Gold Pediatrics LLC

Notice Of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my child(ren)'s treatment and follow-up among the physicians of our practice as well as any specialists/physicians outside of our practice involved in the treatment directly or indirectly.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Obtain payment for services rendered.

I have received, read and understand your Notice of Privacy Practices written in plain language containing a more complete description of the uses and disclosures of my/my child(ren)'s protected health information. I understand that Gold Pediatrics, LLC has the right to change their Notice of Privacy Practice at any time and that I may contact the practice at any time to obtain a current copy of this notice. I further understand my individual rights and the process that needs to be taken if I have a concern about this policy.

I understand that Gold Pediatrics, LLC has chosen to participate in the Chesapeake Regional Information System (CRISP), a regional information health information exchange serving Maryland and D.C. As permitted by law, my health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "Opt-Out" and disable access to your child(ren)'s health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax, or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

I understand that I may request in writing that Gold Pediatrics, LLC restricts how the private information of my child(ren) is used or disclosed to carry out treatment, payment and healthcare operations. I also understand you are not required to agree to my requested restrictions.

Patient Name(s): _____

_____

_____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY: I attempted to obtain a signature in acknowledgement of this Notice of Privacy Practices but, was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____

Gold Pediatrics LLC

HIPAA Authorized Representative

HIPAA Representative is a person named by a patient granting authority to have access to the patient's Protected Health Information (PHI). This form was created in response to requests by patients that they have a way to document family members or friends who are involved in caring for or facilitating the patient's care. For example, a patient may want their spouse or adult child to assist in billing questions, to book appointments on their behalf or to be appraised of their health status. This form assures that we have a record of the patient's wishes in this regard and we can share information in accordance with this request.

I, _____ direct my healthcare provider and payer to disclose and release my medical information my protected health information described below to:

Name: Relationship:

_____ _____

_____ _____

Contact Information: _____

_____

Health Information to be disclosed upon request of the person named above-
(Check either A or B):

- ☐ A. **Disclose** my complete medical record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing for all conditions) **OR**
- ☐ B. **Dislcose** my medical record as described above **BUT do not disclose** the following (Check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/Drug abuse treatment
  - ☐ Other (please specify):

_____

_____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard Copy

This authorization shall remain effective until (Check one):

- ☐ All past, present, and future periods OR,
- ☐ Date or event: _____

Unless I revoke it. (Note: You may revoke this authorization in writing at any time by notifying your Healthcare providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of Birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Rights Access: 45 CFR § 164.524