NW PEDIATRICS

INTEGRATIVE MEDICINE

NOTICE OF HIPAA PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: December 1, 2022

A. PURPOSE OF THIS NOTICE.

NW Pediatrics Integrative Medicine ("NWPIM") is committed to preserving the privacy of your health information. In fact, we are required by law to do so for any health information created or received by us. NWPIM is required to provide this Notice of Privacy Practices ("Notice") to you. The Notice tells you how we can and cannot use and disclose the health information that you have given to us or that we have learned about you when you were a patient in our system. It also tells you about your rights and our legal duties concerning your health information.

NWPIM is required to abide by this Notice. This Notice applies to the practices of:

- All NWPIM employees, contractors, volunteers, students and service providers, including clinicians, who have access to health information.
- Any health care professional authorized to enter information into your NWPIM health record.

For the rest of this Notice, "NWPIM," "we" and "us" will refer to all services, service areas, and workers of NWPIM. When we use the words "your health information," we mean any information that you have given us about you and your health, either in written, electronic or spoken words, as well as information that we have received while we have taken care of you (including health information provided to NWPIM by those outside of NWPIM).

B. USES AND DISCLOSURES OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS AT NWPIM.

1. Treatment, Payment and Health Care Operations.

The following section describes different ways that we use and disclose health information for treatment, payment and health care operations. Not every use or disclosure will be noted and there may be incidental disclosures that are a byproduct of the listed uses and disclosures. The ways we use and disclose health information will fall within one of the categories.

a. **For Treatment.** We may use your health information to provide you with health care services. We may disclose your health information to physicians, nurse practitioners, nurses, technicians and other personnel involved in your health care.
b. **For Payment.** We may use and disclose your health information so that we may bill and collect payment from you.
c. **For Health Care Operations.** We may use and disclose your health information in order to run the necessary administrative, educational, quality assurance and business functions at NWPIM.

2. Your Choices Regarding Disclosures.

a. **Family and Friends.** Unless you notify us that you object, we may provide your health information to individuals, such as family and friends, who are involved in your care or who help pay for your care. We may do this if you tell us we can do so, or if you know we are sharing your health information with these people and you don't stop us from doing so. There may also be circumstances when we can assume, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your information to your spouse if your spouse comes with you into the room during a consultation or visit. Also, if you are not able to approve or object to disclosures, we may make disclosures to a particular individual (such as a family member or friend), that we feel are in your best interest and that relate to that person's involvement in your care.
b. **Disaster Relief Situation:** You may choose to tell us to share your information in a disaster relief situation
c. **Fundraising Efforts:** We may contact you for fundraising efforts, but you can tell us to not contact you again.

C. OTHER PERMITTED USES AND DISCLOSURES OF HEALTH CARE INFORMATION.

We may use or disclose your health information without your permission in the following circumstances, subject to all applicable legal requirements and limitations:

1. **Required By Law.** As required by federal, state, or local law.

2. **Victims of Abuse, Neglect or Domestic Violence.** To a government authority authorized by law to receive reports of abuse, neglect or domestic violence or when we reasonably believe you are the victim of abuse, neglect or domestic violence and other criteria are met.
3. **Health Oversight Activities.** To a health oversight agency for audits, investigations, inspections, licensing purposes, or as necessary for certain government agencies to monitor the health care system, government programs, and compliance with civil rights laws.
4. **Lawsuits and Disputes.** In response to a subpoena, discovery request or a court or administrative order, if certain criteria are met.
5. **Law Enforcement.** To a law enforcement official for law enforcement purposes as required by law; in response to a court order, subpoena, warrant, summons or similar process; for identification and location purposes if requested; to respond to a request for information on an actual or suspected crime victim; to report a crime in an emergency; or to report a death if the death is suspected to be the result of criminal conduct.
6. **Serious Threat to Health or Safety.** To appropriate individual(s) when necessary to prevent a serious threat to your health and safety or that of the public or another person.
7. **Research.** We can use or share your information for health research.
8. **Respond to Organ and Tissue Donation Requests.** We can share information about you with organ procurement organizations.
9. **Medical Examiner.** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
10. **Public Health and Safety.** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, and/or reporting adverse reactions to medications.

D. WHEN WRITTEN AUTHORIZATION IS REQUIRED.

Other than for those purposes identified above in Sections B and C, we will not use or disclose your health information for any purpose unless you give us your specific written authorization to do so. You can withdraw this written authorization at any time. To withdraw your authorization, deliver or fax a written revocation to NW Pediatrics Integrative Medicine, LLC 11790 SW Barnes Rd. Bldg A Ste 149, Portland, OR 97006. If you revoke your authorization, we will no longer use or disclose your health information as allowed by your written authorization, except to the extent that we have already relied on your authorization.

E. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

You have certain rights regarding your health information, which we list below. In each of these cases, if you want to exercise your rights, you must do so in writing by completing a form that you can obtain from NWPIM. In some cases, we may charge you for the costs of providing materials to you.

1. **Right to Inspect and Copy.** With some exceptions, you have the right to inspect and get a copy of the health information that we use to make decisions about your care. For the portion of your health record maintained in our electronic health record, you may request we provide that information to or for you in an electronic format. If you make such a request, we are required to provide that information for you electronically (unless we deny your request for other reasons). We may deny your request to inspect and/or copy in certain limited circumstances, and if we do this, you may ask that the denial be reviewed.
2. **Right to Amend.** You have the right to amend your health information maintained by or for NWPIM or used by NWPIM to make decisions about you. We will require that you provide a reason for the request, and we may deny your request for an amendment if the request is not properly submitted, or if it asks us to amend information that (a) we did not create (unless the source of the information is no longer available to make the amendment); (b) is not part of the health information that we keep; (c) is of a type that you would not be permitted to inspect and copy; or (d) is already accurate and complete.
3. **Right to an Accounting of Disclosures.** You have the right to request a list and description of certain disclosures by NWPIM of your health information for six years prior to the date you ask.
4. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use.
5. **Right to Copy of this Notice.** You have the right to request a copy of this Notice.
6. **Right to Choose Someone to Act For You.** If you have a medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
7. **File a Complaint If You Feel Your Rights Are Violated.** You can complain if you feel we have violated your rights by contacting us using the information above. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr

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 you. The new notice will be available upon request, in our office and on our website.

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INTEGRATIVE MEDICINE

HIPAA PRIVACY PRACTICES CONSENT

SECTION A: PATIENT CONTACT INFORMATION

Name:_____ Date of Birth: _____

Address:_____

Telephone:_____E-mail:_____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to NW Pediatrics Integrative Medicine, LLC ("NWPIM") use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations (the "Consent") by NWPIM.

Notice of Privacy Practices: You have the right to read NWPIM's Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice of Privacy Practices provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

NWPIM may leave voicemails and send text messages, email or mail to the contact information provided above regarding my appointments, treatment or other protected health information related to my care with NWPIM _____ [***initial***]

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed below. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent and NWPIM Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to NWPIM's use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations. Send written revocation request to: Office Manager; 11790 Southwest Barnes Road Bldg A Ste 140, Portland, OR, 97006.

Patient Signature: _____ Date: _____

If this Consent is signed by a personal representative, parent or guardian on behalf of the patient, complete the following:

Personal Representative/Parent/Guardian Name:_____

Relationship to Patient:_____

Signature:_____