Belmont Cambridge Health Care
Boston Children's
Primary Care Alliance

Ph: 617-491-5111 Fax: 617-491-5222

HIPAA Authorization

This notice describes how your medical information, as a patient of this practice, may be used/disclosed, and how you can get access to this information.

The privacy of your medical information is very important to us. You may be aware that the U.S. government regulators established a privacy rule, the Health Insurance Portability and Accountability Act ("HIPPA"), governing protected health information ("PHI"). PHI includes individually identifiable health information, such as demographic information, and relates to your past, present, or future, physical/mental health, or condition(s), as well as related health care services.

This notice tells you about how your PHI may be used, and about certain rights that you have.

Use and disclosure of protected information

Federal law provides that we may use your PHI for your treatment, without further specific notice to you, or written authorization by you. For example, we may provide laboratory/test data, to a specialist.

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. For example, under a health plan, we are required to provide the health insurance company with a diagnosis code for your visit, and a description of the services rendered.

Federal law provides that we may use your medical information for health care operations, without further specific notice to you, or written authorization by you. For example, we may use the information on evaluate the quality of care that you have received from us, or, to conduct cost-management, and business planning activities, for our practice.

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

- Required for public health purposes
- Required by law to report child abuse
- Required by a health oversight agency for oversight actives authorized by law, such as the Department of Health, Office of Professional Discipline, or Office of Professional Medical Conduct
- Required by law in judicial or administrative proceedings
- Required for law enforcement purposes by a law enforcement official
- Required by a coroner or medical examiner
- Permitted by law to a funeral director
- Permitted by law for organ donation purposes
- Permitted by law to avert a serious threat to health of safety
- Permitted by law and required by military authorities if you are a member of the armed forces of the U.S.
- Required for national security, as authorized by law
- Required by correctional institutions or law enforcement officials, if you are an inmate, or under the custody of a law enforcement official
- Otherwise required or permitted by law.

Certain types of uses and disclosures of protected health information require authorization, these include:

- Uses and disclosures of psychotherapy notes
- Uses and disclosures of PHI for marketing purposes; and disclosures that constitute the sale of PHI.
- Other uses and disclosures not described in this Notice of Privacy Practices will be made only with an individual's authorization.

Minors

For divorced, or separated, parents: each parent has equal access to health information about their unemancipated child{ren), unless there is a court order to the contrary, that is known to us, or unless it is a type of treatment/service, where parental rights are restricted.

We can release your medical information to a friend, or family member, which is involved in your medical care. For example, a babysitter, or relative, who is asked by a parent/guardian to take their child to the pediatrician's office, may have access to this child's medical information. We prefer to have written authorization from the parent/guardian for someone else to accompany the child, and may make reasonable attempts to obtain this authorization.

You can make reasonable requests, in writing, for us to use alternative methods of communication with you in a confidential manner. A separate form is available for this purpose.

Other uses/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 uses/disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to request 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 e.g. at home, and not at work. Such requests must

Belmont Cambridge Health Care
Boston Children's
Primary Care Alliance

Ph: 617-491-5111 Fax: 617-491-5222

HIPAA Authorization

be made in writing to your physician. Our practice will accommodate reasonable requests.

You have the right to inspect, and obtain, copies of your medical information (a reasonable fee may 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 that we make of your medical information. This is a list of certain non-routine disclosures that our practice has made of your health information for non-treatment, payment, or health care operations purposes. An accounting does not have to be made for disclosures we make to you, or to carry out treatment, payment, or 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 disclosures made before April 14, 2003.

You have the right to restrict certain disclosures of Protected Health Information to a health plan, for carrying out payment or health care operations, where you pay out of pocket in full for the healthcare item/service (only healthcare providers are required to include such a statement; other covered entities may retain the existing language indicating that a Covered Entity is NOT required to agree to a requested restriction).

You are required to notify a Business Associate and a downstream Health Information Exchange of the restriction.

A family member or other third party may make payment on your behalf and the restriction will still be triggered.

You have the right to, or will receive, notifications of breaches of your unsecured patient health information.

All requests must state a time period, which may not be longer than six (6) years, from the date of disclosure.

You have the right to receive a paper copy of our notice of privacy policies.

You have the right to receive electronic copies of health information.

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 that we maintain. Any revised notices will be posted in our office, and copies will be available there.

We will inform you of our intentions to raise funds, and your right to opt out of receiving such communications.

If you believe that these privacy rights have been violated, you may file a written complaint with our Privacy Officer, or, with the U.S. Department of Health and Human Services' Office for Civil Rights (OCR). We will provide the address of the OCR Regional Office, upon your request. No relation will occur against you for filing a complaint

Organization contact information

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR OFFICE MANAGER:

Kerri Bonacci
617-491-5111

Authorization

Signature of parent/guardian, or patient if over 18:

_____

Date: _____