



Notice of Patient Privacy Practices and Rights

Patient Information Consent Form
Notice of Patient Privacy Practices and Rights
PonyUp4Kids Foundation
2536 Wingdale Mountain Road
Poughquag, NY 12570
PU4K EAOT Director- Cathy Reid

This notice describes how medical information about your child may be disclosed and used and how you, the guardian, can access this information. Please read carefully.

Your basic rights and our basic responsibilities under HIPAA. As a Guardian of a patient of this practice, you have the right to obtain a copy of paper or electronic medical records, make corrections to the records, request confidential communication, request that we limit the information we share, get a list of entities with whom we have shared your child's information, get a copy of this notice, and file a complaint if you believe your child's privacy rights have been violated.

Get a copy (paper or electronic) of your child's records. We will provide a copy of your child's records and can charge you a reasonable, cost-based fee.

Ask us to correct your child's medical record. As a Guardian of a patient of this practice, you can ask us to correct health information about your child that you think is incomplete or incorrect.

Request preferred confidential communications. As a Guardian of a patient of this practice, you can ask us to contact you by a preferred method (i.e., Home/office/cell) or ask to send mail to a specified address. **Limit what we share or use.** As a Guardian of a patient of this practice, you can ask us not to share or use certain of your child's health information for our operations, treatment, or payment, although we are allowed to refuse your request if it would affect your child's care. If you pay for a service out of pocket in full, you can ask us not to share that with your health insurer, and we will comply unless a law requires us to share that information. **Get a list of those with whom we have shared information.** Upon request, as a Guardian of a patient of this practice, you are entitled to receive a list of the times we have shared your child's health information, who we shared it with, and why for up to six years prior to the date you asked. We will include all the disclosures except those about treatment, payment and health care operations, and certain other disclosures, such as any you requested. There is no charge for a yearly request of this list, but there is a reasonable cost-based fee if such a list is requested more than once in a 12 month period.

Get a hard copy of this privacy notice. Upon request, as a Guardian of a patient of this practice, you can receive a paper copy of this notice if you have previously received this electronically.

File a complaint if you think your rights are violated. If, as a Guardian of a patient of this practice, you feel your child's rights have been violated, please contact us (info on page 1). You can file a complaint with the US Dept of Health and Human Services Office of Civil Rights by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/, calling 877.696.6775, or writing to: US Dept of H and H Services, Office of Civil Rights, 200 Independence Avenue, S.W. Washington, D.C. 20201. We will not retaliate against you for filing a complaint.

Your Basic choices and our basic responsibilities as your child's guardian under HIPAA. For certain healthcare information, as a Guardian of a patient of this practice, you can tell us your choices about what we share. You can tell us whether to share information with your child's family, close friends, or others involved in your child's care. You can tell us whether to share information in a disaster relief situation. We will never share your child's information for the sale of the information or marketing purposes unless we have express written permission. We can contact you in the case of fundraising, but you can tell us not to contact you again.

Our use and disclosures of your child's health information to treat your child, run our practice, or bill for your child's services. We may use and share your child's health information to treat them and share it with others treating your child. Ex – a child, being treated by multiple therapists and disciplines. We can use and share your child's health information to run our practice, improve your child's care and contact you when necessary. We can use and share your child's health information to bill and get payment from health plans or other entities. Ex- we give information to your child's insurer so they will pay for our services.

Other ways we may share or use your child's health information. We are required (upon request) to share your child's information in other ways that contribute to the public good, such as public health and research. These conditions are stringent and regulated by many laws before any information can be shared. **Help with safety and public health issues.** We can share health information about your child for certain situations such as preventing disease, helping with a product recall, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or mitigating a serious threat to someone's health, or safety.

Do research. We can use or share your child's information for health research.

Respond to organ and tissue donation requests. We can share health information about your child with organ procurement organizations.

Work with a medical examiner or funeral director. We can share information upon request when an individual dies. Comply with the law, respond to any legal action. We will share information about your child if state or federal law requires it, including any audits conducted by the Dept. of Health and Human Services. We can share information about your child in response to a court or administrative order or in response to a subpoena.

Comply with worker's compensation, law enforcement, other gov't requests. Information about your child can be shared for worker's comp claims, law enforcement purposes, health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.

Blue Button protocol. Any patients with medical care managed by the Blue Button protocol can learn more about access to their health information at

<http://www.hhs.gov/digitalstrategy/open-data/introducing-blue-button-plus.html>

Summary of our responsibilities. We are required by law to maintain the privacy and security of your child's protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your child's information. We will give you a hard copy of this notice and follow the duties and privacy practices described in this notice. We will not use or share your child's information other than as described here unless you tell us we can in writing. You may also change your mind at any time and let us know in writing if you do. Add't info is available at:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the terms of this notice. We can change the terms of this notice, and the changes will apply to all information we have about your child. The new notice will be available upon request, on our website.

Effective date:

January 2026 PU4K EAT Director: Cathy Reid



PONY UP 4 KIDS

PATIENT INFORMATION CONSENT FORM

I have read and understand this practice's Notice of Patient Information Practices. I understand that the practice may use or disclose my child's personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. As my child's guardian, I understand that I have the right to restrict how my child's personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the company. I also understand that the Company will consider requests for restrictions on a case-by-case basis but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my child's personal health information for purposes as noted in the Company's Notice of Patient Information Practices. In doing so, I hereby release

_____ from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original.

I understand that I retain the right to revoke this consent by notifying the Company in writing at any time except for that action that has already been taken. It shall be effective only long enough to answer the purpose of which it is given, and no further confidential information will be released without the execution of an additional written authorization.

Patient and Parent/Guardian's Printed Name if Patient is under 18

Signature