the solo practices of
Jo Anne Nielsen MD, PC; James Resk MD, PC;
Troy Stoeber MD, LLC; Kristine Uyesugi MD, LLC;
14279 S. Glen Oak Road Oregon City, OR 97045
Phone: 503-657-7629 Fax: 503-557-8651

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. The clinic is required by law to maintain your privacy. This notice describes how we may use or disclose your health information. We are required by law to give you this notice, and we are required to follow the terms of this notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION

Treatment. We may use or disclose health information about you to provide you with treatment or other services. For example, information may be shared with the clinic doctors, nurses, medical assistants and other healthcare personnel. We may also share information with providers at another clinic or hospital that will be seeing you for treatment purposes.

Payment. We may use or disclose your health information to get payment for the services that you receive at the clinic. For example, we may provide information to your health plan in order to obtain payment for the care that we provided to you.

Healthcare Operations. We may use or disclose your health information for healthcare operations. Healthcare operations include quality improvement for the services you receive at our clinic. We may also give information about you to Children's Health Alliance for population based activities to improve the health of our patients. Healthcare Operations includes reporting information for public health activities, such as immunization reporting and communicable disease reporting.

Your health information may be shared by Drs. Nielsen, Resk, Stoeber, and Uyesugi with other providers when necessary for health care operations purposes of the clinic.

Appointment Reminders. We may call, text, email or mail you a letter to remind you that you have an appointment at the clinic, unless you tell us not to.
Treatment Alternatives. We may use your health information to tell you about services that may be of interest to you.
Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or other people who are involved in your health care. You have the right to object to the sharing of your information.
Public Health Activities. We may use or disclose health information about you for public health activities required or permitted by law.
Victims of Abuse, Neglect or Domestic Violence. If we suspect abuse, neglect or domestic violence, we may disclose health information about you as required or permitted by law.
Health Oversight Activities. We may give health information to a health oversight agency that monitors the State health care delivery system.
Judicial and Administrative Proceedings. We may disclose health information about you in response to a court order.
Law Enforcement. We may disclose health information about you when required or permitted by Federal or State law.
Required by Law. We may disclose health information about you when we are required to do by Federal or State law.
Coroners. We may disclose your health information to a coroner, medical examiner or funeral director as authorized by law.
Organ and Tissue Procurement. We may disclose your health information to organizations for organ, eye or tissue procurement, tissue banking or transplantation.
Research. We may disclose your health information for research purposes if you have signed an authorization to disclose your information, or if an Institutional Review Board has waved that requirement.
Health or Safety. We may disclose your health information to law enforcement in order to avoid a serious threat to the health and safety of a person, or the public.
Worker's Compensation. We may disclose your health information as authorized by law to the Worker's Compensation Program.

Specialized Government Functions. We may disclose your health information to government agencies with special functions as required or permitted by law.

DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Marketing. We may communicate with you about products or services related to your treatment, case management or care coordination. However, we must obtain your authorization prior to using your health information to send you any marketing material that results in payment to us that is above and beyond the cost of providing the service for our clinic. **Sale of Protected Health Information.** We are required to obtain your authorization for the sale of your protected health information in exchange for payment.

Other Laws Protecting Health Information. Other laws may require your written authorization to disclose certain mental health, alcohol and drug treatment, HIV/AIDS testing or treatment and genetic testing information.

Other uses and disclosures not described in this notice will be made only with your written authorization.

YOUR PROTECTED HEALTH INFORMATION PRIVACY RIGHTS

Right to Inspect and Copy. You have the right to look at or get copies of your records. You must make that request in writing. You may be charged a fee for copying your records; however, if you are unable to pay, we won't restrict your right to obtain copies. You also have a right to request your records in an electronic format.

Right to Request an Amendment. You have the right to request that we amend your health information that we maintain in your medical record or billing records. You must request the change in writing. We may deny your request under certain circumstances.

Right to a List of Disclosures. You have the right to be notified following any unauthorized disclosure of your protected health information. It is the intention of our clinic to notify affected individuals immediately following the discovery of a breach of protected health information. You also have the right to ask for a list of certain disclosures of your health information that occurred after February 2006. The list will not include disclosures that were made with your authorization.

Right to Opt Out of Fundraising Campaigns. Some clinics participate in fundraising activities using individuals' names and treatment dates. If our clinic chooses to participate in any fundraising campaigns using your information, you will be sent a notice about the fundraising activity and you will be given an opportunity to tell us that you don't want your information used that way. Doing that will mean that you have opted out of participating. You may also request to opt out of all future fundraising communications, but if you do that, you will need to opt back in if you change your mind, by sending us a letter telling us that you would like to start getting those letters or notices, again.

Right to Request Restrictions. You have the right to request restrictions on how your information is used or disclosed. You must make your request in writing. This includes your right to limit disclosure of information for treatment or services you (or a family member or friend) paid for in-full out of your own pocket. This does not include services that have been paid for in-whole or in-part by your health plan.

Right to Request Confidential Communications. You have the right to request to receive communications from us in a certain way or to a certain place in order to protect your confidentiality. We will accommodate reasonable requests.

Right to Revoke Your Authorization. You have the right to revoke an authorization that you previously made for release of your health information. In situations where we may have already released your health information, we cannot take the information back. However we will stop releasing any more of your information.

Right to Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this notice at any time.

Complaints. You have the right to file a complaint with The Compliance Officer who is the clinic's Office Manager. You may also file a written complaint with the Secretary of the Department of Health and Human Services in Washington, DC. We will not retaliate against you if you file a complaint.

EFFECTIVE DATE OF THIS NOTICE

This notice is effective on 4/1/2003 and revised 05/08/18. We reserve the right to change this notice. If we change the notice, we will post a current copy of the notice, and will make a copy of the new notice available to you.

FOR MORE INFORMATION

For more information about this notice, or if you need more information, please contact the clinic's Office Manager.

the solo pediatric practices of
JO ANNE NIELSEN, MD, PC; JAMES RESK, MD, PC; TROY STOEBER, MD, LLC; KRISTINE UYESUGI, MD, LLC
14279 S Glen Oak Road - Oregon City, OR 97045-8008
Telephone: 503-657-7629 Facsimile: 503-557-8651

PATIENT NAME: **DOB:**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices for the solo pediatric practices of Doctors Nielsen, Resk, Stoeber, and Uyesugi.

_____
Print Name of Patient

_____
Signature of Parent or Legal Guardian

_____
Relationship to Patient

THIS SECTION TO BE COMPLETED BY OFFICE STAFF ONLY

ATTEMPT TO OBTAIN AN ACKNOWLEDGMENT OF THE RECEIPT OF NOTICE OF PRIVACY PRACTICES

An attempt was made to obtain an acknowledgment of receipt of the Notice of Privacy Practices on ____/ ____/ ____. The acknowledgment was not obtained for one of the following reasons:

[ ] The parent or legal guardian declined to sign the acknowledgment [ ] Other

SIGNATURE OF STAFF

_____
Print Name of Patient

_____
Print Name of Staff Member

_____
Signature of Staff Member Date