LYNDON PEDIATRIC ASSOCIATES, LLP

6851 EAST GENESEE STREET

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Tel: 315-446-4580 Fax: 315-446-3426

**PRIVACY POLICIES**

It is the policy of our practice that all physicians and staff preserve the dignity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not fear about providing information to our practice and its physicians and staff for purposes of treatment, payments and healthcare operations (TPO). To that end, our practice and its physicians and staff will:

\*Adhere to the standards set forth in the Notice of Privacy Practices.

\*Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of Practice’s TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.

\*Adhere to prohibiting the sale of PHI in the absence of the patient’s written authorization.

\*Adhere to limiting of circumstances when physicians may provide marketing communications to their patient in the absence of patient’s written authorization.

\*At the patient’s request, physicians and staff may not disclose information about care the patient has paid for out-of-pocket to health plans unless for treatment purposes or in the rare event the disclosure is required by law.

\*Recognize that PHI collected about patients must be accurate, timely, complete and available when needed.

\*Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.

\*Not disclose PHI data unless the patient (or authorized representative) has properly consented to or authorized the release or the release is authorized by law.

\*Report breaches of unsecured patient PHI, as those defined in “Breach Notification for Unsecured Protected Health Information” published on 8/24/09 pursuant to the HITECH Law (Health Information Technology for Economic and Clinical Health) part of the American Recovery and Reinvestment Act of 2009, as modified by the HIPAA Omnibus Regulation published 1/26/13, will be investigated in accordance with the guidelines published therein and our separated written policies.

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

With my consent Lyndon Pediatric Associates may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Lyndon Pediatric Associates’ Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Lyndon Pediatric Associates reserves the right to revise its Notice of Privacy Practices anytime. A copy Notice of Privacy Practices may be obtained by sending written request to Lyndon Pediatric Associates privacy officer.

With my consent, Lyndon Pediatric Associates may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. Lyndon Pediatric Associates may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

Lyndon Pediatric Associates may disclose immunization records, PE forms, therapy referrals, medication permission slips, etc. to schools via fax at the parent’s request.

By signing this form, I am consenting to Lyndon Pediatric Associates’ use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Lyndon Pediatric Associates may decline to provide treatment to me.

Parent or Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date conceived:3/03, 9/13