Harvest Pediatrics

Comprehensive Health Care for Infants, Children & Adolescents

PATIENT PRIVACY NOTICE

OUR PLEDGE TO YOU

We understand that medical information about you is private and personal. We are committed to protecting it.
Doctors and other staff make a record each time you visit our office. This notice applies to the records of your care at Harvest Pediatrics, whether created by your doctor or other staff.
We are required by law to:

* Keep medical information about you private.
* Give you this notice describing our legal duties and privacy practices for medical information about you.
* Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND SHARE YOUR MEDICAL INFORMATION

This section of our notice tells how we may use medical information about you. In all cases not covered by this notice, we will obtain a separate written permission from you before we use or share your medical information. You can later cancel your permission by notifying us in writing. We will protect medical information as much as we can under the law. Sometimes State law gives more protection to medical information than Federal law. Sometimes Federal law gives more protection than State law. In each case, we will apply the laws that protect your medical information the most.
Treatment: We will use and share medical information about you for purposes of treatment.
Payment: We will use and share medical information about you so we can be paid for treating you.
Healthcare Operations: We will use and share medical information about you for the purpose of improving our healthcare operations.
Appointment Reminders: We may contact you with appointment reminders.
Treatment Options and Health-related Benefits and Services: We may contact you regarding possible treatment options, health-related benefits or services that you might want.
Public Health: We will report certain medication information for public health purposes.
Required by Law: We are sometimes required by law to report certain information.
Public Safety: We may, and sometimes have to, share medical information about you in order to prevent or lessen a serious threat to the health or safety of a particular person or the general public.
Coroners, Medical Examiners and Funeral Directors: We may share medical information about deceased patients with coroners, medical examiners or funeral directors.
Organ and Tissue Donation: We may use or share medical information with organizations that handle organ, eye or tissue donation or transplantation.
Military, Veteran, National Security and Other Government Purposes: We may use or share medical information about you for national security purposes.
Judicial Proceedings: We may share medical information about you in response to court orders or subpoenas only when we have followed procedures required by law.
Law Enforcement: We may share medical information about you with police without your written permission.
Family Members and Others Involved in Your Care: Unless you tell us otherwise, we may share medical information about you with family members or others you have named who help with your medical care.

YOUR RIGHTS REGARDING MEDICAL INFORMATION

Requesting Information About You: You can look at, or get a copy of medical information about yourself.
Correcting Information About You: If you believe that information about you is wrong or missing, you can ask us in writing to amend the records. We do have the right to deny this request.
Restricting How We Use or Share Information About You: You can ask that medical information be given to you in a confidential manner. You must tell us in writing of the exact way or place for us to communicate with you.

DO YOU HAVE CONCERNS OR COMPLAINTS?

If you believe your privacy rights may have been violated, you may contact our Chief Privacy Officer, below:
Linda Simas
Office Manager, Harvest Pediatrics
1100 Trancas St., Suite 270, Napa, CA 94558
707-252-1076

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HIPAA AUTHORIZATION FORM

Patient Authorization for Use and Disclosure
of Protected Health Information

By signing, I authorize Harvest Pediatrics to use and/or disclose certain protected health information about me to insurance carriers, other physicians, or agencies to whom a referral for care may be made.

This Authorization permits Harvest Pediatrics to use and/or disclose the following individually identifiable health information about me, including but not limited to, dates of services, types of services and diagnosis rendered.

I acknowledge that by signing I authorize Harvest Pediatrics to receive payment from a third party (insurance) in exchange for using or disclosing the Protected Health Information.

I do not have to sign this Authorization in order to receive treatment from Harvest Pediatrics. I have the right to refuse to sign this Authorization. When my information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this Authorization. My written revocation must be submitted to the Privacy Officer at Harvest Pediatrics.

I also acknowledge that by signing, I authorize Harvest Pediatrics to leave Protected Health Information on a secured voicemail, i.e., lab results and appointment confirmation calls.

_____	_____
Signature of Patient or Legal Guardian	Relationship to Patient
_____	_____
Please Print Patient's Name	Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

I hereby acknowledge that I have received a copy of Harvest Pediatric's Notice of Privacy Practices.
I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____

Signature of Patient or Legal Representative Date

_____

Printed Name of Patient's Representative (if applicable)

Relationship to Patient (if applicable)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice Privacy Practices on the following date,

_____ but acknowledgement could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (explain):

_____

_____

_____

_____

_____

- ☐ Other (specify):

_____

_____

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