HIPAA Notice of Privacy Practices

This Notice of Privacy Practices outlines how Bee Well Pediatrics may use and disclose your Protected Health Information (PHI) according to the Health Insurance Portability and Accountability Act (HIPAA). It also describes your rights and our duties regarding your health information.

Our Commitment to Your Privacy

At Bee Well Pediatrics, we are committed to protecting the privacy of information we gather about you while providing health-related services.

Use and Disclosure of Your Health Information

- **Treatment:** Your PHI may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.
- **Payment:** Your PHI will be used, as needed, to obtain payment for the healthcare services provided to you. This may include activities such as billing and collection efforts.
- **Healthcare Operations:** We use and disclose PHI in performing various business activities, which may include quality assessments, employee reviews, training medical students, and conducting or arranging other business activities.
- **Business Associates:** We share your PHI with third-party business associates that perform various activities (e.g., billing, transcription services) for the clinic. We ensure all business associates agree to protect the privacy of your PHI.

For Appointment Reminders and Health-Related Benefits or Services:

- We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at our clinic.
- We may also use and disclose medical information to inform you about health-related benefits, services, or medical education classes that may be of interest to you.

Special Situations:

- **Public Health Risks:** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- **Health Oversight Activities:** We may disclose medical information to a health oversight agency for audits, investigations, inspections, or licensing.
- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information in response to a court or administrative order.

Your Health Information Rights

- **Right to Inspect and Copy:** You have the right to inspect and copy PHI that may be used to make decisions about your care.
- **Right to Amend:** You may ask us to amend your health information if you believe it is incorrect or incomplete.
- **Right to an Accounting of Disclosures:** You have the right to request an accounting of certain disclosures we have made of your PHI.
- **Right to Request Restrictions:** You may request that we restrict the use or disclosure of your PHI.
- **Right to Request Confidential Communications:** You can request that we communicate with you about medical matters in a certain way or at a certain location.

Changes to this Notice: We reserve the right to amend this Notice of Privacy Practices at any time in the future and will comply with the current notice in effect. A current version of this notice will always be available at our facility and on our website.

Privacy Officer Contact Information: For complaints regarding your PHI, please contact:

- **Privacy Officer:** Audrey Gilliam
- **Address:** 9362 Grand Cordera Parkway, Suite 205, Colorado Springs, Colorado 80924
- **Phone:** (719) 719-1233

Complaints: If you believe your privacy rights have been violated, you may file a complaint with us or with the Department of Health and Human Services, Office for Civil Rights. Complaints to the federal agency can be filed at the following website: www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html

Acknowledgement of Receipt:

I acknowledge that I have received the Notice of Privacy Practices from Bee Well Pediatrics.

Patient Name: _____ **Parent or Guardian Name**: _____

Signature: _____ **Date:** _____

Authorization for Use or Disclosure of Protected Health Information

I authorize Bee Well Pediatrics to use and disclose my health information for purposes of providing me treatment, processing my health insurance claims, and conducting healthcare operations.

Patient Name: _____ **Parent or Guardian Name**: _____

Signature: _____ **Date:** _____