HIPAA NOTICE OF PRIVACY POLICY

STREETERVILLE PEDIATRICS

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

The privacy of your medical information is important to us. You may be aware the U.S. government regulators established a privacy rule, the Health Insurance Portability & Accountability Act ("HIPAA") governing protected health information ("PHI"). PHI includes individually identifiable health information including demographic information and relates to your past, present or future physical and mental health or condition and 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 or test data to that 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 to evaluate the quality of care you 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:
    1. required for public health purposes
    2. required by law to report child abuse
    3. required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct
    4. required by law in judicial or administrative proceedings
    5. required for law enforcement purposes by a law enforcement official
    6. required by a coroner or medical examiner
    7. permitted by law to a funeral director
    8. permitted by law for organ donation purposes
    9. permitted by law to avert a serious threat to health or safety
    10. permitted by law and required by military authorities if you are a member of the armed forced of the U.S.
    11. required for national security, as authorized by law
    12. required by correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official
    13. 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 or service where parental rights are restricted.
- We can release your medical information to a friend or family member that is involved in your medical care. For example, a babysitter or relative who is asked by a parent or 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 or 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 communicating with you in a confidential manner. A separate form is available for this purpose.
- Other uses or 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 or 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 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 will 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 we make of your medical information. This is a list of certain non-routine disclosures 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 or 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 the payment on your behalf and the restriction will still be triggered
- You have a 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 a right to receive a paper copy of our notice of privacy policies.
- You have a 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 we maintain. Any revised notice 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 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 retaliation will occur against you for filing a complaint.

Health Information Exchange

Your health information is kept in an electronic format. A Health Information Exchange allows health care providers to access clinical information about patients from other treating facilities. Streeterville Pediatrics participates in three

health information exchanges: the Community Connect Health Information Exchange operated by Ann & Robert H. Lurie Children's Hospital of Chicago (the "Exchange"), *CareEverywhere*®, and the Illinois Health Information Exchange (ILHIE).

Community Connect Health Information Exchange We, along with certain other health care providers and practice groups in the area, participate in a health information exchange operated by Ann & Robert H. Lurie Children's Hospital of Chicago (the "Exchange"). The Exchange facilitates the electronic sharing and exchange of medical and other individually identifiable health information regarding patients among health care providers that participate in the Exchange. Through the Exchange, we may electronically disclose demographic, medical, billing, and other health-related information about you to other health care providers that participate in the Exchange and request such information for purposes of facilitating or providing treatment, arranging for payment for health care services, or otherwise conducting or administering their health care operations.

CareEverywhere® We have a software product called *CareEverywhere*® that allows us to exchange health information with other providers that have the *CareEverywhere*® product. The *CareEverywhere*® exchange facilitates the electronic sharing and exchange of medical and other individually identifiable health information regarding patients among health care providers also have the *CareEverywhere*® software. Through the software *CareEverywhere*®, we may electronically disclose demographic, medical, billing, and other health-related information about you to other health care providers that participate in the Exchange and request such information for the purposes including but not limited to facilitating or providing treatment, arranging for payment for health care services, or otherwise conducting or administering their health care operations. Due to our participation in the Exchange, your electronic health information from our practice may be made available to other providers through Lurie Children's shared electronic medical record.

Illinois Health Information Exchange EHR Connect Your electronic medical records may be shared with the Illinois Health Information Exchange (ILHIE). The ILHIE facilitates the electronic exchange of electronic health information among health care providers that participate in the ILHIE, and with the ILHIE Authority, for the purposes including but not limited to facilitating or providing treatment, arranging for payment for health care services, or otherwise conducting or administering health care operations. Participation is voluntary, unless required by law. The ILHIE is helpful if you require treatment at other participating health care facilities in Illinois because it enables other facilities to obtain your medical history and coordinate care.

Participation in the three health information exchanges described above is voluntary, unless required by law, and you may opt out of participation by not signing this Consent form. If you do not provide consent, your electronic health information will not be electronically shared with other health care partners. You can change your mind or withdraw consent at any time, unless disclosure is required by law, by contacting Streeterville Pediatrics. Health information that has already been shared cannot be revoked.

Organization Contact Information

STREETERVILLE PEDIATRICS
233 EAST ERIE #304
CHICAGO, IL 60611
312/280-1480
FAX 312/280-1485

Update 9/2014

Receipt of Notice of Privacy Practices/Written Acknowledgement Form
Streeterville Pediatrics

I understand that Streeterville Pediatrics participates in a health information exchange (the “Exchange”) operated by Ann & Robert H. Lurie Children’s Hospital of Chicago (”Lurie Children’s”) that facilitates the electronic sharing and exchange of medical and other individually identifiable health information regarding patients among all health care providers that participate in the Exchange, including Lurie Children’s Affiliates. I understand that by participating in the Exchange, my/my child’s electronic health record is accessible to all health care providers that participate in the Exchange.

I understand that by participating in the Exchange, Streeterville Pediatrics may disclose my/my child’s electronic health information with the other exchange participants. I understand that such disclosure may also include the following highly confidential types of protected health information:

- HIV/AIDS related health information and/or records;
- Behavioral or mental health information and/or records;
- Information about sexually transmitted diseases;
- Pregnancy;
- Birth control;
- Drug/alcohol diagnosis, treatment, and/or referral information;
- Genetic testing information and/or records;
- Information about sexual assault/abuse;
- Information about child abuse and neglect; and
- Domestic abuse of an adult with a disability.

I understand that I may revoke my consent to disclosures of information about me/my child through the exchanges by notifying Streetervile Pediatrics of such revocation in writing, but that no such revocation will affect any disclosures made prior to acceptance of such revocation by Streeterville Pediatrics and Ann & Robert H. Lurie Children’s Hospital of Chicago.

By signing this form, I authorize Streeterville Pediatrics to electronically search for and disclose my/my child’s demographic, medical, billing, and other health-related information, including any highly confidential health information, to other health care providers that participate in the Exchange and request such information for purposes including but not limited to facilitating or providing treatment (both primary and specialty care), arranging for payment for health care services, or otherwise conducting or administering their health care operations.

I hereby release Streeterville Pediatrics and Ann & Robert H. Lurie Children’s Hospital of Chicago from any liability for any disclosures authorized by me that are made through the exchanges.

I UNDERSTAND THAT MY CONSENT IS VALID FOR ONE (1) YEAR AFTER THE DATE OF THIS CONSENT.
Please sign here, indicating your consent and receipt of a copy of this Notice of Privacy

Signature of Parent/Legal Guardian: ____ **Date** ______________________

Child/Children’s Names: