NOTICE OF PRIVACY PRACTICES - Effective Date: 4-14-03

PEDIATRIC MEDICAL GROUP of RIVERSIDE, INC.
6950 Brockton Avenue, Riverside, CA 92506
(951)686-8223

How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about your children and stores it in a chart or on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you (or your child, when he/she becomes 18 years old). The law permits us to use or disclose such health information for the following purposes:

1. **Treatment:** We use such information to provide medical care. We disclose information to our employees and others who are involved in providing the care your children need. For example, we may share medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a medication, or with a laboratory that performs a test.

2. **Payment:** We use and disclose medical information about your child to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided for your family members.

3. **Health Care Operations:** We may use and disclose your medical information to operate this medical practice. For example, we may need to use such information to get your health plan to authorize services or referrals. We may also share medical information with our "business associates", such as our billing service and answering service. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. We are required to share your information with health plans that have a relationship with you, when they request this information to help them with their quality review of competence, qualifications and performance of our staff.

4. **Appointment Reminders:** We may use medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine, or as a message left with the person answering the phone.

5. **Sign in Sheet:** We may have you sign in when you arrive at our office, or we may call out your name when we are ready to see you. If you feel that your privacy would be violated by such practices, please let the receptionist know when you arrive. We will assign you a number, and call your number when ready to see you.

6. **Communication with Family:** We may disclose your medical information to a friend or family member who is involved in your children's care, or who assists in caring for your children (such as grandparents or babysitters).

7. **Disclosures Required by Law:** As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or violence, we will comply. We will also use and disclose your health information in response to a court or administrative order, discovery request, subpoena, or other lawful process if you are involved in a lawsuit or similar proceeding.

8. **Serious Threats to Health or Safety:** We may use and disclose your health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. **Specialized Government Functions:** We may disclose your health information for military or national security purposes, when authorized by law.

10. **Workers' Compensation:** Our practice may release your health information for Workers' compensation and similar programs, when authorized by law.

Your rights regarding your medical information:

1. **Confidential Communications:** You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit. We reserve the right to accept or reject your request, and will notify you of our decision.

2. **Right to Inspect and Copy:** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California and federal law.

3. **Right to Amend or Supplement:** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, but you may add to your a record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

4. **Right to an Accounting of Disclosures:** You have a right to obtain a list of any non-routine disclosures our practice has made of your medical information.

5. **Right to a Paper Copy of this Notice:** You are entitled to receive a paper copy of this Notice of Privacy.

6. **Right to File a Complaint:** If you believe your privacy rights have been violated, you should contact our Privacy Officer (Donald Boone). All complaints must be submitted in writing. You will not be penalized for filing a complaint. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

Department.of Health & Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Washington, DC 20201

TIMOTHY MACKEY M.D.
ALAN KWASMAN M.D.

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Acknowledgement of Receipt of Notice of Privacy

I hereby acknowledge that I received a copy of this Medical Group's *Notice of Privacy Practices*. I further acknowledge that a copy of the current notice will be posted in the Reception Room area, and that I will be offered a copy of any amended *Notice of Privacy Practices* at each appointment.

Signed:_____Date:_____

Printed Name: _____

Relationship to Patient: _____