POOLE PEDIATRICS, P. A.
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about your child may be used and disclosed and how you can get access to this information. Please review it carefully.

With my authorization, Poole Pediatrics, P.A. or staff thereof may use and disclose protected health information (PHI) about me or my child to carry out treatment, payment and healthcare operations (TPO). Please refer to our Privacy Policy for a more complete description of such uses and disclosures. A copy is located in our waiting area. I have the right to review the Privacy Policy prior to signing this authorization. Our practice reserves the right to revise its Privacy Policy at anytime. A revised Privacy Policy may be obtained by forwarding a written request to our Privacy Officer at this office address. With my authorization, Poole Pediatrics, P.A. or staff thereof may fax PHI or call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my child's clinical care, including but not limited to non critical or case sensitive laboratory results. Although every effort will be made to get this information to the correct person, there may be circumstances where PHI is misdirected, due to misdialing or incorrect fax numbers. We are not liable in these instances. With my authorization, Poole Pediatrics, P.A. or staff thereof may mail to my home or other designated location any items that assist the practice in carrying out TPO, items such as but not limited to statements. I have the right to request that Poole Pediatrics, P.A. or staff thereof restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am authorizing Poole Pediatrics, P.A. or staff thereof use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Poole Pediatrics, P.A. or staff thereof may decline to provide treatment to my child.

I understand that, under HIPAA Act of 1996, I have certain rights to privacy regarding PHI. I understand that this information can and will be used to (1) conduct, plan and direct my child's treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, (2) obtain payment from third-party payers, (3) conduct normal healthcare operations such as quality assessments and physician certifications. I have read and understand this Notice of Privacy Practices and may request a copy containing a more complete description of the uses and disclosures of my health information. I understand it may be changed at any time and that I can receive a copy upon request. You have a right to receive confidential communications of your child's PHI. You may also request an accounting of disclosures of your PHI from this office. I understand that this office will provide this information within 30 days from receipt of written request and that a fee for this may be charged. I understand that I may register a complaint with this office if I suspect that my privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Dept. of Health & Human Services. You may speak with the Office Manager to obtain additional information regarding any questions you may have concerning this notice or to receive a printed copy of this notice. This Notice of Privacy Practices is effective as of April 14, 2003.

Text/Voice/Automated Messaging: I authorize Children's Health Mobile Messaging to send communications by text message, voice and automated calls to the cell phone number I provide. I acknowledge that message and standard data rates and fees will apply, message frequency rates may vary, full security is not guaranteed over telephone networks, and I will need to protect my phone with a password or PIN to prevent unauthorized access. I understand that text and automated messaging may not be used by me to notify of the patient's health care needs. Children's Health Mobile Messaging privacy policy and SMS terms of service are available at childrens.com/footer/policies-procedures. Text HELP to 77444 for mobile messaging assistance, or text STOP to 77444 to opt out of Children's Health Mobile Messaging.

Note: Recipients of text, voice and/or automated messaging may opt-out at any time. Reminders are included of how to opt-out upon initial text and annually thereafter.

PLEASE LIST FIRST AND LAST NAMES OF ANYONE WHO MAY BRING IN YOUR CHILD TO SEEK TREATMENT OR RECEIVE PHI:

1. _____ **3.** _____
2. _____ **4.** _____

Patient's Last Name _____ First Name _____

Patient's Last Name _____ First Name _____

Patient's Last Name _____ First Name _____

Patient's Last Name _____ First Name _____

Parent's Printed Name _____ Date _____

Parent's Signature _____