THH PEDIATRICS
TENDER HEARTS & HANDS

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my child(ren)'s treatment and follow-up among the physicians of our practice as well as any specialists/physicians outside of our practice involved in the treatment directly or indirectly.
- Obtain payment for the services provided.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices written in plain language containing a more complete description of the uses and disclosures of my/my children's protected health information. I understand that THH Pediatrics has the right to change their Notice of Privacy Practices at any time and that I may contact the practice at any time to obtain a current copy of this notice. I further understand my individual rights and the process that needs to be taken if I have a complaint or concern about this policy.

I understand that the clinic has chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, my health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. I may "opt-out" and disable access to my health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

I understand that I may request in writing that THH Pediatrics restricts how the private information of my child(ren) is used or disclosed to carry out treatment, payment and healthcare operations. I also understand you are not required to agree to my requested restrictions.

Patient Name(s): _____

_____

_____

_____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY: I attempted to obtain a signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____