NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

BROCKTON PEDIATRICS is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:
We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered, and by administrative personnel reviewing the quality of the care you received. We may also use and /or disclose your information in accordance with federal and state laws for the following purposes:

Appointment Reminders:
We may contact you to provide appointment reminders

Treatment Information:
We may use health information about you to provide you with medical treatment and services. We may disclose health information and demographic information about you to doctors, nurses, technicians, medical students, interns or other personnel who are involved in taking care of you during your visit with us.

Payment:
We may use and disclose health information about you so the treatment and services you receive at BROCKTON PEDIATRICS may be billed to and payment collected from you, an insurance company, or a third party. This may also include the disclosure of health information to obtain prior authorization for treatment and procedures from you insurance plan.

Family and Friends:

☐ We may disclose your health information to individuals, such as **family members and friends**, who are involved in your care, or who help pay for your care.

☐ We also may share your health information with a family member or friend who calls us to request a prescription refill on your behalf.

AUTHORIZATIONS:
We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. To request a Revocation of Authorization form, you may contact:

BROCKTON PEDIATRICS, INC
65 LIBBY STREET
BROCKTON, MA 02302
508-584-6060

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:
You have the following rights with respect to your medical information:

☐ You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.

☐ You have the right to receive communications from us in a confidential manner.

☐ Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.

☐ You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.

☐ You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.

☐ You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way

I acknowledge that I was provided with a copy of the BROCKTON PEDIATRICS Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that BROCKTON PEDIATRICS continues to its good faith effort to comply with the requirements of the Federal privacy law, I hereby consent to the use and disclosure of my Health Information for the purposes and the activities permitted under the federal privacy law.

I AUTHORIZE BROCKTON PEDIATRICS to discuss health information with the following:

MOTHER: ( ) YES ( ) NO
FATHER: ( ) YES ( ) NO

SCHOOL NURSE: ( ) YES ( ) NO
SCHOOL: ( ) YES ( ) NO
LEGAL GUARDIAN: ( ) YES ( ) NO

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Patient's name (please print)

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Parent/Legal Guardian Signature

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Patient's Signature (over 18)

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Date

____
Patient's DOB