

**This notice describes how information about you may be used and disclosed and how you can gain access to this information.
Please review it carefully**

NOTICE OF INFORMATION PRACTICES

1. NADAL PEDIATRICS may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, requested preschool, life insurance or sports physicals, referral to nursing homes, foster care homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; and collection agencies. Healthcare operations includes, but is not limited to, internal quality control and assurance including auditing of records.
2. NADAL PEDIATRICS is permitted or required to use or disclose protected health information without the individuals written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.
3. NADAL PEDIATRICS will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.
4. NADAL PEDIATRICS may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that may be of interest to the individual patient.
5. NADAL PEDIATRICS will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.
6. NADAL PEDIATRICS reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information of the patient. Copies may also be obtained at any time at our offices.
7. NADAL PEDIATRICS will provide each patient with a copy of any revisions of it's Notice of Information Practice at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.
8. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the following address and/or phone number: 621 Victoria Street, Brandon, Florida 33510, (813) 655-0292. All complaints will be addressed and results will be reported to the Corporate Compliance Officer.
9. It is NADAL PEDIATRICS 's policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.
10. The name, title and telephone number of a person in the office to contact for further information is the Privacy Officer, (813) 655-0292.
11. The effective date of this Notice is April 1, 2003.

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH
INFORMATION
FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS**

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I understand that as part of my healthcare, NADAL PEDIATRICS originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

Notification of Family Members: Please share information with _____

_____.

I request the following restrictions to the use or disclosure of my health information.

Signature of Patient or Legal Representative

Date

Signature

Title

Date