

**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.**

Effective April 14, 2003

The privacy of your medical information is important to us. You may be aware that U.S. government regulators established privacy rules ("HIPPA") governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

Barbara Bennett, is in charge of privacy matters at our office. You can contact her at 884-0230 if you desire further information, or have any questions or concerns.

Use and disclosure of protected information:

Federal law provides that we may use your medical information (protected health information) for the treatment of you, without further specific notice to you, or written authorization by you [Such as: if we were to refer you to a specialist, we may provide laboratory or test data to that specialist (subject to more stringent New York laws, such as restriction on disclosure of information concerning HIV/AIDS).]

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you. (Such as: under your health plan, we are required to provide them with a diagnosis code for your visit and a description of the services rendered, or for collection by our collection agency.)

We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:

1. Required by law;
2. Required for public health purposes;
3. Require by law to report child abuse
4. Where required by a health oversight agency for oversight activities

Authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct

5. Required by law in judicial or administrative proceedings;
6. Required for law enforcement purposes by a law-enforcement official;
7. Required by a coroner or medical examiner;
8. Permitted by law to a funeral director;
9. Permitted by law for organ donation purposes;
10. Permitted by law to avert a serious threat to health or safety;
11. Permitted by law and required by military authorities if you are a member of the armed forces of the United States;

New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights that you have:

You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information, except for: disclosures we make to you, or to carry out treatment, payment of health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law [or for research or public health purposes after being de-identified or limited to remove personally identifiable information] or disclosures made before April 14, 2003.

If you have received this notice electronically, you have the right to obtain a paper copy from our office.

Obligations that we have:

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.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file

a complaint with the Secretary of the department of Health and Human Services of the United States. You may also file a complaint with us.

No retaliatory action will be taken against you for any complaint you may make.

*Acknowledgment of receipt of notice of Privacy Practices will be electronically signed in office.

Consent for Purposes of Treatment, Payment and Healthcare Operations

Consent for Purposes of Treatment, Payment and Healthcare Operations I consent to the disclosure of my child's protected health information by Delaware Pediatric Associates for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to understand that diagnosis or treatment of my child by Delaware Pediatric Associates may be conditioned upon my consent as evidenced by my signature*.

I understand I have the right to request a restriction as to how protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Delaware Pediatric Associate is not required to agree to the restrictions that I may request, the restriction is binding on Delaware Pediatric Associates.

I have the right to revoke this consent, in writing, at any time except to the extent that Delaware Pediatric Associates has taken action in reliance on this consent. "Protected Health Information" means health information, including demographic information, collected and created or received by my physician, another health care provider, a health plan, employer or a health care clearinghouse. This protected health information relates to past, present and future physical or mental health or condition, or there is a reasonable basis to believe the information may identify my child.

I understand I have a right to review Delaware Pediatric Associates' Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Delaware Pediatric Associates. The Notice Of Privacy Practices for Delaware Pediatric Associates is also provided in the patients' waiting room. This Notice of Privacy Practices also describes my rights and the Delaware Pediatric Associates duties with respect to protected health information.

Delaware Pediatric Associates reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

***Electronic signature will be obtained in office.**