

NOTICE OF PRIVACY PRACTICE

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996

This notice describes how Medical information about you or your child (as a patient of this practice) may be used and disclosed, and how you can get access to your information.

A. OUR COMMITMENT TO PRIVACY

Pediatric Associates is dedicated to maintaining the privacy of your Individual Identifiable Health Information (IIHI). In conducting business, we will create records regarding your child's treatment and any service we provide to you. We are required by law to maintain confidentiality of the IIHI. We also are required to provide you with this legal notice of our duties and the privacy practices that we maintain in our practice concerning your child's IIHI. By federal and state law, we must follow the terms of the act listed above.

We realize that these laws are complicated but we must provide you with the following important information:

- How we may disclose your IIHI.
- Your privacy rights in your IIHI.
- Our obligations concerning the use and disclosure of your IIHI.

The terms of this notice apply to all records containing your child's IIHI that are created or retained by our practice. We reserve the right to revise or amend this notice of privacy practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your child's records that we will create in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current notice at any time.

A. If you have any question, please contact: **Alex Galindo, Privacy Administrator.**

C. The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice—including, but not limited to our doctors and nurses—may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member who is involved in your care, or who assists in taking care of your ---. For example, a parent or guardian may ask that a baby sitter take a child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information—in writing (written) or verbal.

8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for purposes such as:

- maintaining vital records, such as births and deaths.
- reporting child abuse or neglect.
- preventing or controlling disease, injury or disability.

- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition.
- reporting reactions to drugs or problems with products or devices .
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights law and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain a court or administrative order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law-enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
- Concerning a death we believe has resulted from criminal conduct.
- Regarding criminal conduct at our offices.
- In response to a warrant, summons, court order, fugitive or missing person.
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the

health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

9. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Alex Galindo, Privacy Officer**, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Alex Galindo, Privacy Officer**. Your request must describe in a clear and concise fashion:

- (a) the information you wish restricted;
- (b) whether you are requesting to limit our practice's use, disclosure or both; and
- (c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Alex Galindo, Privacy Officer** in order to inspect and/or obtain a copy of your IIHI. Our practice will charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Alex Galindo, Privacy Officer**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Alex Galindo, Privacy Officer**.

6. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Alex Galindo, Privacy Officer (319) 351-1448**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

7. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the purposes described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact [**Alex Galindo, Privacy Officer**].

Exhibit 12

**PEDIATRIC ASSOCIATES OF IOWA CITY AND CORLAVILLE,
L.L.P**

**REQUEST FOR AN ACCOUNTING OF CERTAIN DISCLOSURES OF
PROTECTED HEALTH INFORMATION FOR NON-TPO PURPOSES**

As a patient, you have the right to receive an accounting of certain non-routine disclosures of your identifiable health information made by our practice for non-TPO purposes. Your request must state a time period that may not be longer than six (6) years and may not include dates

before April 14, 2003. The first list you request within a 12-month period will be provided free of charge. For additional lists during the same 12-month period, you may be charged for the costs of providing the list; however the practice will notify you of the cost involved and you may choose to withdraw or modify your request.

To request an accounting of disclosures for non-TPO purposes made by the practice, you must submit your request in writing to Alex Galindo, **605 East Jefferson Iowa City, 319-351-1448**.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Street

Apartment #

City, State, Zip

Signature of Patient or Legal Guardian Date

FOR INTERNAL PURPOSES ONLY:

Date Request Received: _____

**PEDIATRIC ASSOCIATES OF IOWA CITY AND CORLAVILLE,
L.L.P**

**REQUEST FOR LIMITATION AND RESTRICTIONS OF
PROTECTED HEALTH INFORMATION**

**PATIENT PLEASE NOTE: THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR
REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY
PRACTICES FOR MORE INFORMATION REGARDING SUCH
REQUESTS.**

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Street

Apartment #

City, State, Zip

Type of PHI to be restricted or limited: (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Home phone # | <input type="checkbox"/> Patient History |
| <input type="checkbox"/> Home address | <input type="checkbox"/> Office address |
| <input type="checkbox"/> Occupation | <input type="checkbox"/> Office phone |
| <input type="checkbox"/> Name of employer | <input type="checkbox"/> Spouse's name |
| <input type="checkbox"/> Visit notes | <input type="checkbox"/> Spouse's office phone # |
| <input type="checkbox"/> Prescription information | <input type="checkbox"/> Other _____ |

How would you like your PHI restricted?

Signature of Patient or Legal Guardian

Date

FOR INTERNAL PURPOSES ONLY:

Date Request Received: _____

**PEDIATRIC ASSOCIATES OF IOWA CITY AND CORLAVILLE,
L.L.P**

REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth _____

Street

Apartment #

City, State, Zip

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is \$1 per page, with a minimum charge of \$10.

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian

FOR INTERNAL PURPOSES ONLY:

Date Request Received: _____

**PEDIATRIC ASSOCIATES OF IOWA CITY AND CORLAVILLE,
L.L.P**

**REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED
HEALTH INFORMATION**

Patient Name: _____ Date of Birth _____

Street

Apartment #

City, State, Zip

Type of Entry to be Amended: _____ Visit note
 Nurse note
 Prescription information
 Patient History

Please explain how the entry is inaccurate or incomplete.

Please specify what the entry should say to be more accurate or complete.

Signature of Patient or Legal Guardian

Date

FOR INTERNAL PURPOSES ONLY: Date Request Received: _____

Amendment has been: Accepted

- Denied
- Denied in part, Accepted in part

If denied (in whole or in part)*, check reason for denial:

- PHI was not created by this organization.
- PHI is not available to the patient for inspection in accordance with the law.
- PHI is not a part of patient's designated record set.
- PHI is accurate and complete.

Name of Staff Member Completing Form: _____

Title: _____

Signature of Healthcare Provider Who Provided Service

Date

*If your request has been denied, in whole or in part, you have the right to submit a written statement disagreeing with the denial to the practice, *Attn: Alex Galindo 605 East Jefferson Iowa City*. If you do not provide us with a statement of disagreement, you may request that we provide to you copies of your original request for amendment, our denial, and any disclosures of the protected health information that is the subject of the requested amendment. Additionally, you may file a complaint with our Privacy Officer *Alex Galindo 605 East Jefferson Iowa City, 319-351-1448* or the Secretary of the U.S. Department of Health & Human Services.

***PRACTICE MUST INFORM PATIENT THAT A WRITTEN REQUEST IS REQUIRED, AND THAT THE PATIENT IS REQUIRED TO PROVIDE A REASON TO SUPPORT THE REQUESTED CHANGE.**