



Benton Pediatrics, Inc.

Board Certified Pediatrics

5612 N.W. 43rd Street • Gainesville, FL 32653-3332 • (352) 376-4542

HIPAA Protected Health Information (PHI) Notice of Privacy

Patient Name _____ Date of Birth _____

As a patient at Benton Pediatrics you have the right to:

- Access your Protected Health Information (PHI)
- Request restrictions in the use disclosure of your PHI
- Request an amendment to your PHI
- Request an accounting of disclosures
- File a complaint
- Receive a Notice of Privacy Practices

I. Benton Pediatrics is morally, ethically, and legally obligated to protect patient privacy by guarding the confidentiality of patient information and by maintaining its integrity. We are also committed to preserving the patient's rights related to privacy. The patients' protected health information (PHI) will not be used without the patient's authorization for any purposes other than Treatment, Payment, and/or Health Care Operations.

II. Benton Pediatrics commits:

- To use or disclose protected health information only for work-related purposes.
- To limit uses and disclosures to the "minimum necessary" to achieve those work purposes. (Minimum necessary rules do not apply to disclosures to a health care provider for treatment.)
- To exercise reasonable caution, to protect all PHI under our control.
- To offer a process to handle privacy-related problems and complaints and to receive and manage requests for access to records, restrictions of uses, and amendments to records.
- To try to remedy any privacy problems.
- To get specific authorization for certain additional kinds of uses and disclosures, beyond those for treatment, payment or basic health care.
- To undertake the additional uses and disclosures permitted or required by law in an appropriate manner such as reporting child abuse.
- To maintain privacy records or documentation at least six years.
- To train all members of the workforce in those policies "as necessary and appropriate" to their job duties.
- To get assurances from any business partners or vendors that handle PHI on the covered entity's behalf.

Today's Date _____ Subscriber _____

Responsible Party _____

Printed Name

Signature

Original signature on file at physician's office