NOTICE OF PRIVACY PRACTICES

Margiotti & Kroll Pediatrics, PC ("Provider") is dedicated to protecting your child's health information. Provider is required by law to maintain the privacy of Protected Health Information (PHI), to provide you adequate notice of your rights and our legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. PHI is defined to include past, present, and future information created or received by Provider. It also includes demographic information that may identify your child and that relates to your child's past, present, or future medical condition (physical or mental), the provision of health care to your child, or payment for health care treatment.

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND YOUR RIGHTS WITH REGARD TO YOUR CHILD'S HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHAT INFORMATION DOES THIS NOTICE CONCERN:
We are required by law to protect the privacy of your child's health information and to provide you with a Notice of Privacy Practices (the "Notice") describing our privacy practices, legal responsibilities, and your rights regarding your child's PHI. This information includes your child's individually identifiable information, insurance and payment information, and medical information such as diagnosis, medications, medical billing history, address, and social security number that are related to past, present, or future health care services provided by us. Provider maintains a record of the information we receive and collect about your child and of the care we provide to them. This record may include physicians' orders, assessments, medication lists, clinical progress notes, and billing information.

This Notice of Privacy Practices describes how we may use and disclose your child's PHI to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights regarding your child's PHI.

As required by law, Provider maintains policies and procedures about our work practices, including how we coordinate care and services provided to our patients. These policies and procedures include how we create, receive, access, transmit, maintain, and protect the confidentiality of all health information in our workforce and with contracted business associates and/or subcontractors, security of Provider's building and electronic files, and how we educate staff on privacy of patient information.

This Notice is organized into the following parts:

1. Permitted and Required Uses and Disclosures
2. Additional Permitted Uses and Disclosures
3. Uses and Disclosures to Which You May Object
4. Other Uses and Disclosures
5. Rights Regarding Your Child's Medical Information
6. Our Practice's Legal Duties
7. Complaints
8. Changes to this Notice

1. **PERMITTED AND REQUIRED USES AND DISCLOSURES**
   As our patient, information about your child must be used and disclosed to other parties for purposes of treatment, payment, and health care operations. Examples include:
   - **Treatment:** We may use your child's health information to provide, coordinate, or manage their medical treatment or services. This may involve disclosing your child's medical information to doctors, nurses, technicians, or other Provider employees or contractors who are involved in providing health care to your child. For example, we may share your child's health information with another provider for a consultation or referral for further treatment.
   - **Payment:** We may use and disclose your child's information to bill for medical treatment and services and receive payment from you, insurance companies, or third parties. For instance, we may need to provide

information to your health plan about treatment your child received so that the health plan will pay us or reimburse you.

- **Health Care Operations:** We may use and disclose information about your child for our health care operations, including accounting, general administrative functions, and ensuring quality care through staff and physician performance evaluations.

2. ADDITIONAL PERMITTED USES AND DISCLOSURES

We may use or disclose information about your child without consent or authorization in the following circumstances:

- Appointment reminders
- Treatment alternatives
- Emergency situations
- When required by law
- Research purposes (if authorized)
- Public health reporting
- Health care oversight
- To business associates for contracted services (e.g., software vendors, accountants)
- In lawsuits or disputes (e.g., subpoenas)
- Law enforcement purposes
- For organ or tissue donation
- To avert a serious threat to health and safety

3. USES AND DISCLOSURES TO WHICH YOU MAY OBJECT

We may use or disclose information provided that you are informed in advance and given the opportunity to object, such as:

- Sharing proof of immunization with schools (with consent)
- Communicating with you by encrypted email or text
- Use of medical information for fundraising purposes (opt-out available)

4. OTHER USES AND DISCLOSURES

Other uses and disclosures not covered in this notice will be made only with your written authorization, such as:

- Marketing communications
- Psychotherapy notes
- Sale of PHI for financial gain

5. RIGHTS REGARDING YOUR CHILD'S MEDICAL INFORMATION

You have the right to:

- Request restrictions on uses and disclosures
- Request confidential communications
- Access, inspect, and copy your child's medical information
- Request amendments to medical records
- Receive an accounting of disclosures
- Be notified of any breaches involving your child's PHI

6. OUR PRACTICE'S LEGAL DUTIES

We are required to:

- Maintain the privacy of your health information
- Provide you with this notice of our legal duties and privacy practices
- Follow the terms of the current Notice of Privacy Practices
- Implement additional security measures to protect electronic health information (ePHI), including:
    - Multifactor Authentication (MFA) for accessing ePHI

- Data encryption for both data at rest and in transit
- Periodic risk assessments to identify and mitigate security vulnerabilities
- Network segmentation to limit the spread of potential data breaches

7. COMPLAINTS

If you believe your child's privacy rights have been violated, you may file a complaint with the Provider or the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

8. CHANGES TO THIS NOTICE

This notice has been updated effective December 2024. We reserve the right to amend this notice at any time. You may request a current copy at any time by contacting our office or visiting our website. For additional information, please contact:

Privacy Officer
Margiotti & Kroll Pediatrics, P.C.
4829 Street Road, Suite 100
Trevose, PA 19053
215-364-5800
www.mkpeds.com

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act off 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand the Notice of Privacy. I understand that Margiotti & Kroll Pediatrics, PC has the right to change its Notice of Privacy Practices. I understand that I may request in writing that Margiotti & Kroll Pediatrics can restrict how my information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that Margiotti & Kroll Pediatrics is not required to agree to my requested restrictions. I understand that this assignment will remain in effect until revoked by me in writing or when the patient reaches the age of eighteen.

I certify that I have been offered and/or have received a copy of Margiotti & Kroll Pediatrics, P.C.'s Notice of Privacy Practices.

Patient/Parent/Guardian Signature:	Date:

Notice of Privacy Practices

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION		
(Complete to permit the disclosure of information to Outside Entity OR Parent/Guardians if Patient is over 18 years of age) Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164		
Patient's Last Name:	First Name:	Date of Birth:

1. AUTHORIZATION:

By signing this authorization, I authorize Margiotti & Kroll Pediatrics, P.C. to use and/or disclose certain protected health information (PHI) about me to:

Name of Person/Entity **Receiving** Information:	Relationship to Patient: (if applicable)

2. EFFECTIVE PERIOD:

This authorization for release of information covers the period of healthcare from:

A:	☐	Start Date:	End Date:
****OR****			
B:	☐	All past, present, and future periods.	

3. EXTENT OF AUTHORIZATION :

A:	☐	I authorize the release of my complete health record (including but not limited to records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
****OR****		
B:	☐	I authorize the release of my complete health record with the exception of the following information:
		☐ Mental health records; ☐ Communicable diseases (including HIV and AIDS); ☐ Alcohol/drug abuse treatment; ☐ Other (Please specify): ____________________

1. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct;
2. This authorization shall be in force and effect until ______________________ (date or event), at which time this authorization expires;
3. I understand I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage at the insurer has a legal right to contest a claim;
4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization;
5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient/Guardian/Personal Representative/ Signature:	Date:
Printed Name of Patient/Guardian/Personal Representative:	Relationship to Patient:
Patient Email Address:	Patient Phone Number: