

**RECEIPT OF NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGEMENT FORM**

Patient Name \_\_\_\_\_  
Last Name First Name M.I.

Date of Birth: \_\_\_\_\_

Please initial if you agree:

1. I have received a copy of North Raleigh Pediatric Group's Notice of Privacy Practices.
2. I give permission for North Raleigh Pediatric Group to distribute confidential Information in the following ways: (indicate all that apply)

\_\_\_\_\_ US Mail

\_\_\_\_\_ Fax-please provide number \_\_\_\_\_

\_\_\_\_\_ Telephone-please provide number \_\_\_\_\_

\_\_\_\_\_ Cell Phone-Please provide number \_\_\_\_\_

\_\_\_\_\_ Work Voicemail-Please provide number \_\_\_\_\_

\_\_\_\_\_ Home answer machine-Please provide number \_\_\_\_\_

3. \_\_\_\_\_ I grant permission to receive information concerning appointments (scheduling, cancelling, verifying) by voice reminder calls/ E-Mail

\*\*\*\*\*please provide your E-Mail address: \_\_\_\_\_

4. \_\_\_\_\_
5. \_\_\_\_\_ I grant permission for information to be given to these persons:

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Regarding:

\_\_\_\_\_ scheduling \_\_\_\_\_ billing \_\_\_\_\_ test results

North Raleigh Pediatric Group will NOT release results to anyone other than the parent/guardian; nor will NRPG leave test results on answer machines /voicemail unless you're written consent is obtained

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

## HIPAA Notice of Privacy Practices

### North Raleigh Pediatric Group

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.

#### Uses and Disclosures

**Treatment.** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**Payment.** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

**Health Care Operations.** Your health information may be used as necessary to support the day-to-day activities and management of [name of practice]. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**Law Enforcement.** Your health information may be disclosed to law enforcement agencies who support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

**Public Health Reporting.** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

#### **Research**

Provider may disclose your medical information to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs) so long as the medical information they review is not removed from the premises of this practice. Provider may also disclose the medical information of decedents for a research project, so long as the information is necessary for the research.

**Other uses and disclosures require your authorization.** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

#### Additional Uses of Information

**Appointment Reminders.** Your health information may be used by our staff to send you appointment reminders. If you would like this office to communicate your health information to you in a confidential manner, please indicate your wishes on the '*Acknowledgement of Receipt of HIPAA Notice of Privacy Practices*' form.

**Information about treatments.** Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

#### **Individual Rights**

You have certain rights under the federal privacy standards. These include:

- ♦ The right to request restrictions on the use and disclosure of your protected health information;
- ♦ The right to receive confidential communications concerning your medical condition and treatment;
- ♦ The right to inspect and copy your protected health information;

## HIPAA Notice of Privacy Practices

- ♦ The right to amend or submit corrections to your protected health information;
- ♦ The right to receive an accounting of how and to whom your protected health information has been disclosed; &
- ♦ The right to receive a printed copy of this notice.

### **Practice Duties**

We are required by law to maintain the privacy of your protected health information and to provide you with this "Notice of Privacy Practices".

We are also required to abide by the privacy policies and practices that are outlined in this notice.

### **Right to Revise Privacy Practices**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

### **Requests to Inspect Protected Health Information**

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting this practice. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

### **Complaints**

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter or placing a call outlining your concerns to:

HIPAA Privacy Officer  
PhyServe, Inc. on behalf of Raleigh Durham Medical Group  
9229 LBJ Freeway  
Dallas, TX 75243  
(972) 792-3803

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also submit complaints to the Secretary of Health and Human Services.

You will not be penalized or otherwise retaliated against for filing a complaint.