PROVIDENCE PEDIATRIC PRACTICE, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH 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 INDIVIDUALLY IDENTIFIABLE INFORMATION.

1. Our practice is dedicated to maintaining the privacy of your individually identifiable information. In conducting our business, we are committed to maintaining the confidentiality of your personal health information, including the means by which we may use and disclose your personal health information, your privacy rights to this information and our obligations concerning the use and disclosure of your personal health information.

2. We may use and disclose your individually identifiable health information in the following ways:
   - -Treatment
   - -Payment
   - -Health Care Operations
   - -Certain Special Circumstances
     - -Public Health Risks
     - -Law Suits and Similar Proceedings
     - -Law Enforcement

3. YOUR RIGHTS REGARDING YOUR PERSONAL/CHILD(REN'S) HEALTH INFORMATION
- -You have the right to confidential communication of your personal health information
- -You have the right to request restrictions to the use and disclosure of your individually identifiable health information
- -You have the right to inspect and retain a copy of your individually identifiable health information
- -You have the right to ask for an amendment to your health information if you believe it is incorrect or incomplete
- -You have the right to file a written complaint if you believe your privacy rights have been violated.

4. Please be advised that in cases of Divorce, Separation or Custody conflict, information from medical records may not be denied to either parent without a court order.

5. In addition, we do not keep social security numbers on file. Further, we do not keep credit card information on file.

6. We reserve the right to revise or amend this notice of Privacy Practices

7. Please be advised, when your child reaches the age of 18 years, he or she must sign a separate privacy notice which must indicate whether or not persons other than themselves can be contacted with test results or any information in their medical record. They must also name any person or persons to whom they give this privilege.

8. If questions, please contact the Office Manager.

Parent/Legal Guardian/Patient Signature.....Acct#.....Date.....

Patient Name(s)_____

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This policy is subject to change without notice.