La SHARON SAMUELS, MD, FAAP
PATRICIA BOYST, NP
2240 North Opdyke Road
Auburn Hills, MI 48326
Telephone: 248.289.7400 Facsimile: 248.475.5632
www.countrycreekpeds.com

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

PATIENT NAME: ___________________________________ **DATE OF BIRTH:** ________________

HOW MEDICAL INFORMATION ABOUT YOU/YOUR CHILD/CHILDREN MAY BE USED AND DISCLOSED: Treatment; Payment; Operations; Other Uses and Disclosures

OTHER USES AND DISCLOSURES BEYOND TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS PERMITTED WITHOUT AUTHORIZING OR OPPORTUNITY TO OBJECT: When legally required; when there are risks to public health; to report abuse, neglect or domestic violence; to conduct health oversight activities; in connection with judicial and administrative proceedings; for law enforcement purposes; to coroners, funeral directors and for organ donation; for research purposes; in the event of a serious threat to health or safety; for specified government functions; for Worker's Compensation.

USES AND DISCLOSURES PERMITTED WITHOUT AUTHORIZATION BUT WITH OPPORTUNITY TO OBJECT: We may disclose your child's protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in you/your child's care or payment related to you/your child's care or to try to locate or notify others involved in your/your child's care concerning your/your child's location, condition or death.

USES AND DISCLOSURES WHICH YOU AUTHORIZE: Psychotherapy notes except for treatment, payment or health care operations, (see Notice of Privacy Practices for Country Creek Pediatrics for details), marketing, sale of PHI.

YOUR RIGHTS:

1) The right to inspect and copy your/your child's protected health information.
2) The right to request a restriction on uses and disclosures of your/your child's protected health information.
3) The right to request to receive confidential communications from us by alternative means or at an alternative location.

Messages regarding NORMAL test results can be left on my cell or home voice mail: Yes __ No___

4) The right to have your physician amend your/your child's protected health information.
5) The right to receive an accounting of disclosures.
6) The right to receive notice of discovery of a breach of unsecured protected health information.
7) The right to obtain a paper copy of this notice.

OUR DUTIES: We are required by law to maintain the privacy of your/your child's health information and to provide you with this Notice of our duties and privacy practices. We reserve the right to change the terms of this notice.

COMPLAINTS: You have the right to express complaints to The Practice and to the Secretary of Health and Human Services if you feel your/your child's privacy rights have been violated.

Name of any person(s) other than parents or legal guardian you are authorizing to receive medical information on you/your child/children's behalf. (This information can be changed upon request).

_____________________________ _____________________________
Print Name Relationship to patient

_____________________________ _____________________________
Print Name Relationship to patient

I acknowledge that I have reviewed Country Creek Pediatrics Notice of Privacy Practices and received a written copy if requested:

_____________________________________ ________________________________
Signature of Patient (if aged 18 or over) Date
Parent/Personal Representative (under 18 yrs)