PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Child's Name: _____ **DOB:** _____

Name of Parent/Guardian: _____

Signature: _____ **Date:** _____

Relationship to patient:

□ Parent

□ Legal Guardian

□ Foster Parent

□ Self (over 18 years old)

Please bring:

□ Insurance Card

□ Immunization Record

□ Child's Birth Certificate (Newborns)

□ Photo ID (Parent/Guardian)

□ Foster Parents/Legal Guardians must have guardianship/custody agreement paperwork at all times

PLEASE PRINT CLEARLY, FILL ALL BLANKS *Write N/A if Not Applicable*

Patient Registration

Patients Name: _____ DOB: _____ Age: _____

Patients Social Security Number: _____ Sex: □ Male □ Female □ Prefer Not to Answer

Address: _____

City, State, Zip: _____

Home Phone: (___)___-_____ Cell Phone: (___)___-_____ Alternate Phone: (___)___-_____

Email: _____

Race (optional): _____ Language(s): _____

Emergency Contact: _____ Phone #: (___)___-_____ Relation: _____

Preferred Pharmacy: _____ On (cross street): _____ Phone #: (___)___-_____

NOTE: IF OVER 18 YEARS OF AGE, SKIP TO INSURANCE INFORMATION

Mother's Name: _____ DOB: _____

Driver's License Number: _____ Social Security Number: _____

Address: *(if different from above)* _____

Employer: _____ Work Phone: (___)___-_____

Father's Name: _____ DOB: _____

Driver's License Number: _____ Social Security Number: _____

Address: *(if different from above)* _____

Employer: _____ Work Phone: (___)___-_____

Responsible party status: □ Married □ Single □ Divorced □ Widow

Insurance Information: Please provide receptionist with insurance card(s)

□ Medi-Cal □ HMO □ PPO □ Other: _____

Primary Insurance: _____ **ID #:** _____

Subscriber: _____ Relation: _____ Co-payment: $_____

Secondary Insurance: _____ **ID #:** _____

Subscriber: _____ Relation: _____ Co-payment: $_____

□ I authorize the release of medical information necessary for the completion of insurance forms; I authorize payment directly to Pediatric Medical Group for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature: _____ **Date:** _____

Pediatric Medical Group

Patient History Form

(This medical document is strictly confidential and will not be released without your written authorization)

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Birth Place (City, State, Country): _____

Medical History

AIDS/HIV	□ YES □ NO	Heart Disease	□ YES □ NO	Migraines	□ YES □ NO
Anemia	□ YES □ NO	Heart Murmur	□ YES □ NO	Polio	□ YES □ NO
Arthritis	□ YES □ NO	Hemorrhoids	□ YES □ NO	Seizures	□ YES □ NO
Asthma	□ YES □ NO	Hepatitis	□ YES □ NO	Stroke	□ YES □ NO
Bleeding	□ YES □ NO	Hernia	□ YES □ NO	Thyroid Disease	□ YES □ NO
Cancer	□ YES □ NO	High Cholesterol	□ YES □ NO	Tuberculosis	□ YES □ NO
Depression	□ YES □ NO	High Blood Pressure	□ YES □ NO	Ulcer	□ YES □ NO
Diabetes	□ YES □ NO	Kidney Disease	□ YES □ NO	Venereal Disease	□ YES □ NO
Glaucoma	□ YES □ NO	Low Blood Pressure	□ YES □ NO	Other:	_____
Heartburn	□ YES □ NO	Low Back pain	□ YES □ NO	Other:	_____

Previous Surgeries:	Date(s):	Hospital, City, State:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications (please include prescriptions, over the counter meds, vitamins, herbal remedies, etc):

Name:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies: _____

Pediatric Medical Group

Family Medical History

□ No Significant Family History is known

Check ALL that apply	Alcohol/Drug Abuse	Asthma	Cancer (type: ____)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other: ____	Other: ____
Mother																	
Father																	
Brother																	
Sister																	
Child																	
MGM																	
MGF																	
PGM																	
PGF																	
Other: _____																	

Patient Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____

Parent Consent to Treat a Minor

Date: _____

As the parent/legal guardian of _____,
(Minor's Printed Name)

I _____ do consent to any x-rays, lab tests,
(Parent/Guardian Printed Name)

anesthetics, medical, surgical, or dental diagnosis(es) or treatment that Pediatric Medical Group may deem necessary for my minor child.

Child's Name: _____ **DOB:** _____

Name of Parent/Guardian: _____

Signature: _____

Missed Appointment Declaration

Child's Name: _____ **DOB:** _____

Being the parent/guardian/self (if over 18 years of age), I understand that Pediatric Medical Group has a "Three Strikes" policy and enforces the following:

1. All appointments will be honored by the clinic staff.
2. All office visits are by appointment ONLY. We DO NOT accept walk-ins as they interfere with scheduled appointment times.
3. I understand that it is important to arrive ON TIME for appointments.
4. I understand that at the discretion of the staff, any appointment that is **15 minutes late** will be cancelled and rescheduled.
5. I understand that if I am not able to keep a scheduled appointment, I will give at least a 24-hour notice for all cancelled appointments.
6. I understand that if a Well Child Exam is needed, I must plan and schedule an appointment 1 to 2 months in advance.
7. I understand that Pediatric Medical Group will document missed appointments in that if three (3) appointments are missed without informing the staff my child will or can be dismissed from the clinic.

Name of Parent/Guardian: _____

Signature: _____ **Date:** _____

Chaperone Consent to Treat

Date: _____

Why Your Child Should Have a Consent Form on Record

Parents/Legal Guardians are <u>not</u> always available to take their children to their medical appointments, for example, if they are on vacation or are at work. Pediatric Medical Group will not provide care to a minor patient under the age of 18 years old if a parent or legal guardian is not present, unless a parent has granted permission.

I _____ am the parent/legal
(Parent/Guardian Printed Name)

guardian of Child's Name: _____

DOB: _____, authorize the following people listed below to bring my child to Pediatric Medical Group, to receive ALL medical care needed including immunization(s). I understand the below named party(ies) is/are responsible for informing me of all information related to services received.

_____

_____

_____

Name of Parent/Guardian: _____

Signature: _____

Policy Regarding Financial Responsibility

Providing quality care for our patients is our primary concern. The following is a summary of our financial policy. We would be happy to provide further clarification if necessary. We ask you to read and sign the following acknowledging that you have been advised of your financial responsibilities for medical services provided here at Pediatric Medical Group.

We accept most insurance plans; therefore, please provide us with your insurance card. We will let you know if your plan is one for which our doctors/providers are the designated provider. If you wish to be seen here, you are responsible for payment of ALL co-pays and/or deductibles required by your insurance, if any, are due at the time of service.

Please be aware that not all insurance policies cover all conditions and fees. To be fully aware of your schedule of benefits, please read your insurance policy or contact your insurance representative.

Some elective procedures, such as circumcisions, may not be covered by your insurance, or your insurance may only cover part of the charge. Please be aware that you may be responsible for any charges not fully paid by your insurance.

We accept most forms of payment, including cash, credit cards, or checks. If you are not going to be able to attend a scheduled appointment, a **24 hour notice** is mandatory. Please be aware that you may be charged for a missed appointment. **Three (3) missed appointments may result in discharge from the office.**

I have read this financial policy and understand that I have financial responsibility for payment of medical services provided at this office. I hereby assume and guarantee payment of expenses incurred during any visit. Should legal action be required to secure payment, I agree to pay the legal expenses incurred by this office.

Child's Name: _____ **DOB:** _____

Name of Parent/Guardian: _____

Signature: _____ **Date:** _____

California Child Health and Disability Prevention Program

CONSENT FORM

I hereby give my consent for _____ to receive the health screening tests and
(Name of patient)

immunizations recommended by the CHDP Program from _____.
(Name of provider)

I hereby authorize release of information concerning the results of these screening tests to CHDP Program personnel. I also authorize release of the information to the locations checked below.

I understand that information provided to CHDP Program personnel will be strictly confidential and will be used only to make the provision of health services easier and to permit statistical reporting on the results of screening.

☐ School

Name

Address (number, street)	City	State	ZIP code

☒ Health care provider

Name

Address (number, street)	City	State	ZIP code

☐ Other

Name

Address (number, street)	City	State	ZIP code

Name of parent, guardian, or emancipated minor

Signature of parent, guardian, or emancipated minor	Date

Screening Provider: This form, signed by parent, guardian, or emancipated minor, must be retained in patient's file.

Patient Authorization to Release Protected Health Information

Medical Records Release Request

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

I, _____, authorize the use and/or release of my protected health information (medical records) from:

Doctor's Name/ Office/ Hospital: _____

Address: _____

City: _____ State: _____ Zip: _____

To be released to:

Purpose or need for disclosure: _____

_____

Expiration: This authorization is effective immediately and will remain in effect until _____, or for one year from the date of signature below.

Revocation: This authorization is subject revocation by written notice by the undersigned below. Revocation of this authorization will not affect any action taken in reliance to this authorization before receipt of the revocation notice.

Redisclosure: The request may not lawfully further the protected health information unless another authorization is obtained or required by law.

Signature: I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents with my direction to the health provider. I understand that, by signing this form, I am confirming my authorization that the healthcare provider may use and/or disclose to the person(s) on this form the protected health information described on this form. I understand that I have the right to receive a copy of this authorization.

Signature: _____ **Date:** _____

If not signed by patient:

Name of person signing for patient: _____

Relationship to patient: _____

Office Hours

Monday – Friday: 8:00 am – 5:00 pm

Closed for Lunch from 12:00 pm – 1:30 pm

Closed Saturdays and Sundays

Phone hours are from 8:00 am – 12:00 pm and from 1:30 pm – 4:00 pm.

Calls are forwarded to our answering service from 4:00 pm – 7:59 am Monday – Friday and on weekends.

If there is a life-threatening emergency, please **call 911** or head to your nearest Emergency Room/Hospital.

CDPH | CAIR

Immunization Registry Notice to Patients and Parents

Immunizations or 'shots' prevent serious diseases. Tuberculosis (TB) screening tests help to determine if you may have TB infection and can be required for school or work. Keeping track of shots/TB tests you have received can be hard. It's especially hard if more than one doctor gave them. Today, doctors use a secure computer system called an immunization registry to keep track of shots and TB tests. If you change doctors, your new doctor can use the registry to see the shot/TB test record. It's your right to limit who is able to access your records in the California Immunization Registry (CAIR).

How Does a Registry Help You?

- Keeps track of all shots and TB tests (skin tests/chest x-rays), so you don't miss any or get too many
- Sends reminders when you or your child need shots
- Gives you a copy of the shot/TB record from the doctor
- Can show proof about shots/TB tests needed to start child care, school, or a new job

How Does a Registry Help Your Health Care Team?

Doctors, nurses, health plans, and public health agencies use the registry to:

- See which shots/TB tests are needed
- Remind you about shots needed
- Prevent disease in your community
- Help with record-keeping

Can Schools or Other Programs See the Registry?

Yes, but this is limited. Schools, child care, and other agencies allowed under California law may:

- See which shots/TB tests children need
- Make sure children meet requirements for shots and TB tests needed to start child care or school

What Information Can Be Shared in a Registry?

- patient's name, sex, and birth date
- parents' or guardians' names
- limited information to identify patients
- details about a patient's shots/TB tests or medical exemptions

What's entered in the registry is treated like other private medical information. Misuse of the registry can be punished by law. Under California law, only your doctor's office, health plan, or public health department may see your address and phone number. Health officials can also look at the registry to protect public health.

Patient and Parent Rights

It's your legal right to ask your provider:

- to prevent other providers and schools from accessing your (or your child's) registry records
- not to send shot appointment reminders
- for a copy of your or your child's shot/TB test records
- who has seen the records and to change any mistakes

No action is needed to be part of CAIR. Other CAIR providers, schools, and health officials automatically have access to your or your child's records.

If you want to limit who sees your or your child's records:

1. Check with your provider to see if they can lock your records in CAIR
2. If your provider can't, complete a Request to Lock My CAIR Record form at **CAIRweb.org/cair-forms.**
3. If you change your mind, complete the Request to Unlock My CAIR Record form.
4. Fax printed forms to 1-888-436-8320, or email them to **CAIRHelpDesk@cdph.ca.gov.**

For more information, contact the CAIR Help Desk at 800-578-7889 or **CAIRHelpDesk@cdph.ca.gov**

NOTICE OF PRIVACY PRACTICES

Effective Date: _Sept 23, 2013_____

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law

prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

4. **Appointment Reminders**. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.]
5. **Sign In Sheet**. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Notification and Communication with Family**. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. **Marketing**. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in,
   We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
8. **Sale of Health Information**. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. **Required by Law**. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. **Public Health.** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. **Health Oversight Activities**. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
12. **Judicial and Administrative Proceedings**. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. **Law Enforcement**. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. **Coroners**. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. **Organ or Tissue Donation**. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. **Public Safety**. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. **Proof of Immunization**. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.
18. **Specialized Government Functions**. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. **Worker's Compensation**. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. **Change of Ownership**. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. **Breach Notification**. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [
22. **Psychotherapy Notes**. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if you sue us or bring some other legal proceeding, (4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical

examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

23. **Research**. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.
24. **Fundraising**. We may use or disclose your demographic information, the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status in order to contact you for our fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Office if you decide you want to start receiving these solicitations again.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. **Right to Request Special Privacy Protections**. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. **Right to Request Confidential Communications**. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. **Right to Inspect and Copy**. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
4. **Right to Amend or Supplement**. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in

turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. **Right to an Accounting of Disclosures**. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.