



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW THE MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW AND SIGN THE ACKNOWLEDGMENT.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by Northern Lights Pediatric & Adolescent Medicine in any form are kept confidential.

As required by HIPAA, we have summarized how we intend to maintain the privacy of your personal health information. (PHI)

We may use and disclose your medical records for the following purposes: Treatment, Payment and Health Care Operations.

- **Treatment** may require that your information be disclosed to other health professionals that are involved in your care such as specialists to whom you have been referred.
- **Payment** includes such activities as submitting claims to your insurance company for reimbursement, confirming eligibility or utilization review.
- **Health Care Operations** include the business aspects of running our practice such as internal quality review, auditing functions or cost management analysis.

We may also contact you by phone, voicemail or mail to provide you with appointment reminders or information regarding your treatment.

Any other use and disclosure of your health information will be made only with your written authorization unless already authorized by law.

You have the following rights with respect to your protected health information. (PHI)

- The right to reasonable requests to receive confidential communication of your PHI.
- The right to inspect and copy your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to request an amendment of your PHI.

This NOTICE OF PRIVACY PRACTICES is effective April 1, 2003 and will remain in effect unless changed by law. We are required to abide by its terms. If you feel your privacy protections have been violated, you have the right to file a formal, written complaint and forward it to the attention of the Privacy Officer at any of our clinic locations.

I have read and understand the NOTICE OF PRIVACY PRACTICES of
Northern Lights Pediatric & Adolescent Medicine.

Signed _____ Date _____

Patient name _____ Date of Birth _____