically communicating to your pharmacy for prescription authorization
- Calling your insurance carrier for billing and/or reimbursement purposes
- Faxing / mailing your insurance carrier documentation of care
- Calling / faxing / e-mailing your specialists with results of care or questions
- Handling of the mail, newsletters, claims, bills, referrals
- Requesting that the office / reception staff call, text, or email you to schedule an appointment, acquire a referral, or to inform you about medications that may have to be held for testing
- Medical staff leaving reasonable and limited messages informing you of potential treatment options such as lab or x-ray results
- Inform you of health-related benefits or services that may be of interest to you
- Verbal or written correspondence with insurance companies; yours and ours
- Routine inter-office communication between professional staff of this practice to effectively manage your medical care You may restrict disclosure of any part of your Private Medical Information from within this practice to any outside source or recipient, where not allowed by law: Federal, State or by Court Order. Please note that any unsecure electronic communication initiated by the patient/family is done so at their own risk.

Your Rights under the Law:

- You have the right to receive a notice about our privacy policy
- The right to inspect your protected health information (PHI) with a provider in a private environment
- The right to request a copy of PHI and to have returned to you in 30 days, unless notified in writing of 60-day return
- The right to request a restriction on uses and disclosures of your protected health information

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- The right to request to receive confidential communications from the practice by alternative means or at an alterna tive location
- The right to request an amendment of your protected health information
- The right to request an accounting of disclosures of Protected Health Information (PHI)
- The right to revoke or limit authorization
- The right to be notified of a breach of your PHI

Please list by name and relation the person(s) that may receive messages or talk to us regarding patient's medical care.

_____	_____
Name/relation	Contact Number
_____	_____
Name/relation	Contact Number
_____	_____
Name/relation	Contact Number

Practice Duties

It is our responsibility to guard and maintain information about you and your health in a very private manner. This information will be disclosed within the practice on a "needs to know" basis, and then kept confidential for your assurance that we comply with the Federal, State, and local laws on "Confidentiality of Medical Information."

Patient Name _____

ACKNOWLEDGEMENT

I, _____ (patient, responsible party), acknowledge that I have received a copy of Castle Rock Pediatrics (the practice's) "HIPAA Privacy Notice-Patient Acknowledgment" document regarding protection of Personal Health Information (PHI).

Patient's or Responsible Party's Signature _____ Date _____

If not signed by the patient, please indicate your relationship to the patient:

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient