Children's Community Practices

An Affiliate of Nationwide Children's Hospital

Patient Information Form:

Please Print and fully complete

Patient Information:
First Name _____ Middle Initial _____ Last Name _____
Address _____ City _____ State _____ ZIP _____
DOB _____ Sex: □ Male □ Female Phone# _____

Parent or Legal Guardian Information:
First Name _____ Last Name _____ DOB _____
Address _____ City _____ State _____ ZIP _____
Home Phone _____ Cell Phone _____ Work Phone _____
E-Mail _____ SSN _____ Relationship to Patient _____
Employer _____
Child lives with □ Mother □ Father □ Grandparent □ Foster parent □ Legal Guardian □ Other

Parent or Legal Guardian Information:
First Name _____ Last Name _____ DOB _____
Address _____ City _____ State _____ ZIP _____
Home Phone _____ Cell Phone _____ Work Phone _____
E-Mail _____ SSN _____ Relationship to Patient _____
Employer _____

Primary Insurance: Is this an affordable care marketplace plan? Y N If yes, please stop and see the front desk
Insurance Name _____ Address _____
Policy Holder _____ DOB _____ Employer _____
ID# _____ Group# _____ SS# (If needed for billing) _____

Secondary Insurance: Is this an affordable care marketplace plan? Y N If yes, please stop and see the front desk
Insurance Name _____ Address _____
Policy Holder _____ DOB _____ Employer _____
ID# _____ Group# _____ SS# (If needed for billing) _____

Please list all children in your family who come to this practice:
_____ DOB _____ _____ DOB _____ _____ DOB _____
_____ DOB _____ _____ DOB _____ _____ DOB _____
Preferred E-Mail for the patient portal: _____
Preferred Pharmacy: _____ Address _____ Phone _____

Emergency Contact: Name _____ Relationship _____ Phone _____

How were you referred to this practice? □ Existing patient □ Physician Name of patient/physician _____
□ Newspaper □ Telephone □ Internet □ Website □ Insurance company □ Other _____

I authorize the providers of the practice to provide any medical care deemed necessary according to their professional opinion. I authorize my insurance benefits to be paid directly to the practice. If my insurance company rejects or allows only part of the claim for services, I shall be responsible for payment of the balance due and will pay the balance within thirty (30) days.

Printed name of patient or parent/guardian Signature Date

Patient Policies

Missed Patient Appointments

Our office will do it's best to make reminder calls and text messages 7 days and twenty-four (24) hours prior to your scheduled appointment. If you are unable to make your scheduled appointment, you must call and cancel that appointment at least twenty-four (24) hours in advance of your appointment. If your appointment is on Monday, you may leave a message. If appropriate notification is not given, or you do not show up for your appointment, you may be charged a fee.

Forms

Forms for physicals, daycare, simple school forms, work permits, medication, etc. when presented at the time of your child's appointment the provider will complete and sign without a charge. If presented later outside of an appointment, there may be a $25 charge. For FMLA forms, a $25 will always be charged. Please allow up to five (5) working days for these forms.

Prescription refill

Please allow forty-eight (48) business hours (i.e. not Saturday, Sunday or holidays) when calling for a prescription refill.

Insurance Information

At each appointment, you will be asked to verify your insurance information and effective date. Please make sure you bring your child's up to date insurance card to each appointment. If your insurance is no longer in effect, you will be responsible for the visit charge.

Non-emergent after hour calls

Our office provides after hour coverage for emergent sick calls that cannot wait until the next business day. Please leave a reliable phone number where you can be reached, so your child may receive immediate care.

Patient Portal Access:

The practice offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool but has certain risks. In order to manage these risks, we need to impose some conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Someone who knows the right password or pass- phrase to log in to the portal site can only read secure messages and information. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect, and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

1. Please make sure we have your correct email address and inform us if it ever changes.
2. Also, keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

You may receive bills from Nationwide Children's Hospital for services received by Children's Community Practices.

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Helping Hand™ *Health Education for Patients and Families*

Designation of Another Person to Consent for Treatment

It is best that children are brought for treatment by a parent or legal guardian. However, there may be times when that is not possible and you need others (babysitter, friend, or family member) to act on your behalf.

Should your child need to be seen at Nationwide Children's Hospital, we must have **your written consent** to allow the person you select to seek treatment and sign the consent form. **This person must be 18 years of age or older.**

Please complete the following:

I, (Full Name of Parent or Legal Guardian) _____

(Address) _____

(Home Phone) _____ (Mobile Phone) _____

(Work Phone) _____

(Child's Full Name) _____

(Child's Date of Birth) _____

I give the following person(s) permission to seek treatment and provide consent for such treatment on my behalf.

_____ _____

Full name Relationship

_____ _____

Full name Relationship

My permission for the people listed above begins on the date of my signature below. It will stay in force until cancelled by me in writing. You may e-mail your request to cancel to the Health Information Management Department at HIMMedicalRecordSupportServices@nationwidechildrens.org. For fastest service, please attach a copy of this original Designation form with your e-mail.

X_____ _____

Signature of Parent/Legal Guardian Date and time (required)

Completing the attached medical history sheet, while not required, can be a helpful communication tool between you and your child's provider in your absence.

DO NOT FORGET!!! Make copies of this form and the medical information sheet if you choose to complete it. Provide them to your designated person(s) to bring to your child's visit to Nationwide Children's. Keep a copy for yourself. Put it in a safe place.

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO NATIONWIDE CHILDREN'S HOSPITAL

I hereby authorize (Indicate name facility/organization/person)_____

at (Address of organization) _____
to release my protected health information as instructed below.

Patient Name: _____ Date of Birth:_____

To assist us in easily matching your information to our chart
please verify that the child's name and date of birth are recorded on all documents you send.

Please send the medical records to Nationwide Children's via the following method: Upper Arlington Pediatrics 4919 Dierker Rd. Columbus, OH 43220.

Mail: ATTN: UAP Records Department c/o ~~Nationwide Children's, 700 Children's Drive, Columbus, OH 43205~~
Indicate department/unit/person - Bldg/Room Number or Patient Unit

OR FAX: To the Attention of: UAP Records Department. Fax number (including area code) 614·457·5982
Indicate department/unit/person - Bldg/Room Number or Patient Unit

Description of Record(s) to be Released to Nationwide Children's, Columbus, OH
Check all that apply & specify dates:
- ❑ Inpatient record(s) including psychiatric, drug, alcohol, and/or HIV/AIDS information. _____
- ❑ Discharge Summary(ies) including psychiatric, drug, alcohol, and/or HIV/AIDS information. _____
- ❑ Emergency department record(s) including psychiatric, drug, alcohol, and/or HIV/AIDS information. _____
- ❑ Clinic records (**please specify exact location and dates**) including psychiatric, drug, alcohol, and/or HIV/AIDS information. _____
- ❑ Other Outpatient record(s) including psychiatric, assessment & counseling, drug & alcohol, and/or HIV/AIDS information. _____
- ❑ Other information including psychiatric, drug, alcohol, and/or HIV/AIDS information (**please be specific**)_____

_____

Specify Date(s)_____

_____

The purpose of the authorized use or disclosure of the information described above is as follows:

❑ Medical Evaluation/Treatment ❑ Transfer of Records to New Treatment Provider ❑ Insurance Review or Dispute
❑ Attorney Review ❑ School Examination ❑ Personal Use
❑ Other (be specific) _____

Other Information:

1. As described in the Notice of Privacy Practices of Nationwide Children's, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Nationwide Children's in reliance on this authorization, by sending a written revocation to Nationwide Children's Health Information Management Department 700 Children's Drive, Columbus, OH 43205.

2. I understand that I am not required to sign this authorization form and that Nationwide Children's will not condition the provision of treatment or payment to me on the signing of this form.

3. I understand that if the person or entity that receives the above information is a not a health care provider covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

4. This authorization will automatically expire in 60 days if no expiration option is checked below:
   * Expire immediately upon receipt of information by Nationwide Children's
   * Other (insert applicable date or specific event) _____

Signature of Parent/Legal Guardian (include relationship to patient)_____ Date/Time _____

Full Address _____

Home Phone Number _____

Name of Nationwide Children's representative (as applicable) _____ Date/Time _____

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PATIENT IDENTIFICATION

Authorization for Routine Disclosure/Exchange of Patient Information

I authorize the following Nationwide Children's Hospital clinic(s)/center(s) to communicate as instructed below, medical, behavioral, and/or school information regarding the patient below.
(If a complete copy of medical records is needed, please fill out the MR-9 form.)

Patient Name: _____

Date of Birth:_____MR#_____

Patient/Legal Guardian: _____

I understand that completion of this form will help streamline communications by providing Nationwide Children's and the individual designated below permission, in advance, to talk, or send, and exchange information; such as: to myself via personal email, school nurses, school staff, psychologists, supporting agencies, or extended family members. I understand that this authorization is only binding in the clinics I specify below. Should I select more than one clinic, I will be responsible for the distribution of this form to the other locations. I also understand that Nationwide Children's staff can only honor this authorization when it is made available to them.

Email Acknowledgement:
You have the option below to select email as a routine method of communication for yourself or a designated agency or entity, or authorized individual.
*NCH traditionally uses a secure email portal. You have the option of choosing to receive unsecure email communication. However, if you select to not have email sent through NCH's secure portal, you hereby acknowledge and accept the inherent risk associated with an unsecured email transmission, which can place your information at risk of being read or accessed by an unauthorized individual, and you agree that NCH will not be responsible for disclosures that might occur in transit.

***PLEASE BE SURE TO INDICATE WHICH NCH CLINIC/DEPARTMENT IS DISCLOSING THE INFORMATION.**

AGENCY OR PERSON RECEIVING/EXCHANGING INFORMATION:

Name of Agency/Entity or Authorized Individual:
*NCH Clinic/Department Disclosing Information:
Type of Information to be shared/disclosed: ☐ Medical ☐ Behavioral ☐ School
Delivery Method: ☐ Verbal ☐ Fax ☐ Written ☐ Phone/Leave Voicemail - ☐Yes ☐No *(If a complete copy of medical records is needed, please fill out the MR-9 form.)* ☐ *Email - Secure: _____ ☐ *Email – Unsecure: _____

AGENCY OR PERSON RECEIVING/EXCHANGING INFORMATION:

Name of Agency/Entity or Authorized Individual:
*NCH Clinic/Department Disclosing Information:
Type of Information to be shared/disclosed: ☐ Medical ☐ Behavioral ☐ School
Delivery Method: ☐ Verbal ☐ Fax ☐ Written ☐ Phone/Leave Voicemail- ☐Yes ☐No *(If a complete copy of medical records is needed, please fill out the MR-9 form.)* ☐ *Email - Secure: _____ ☐ *Email - Unsecure:_____

AGENCY OR PERSON RECEIVING/EXCHANGING INFORMATION:

Name of Agency/Entity or Authorized Individual:
*NCH Clinic/Department Disclosing Information:
Type of Information to be shared/disclosed: ☐ Medical ☐ Behavioral ☐ School
Delivery Method: ☐ Verbal ☐ Fax ☐ Written ☐ Phone/Leave Voicemail- ☐Yes ☐No *(If a complete copy of medical records is needed, please fill out the MR-9 form.)* ☐ *Email - Secure: _____ ☐ *Email - Unsecure:_____

Notice of Right to Revoke: I understand that this document will remain in force until I revoke it in writing, except to the extent that action has been taken by Nationwide Children's in reliance on this authorization and that treatment will not be conditioned upon signing or revoking this request. I also understand that any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.

Expiration Date: ☐ No Expiration Date ☐ One year ☐ Other _____
Failure to check one of the expiration boxes permits Nationwide Children's Hospital to assume that there is no expiration date.

Please return form to HIM at (614) 355-0888

_____ _____
Signature of Patient/Legal Guardian Date/Time

_____ _____
Witness Date/Time

For Staff Use Only- Copy provided to family ☐ Yes ☐ No- Family did not want copy of form

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ONE YEAR AMBULATORY GENERAL CONSENT

PATIENT IDENTIFICATION

Consent for Medical Treatment:
I and/or my parent(s) or guardian(s)* consent to let the doctors, nurses, and employees of Nationwide Children's Hospital, attending doctors and other doctors,** (or assistants/ designees) or persons, do all things that may be needed to diagnose, treat and care for the needs of above-referenced patient.

(* Throughout this document the use of the term "I" will refer to "I and/or my parents or guardians." The use of the term "me" "myself" or "my" shall refer to the patient. The use of "the Hospital" will refer to Nationwide Children's Hospital, its attending doctors, other doctors, or agents of the hospital.)

I understand that a pharmacist may be utilized in the management of my care, and I consent to such pharmacist management. I further understand that I have the right to withdraw my consent to the utilization of a pharmacist in the management of my care at any time.

The Hospital may keep, preserve and use, or properly dispose of any tissue, samples, parts or organs that are taken during operation(s) or procedures(s). These specimens may be used for diagnostic or teaching programs.

I understand this is a teaching hospital and that I am included in its teaching and training programs. I also understand that I may be contacted for participation and/or follow-up regarding such programs as applicable.

I authorize Hospital to take photos, video, or audio recording of me for diagnostic, teaching, identification, care conferencing, academic publication, and quality improvement purposes.

I understand that the Hospital is not responsible if any of my clothes or belongings are lost. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me about the result of my examination or treatment at the Hospital.

Patient Rights and Responsibilities (see next page):
I understand I have the right to take part in decisions about my health care and plan for treatment. I have the responsibility to wear my patient identification at all times while at the Hospital. In addition, my parents/family/guardian/visitors have the responsibility to wear their Hospital identification at all times. I have received a copy of the Patient Rights and Responsibilities, and my questions have been answered.

Consent to Release Medical Information:
I consent to let the Hospital share/release/exchange information such as clinical, physical, mental, drug alcohol, HIV or AIDS (including information that state and federal law and accreditation agencies require) to/with my doctors, my referring doctors, or referring/referral health care provider; and/or to any insurance company or organization that helps pay my bill. The Hospital may also give information to any welfare organization, to which I have applied or may apply for aid.

Assignment of Insurance Benefits:
I assign to Hospital, my physician, and other healthcare professionals involved in my care, all my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available to pay the Hospital for medical services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits.

Financial Responsibility:
I (or my guarantor, if appropriate) will pay all bills for my care including bills that insurance benefits do not pay. This includes bills from the hospital, physicians or any other entities that provided services during my care. I certify that the information I have given the Hospital regarding my family size and income is accurate to the best of my knowledge.

Nationwide Children's Price Disclosure:
I have a right to see a list of prices for common medical and surgical procedures. I can ask the Patient Accounts Department about this price list, or about my bill.

Removal from Nationwide Children's Hospital:
If I decide to stop my medical care against the advice of doctors, I understand that the Hospital and doctor(s) are not responsible for any bad result after I leave.

Acknowledgment of Receipt of Notice of Privacy Practices:
I hereby acknowledge that I was offered a copy of the Notice of Privacy Practices which sets forth the ways in which my protected health information may be used or disclosed by the Hospital and outlines my rights with respect to such information.

Consent for Automated Calls and Texts:
I expressly authorize Nationwide Children's Hospital, its affiliated entities, and third party service providers to call or text me and/or my child at any wireless phone number associated with my account(s), including any phone number that may result in charges to me, whether provided in the past, present, or future. I agree that methods of contact may include use of pre-recorded or artificial voices or an automatic dialing system. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services from Nationwide Children's.

One Year Ambulatory General Consent
I agree that this Consent will be effective for one year from the date of signature when the patient arrives in an ambulatory setting, such as Outpatient Lab, Radiology, or Offices/ Clinics and that this document shall serve as my Consent for the next year. This Consent does not apply for Inpatient Admission, Emergency Department, Urgent Care, Surgical or other procedures. If I wish to sign a new Consent upon each visit, I can request a different form at this time. If I wish to change or revoke this Consent, or if there is a change in custody, I will notify the Hospital at my next visit.

BY SIGNING, I CONFIRM THAT I HAVE LEGAL ABILITY TO CONSENT FOR THE TREATMENT.

Signed _____ _____ _____ Signed _____ _____ _____
PATIENT, IF 18 YEARS OR OLDER DATE TIME PARENT/GUARDIAN, IF PATIENT IS LESS THAN 18 YEARS DATE TIME

Signed _____ _____ _____
WITNESS DATE TIME PRINT NAME OF PARENT/GUARDIAN

_____ _____ _____ _____ (_____) _____
STREET ADDRESS CITY STATE ZIP CODE AREA CODE PHONE NUMBER

PATIENT'S BILL OF RIGHTS:

As a patient, parent or guardian at Nationwide Children's Hospital, you can expect to:

1. Be partners with the hospital staff in your care or the care of your child.
2. Be called by your name and be given the names of the doctors, nurses, and others who provide care.
3. Receive care from hospital staff who respect your personal values, beliefs and customs regardless of your race, ethnicity, gender, religion, sexual orientation, gender identity or expression, cultural background, income level (socioeconomic status), physical or mental disability, education or illness.
4. Have hospital staff listen to what you say, value your opinions and choices, and answer your questions. Know that you can take part in the development and implementation of your plan of care, discharge plan, and that you can express your feelings and receive caring responses.
5. Receive prompt, thoughtful care that keeps your daily routine as normal as possible and respects your need to rest and to learn.
6. Have a family member of your choosing and physician notified of your admission to the hospital.
7. Have family and friends around to comfort and help take care of you when they are able, and have another person who can make decisions about care and treatment when you are not able to.
8. Be given pain relief and other forms of comfort care when needed, and not be restrained unless it must be done for your safety or the safety of others.
9. Receive care and treatment in a safe and clean setting, and be protected from harassment and abuse of any kind.
10. Be given as much information as you need to help you decide whether to consent to treatment or refuse it.
11. Have access to an interpreter if needed.
12. Have privacy during exams and treatment and have the information about your illness kept private.
13. Have access to your medical record unless restricted by law. No one else will be given your medical information without your permission unless allowed by law. Have access to your medical record unless restricted by law.
14. Be taught what you need to know and do when you go home. Have assistance in securing home care services for your post hospital care when they are needed.
15. Make a suggestion or complaint to the unit or clinic manager or the Patient & Family Relations office. You can reach the Patient & Family Relations Office in person or by phone at 614-722-6593 to have your complaints heard and/or resolved. You may also make a report to the Ohio Department of Health at 1-800-342-0553 you may contact the Joint Commission at 1-800-994-6610. Behavioral Health patients may contact the Ohio Department of Mental Health and Addiction Services at 1-877-275-6364.
16. Have the right to decide on and to document an advance directive as allowed by law and have hospital staff and doctors comply with your wishes.
17. Examine your medical bills and have the charges explained to you.
18. Have the right to consent to or refuse to take part in any research program.

As a patient, parent or guardian at Nationwide Children's Hospital, it is your responsibility to:

1. Wear Nationwide Children's Hospital ID badge at all times.
2. Give complete information about your health.
3. Follow your treatment plan and tell your health care team if you have pain or changes in condition.
4. Tell those who care for you when you do not understand your care or what is expected of you.
5. Know that if you refuse treatment, you are responsible for the outcome.
6. Follow the hospital's rules out of respect for other families and hospital staff. This includes respect for the property of others, controlling noise, and following the no-smoking policy.

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NATIONWIDE CHILDREN'S AFFILIATED COVERED ENTITY NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how all patients of the affiliated entity can get access to this information. Please review this notice carefully.

I. Affiliated Entities Covered By This Notice

This Notice of Privacy Practices ("Notice") covers the Nationwide Children's Hospital's Affiliated Covered Entity ("ACE"). The Nationwide Children's Hospital ACE (also referred to as "we" or "us" in this Notice), includes the following entities:

- Nationwide Children's Hospital
- Center for Child and Family Advocacy at Nationwide Children's Hospital d.b.a. Center for Family Safety and Healing
- Children's Radiological Institute
- Pediatric Pathology Associates of Columbus
- Pediatric Academic Association, Inc.
- Children's Anesthesia Associates, Inc.
- Children's Surgical Associates Corporation
- Children's Psychiatrists, LLC
- Children's Physical Medicine and Rehabilitation Physicians, LLC
- Nationwide Children's Hospital Toledo, LLC
- Children's Newborn Medicine, LLC
- Northwest Pediatric Specialists, LLC
- Children's Community Practices, LLC
- Northwest Community Practices II, LLC

Federal law requires that we maintain the privacy of your Protected Health Information PHI and provide to you this Notice of our legal duties and privacy practices. We are required to notify affected individuals following a breach of unsecured PHI. We are required to abide by the terms of this Notice, which may be amended from time to time. We reserve the right to change this Notice of Privacy Practices and to make any new practices effective for information we already have and for information that we receive in the future. Any changes made to this Notice of Privacy Practices will be posted in the Patient Registration area, posted on our website (www.nationwidechildrens.org), and made available to you at your next appointment.

II. Organized Health Care Arrangement

We have agreed to participate in an organized health care arrangement ("OHCA") with Bon Secours Mercy Health, Inc.("BSMH").

We will share PHI with each participant in the OHCA to carry out treatment, payment, or health care operation relating to the OHCA, as otherwise permitted by applicable law, or as stated in this Notice of Privacy Practices. We will do so through access to a shared electronic health record ("EHR"). The OHCA applies to any affiliate of the Nationwide Children's Hospital Affiliated Covered Entity that uses the BSMH shared electronic record.

This Notice does not create an agency relationship, a joint venture, or any other legal relationship between any affiliate of Nationwide Children's Hospital ACE and BSMH, and neither party shall be liable for the acts or omission of the other.

III. To what information does this Notice apply?

Protected Health Information or PHI is information that you provide us or that we create or receive about you that re relates to the patient's past, present or future physical or mental health condition; the provision of health care to the patient; or the past, present, or future payment for the provision of health care to a patient. PHI includes demographic information including a patient's name, address, age, race, and sex.

IV. Ways We Can Use or Share Your PHI For Treatment, Payment and Health Care Operations

We can use or share your PHI without your written permission (Authorization) for many activities that are common in hospitals. For instance, we do not need an Authorization from you for the following uses and disclosures:

For Treatment. We use and share your PHI to provide care and other services to you--for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment options. We may tell you about other health-related benefits and services that might interest you. We may also share PHI with other doctors, nurses, and others involved in your care.

To Obtain or Provide Payment. We may use and share your PHI to receive payment for services that we provide to you. For example, we may share your PHI to request and receive payment from Medicare, Medicaid, your health insurer, Health Maintenance Organization (HMO), or other company or program that arranges or pays the cost of some or all of your health care ("Your Payor") and to confirm that Your Payor will pay for health care.

To Conduct Health Care Operations. We may use and share your PHI for our health care operations, which include management, care coordination, planning, and activities that improve the quality and lower the cost of the care that we deliver. For example, we may use PHI to review the quality and skill of our physicians, nurses, and other health care providers. We may use your PHI to conduct quality assessment and improvement activities, including outcomes evaluation and the development of clinical guidelines.

We may also use your PHI to participate in population-based activities relating to improving health or reducing health care costs. Also, we might use your PHI to provide you information on health-related programs or products such as alternative medical treatments and programs.

V. Disclosures You May Authorize Us to Make

We will not use or share your PHI without your authorization, except as described in this Notice. Most uses and disclosures of psychotherapy notes, as applicable, require your authorization. Subject to certain limited exceptions, we may not use or disclose PHI for marketing without your written authorization. We may not sell PHI without your written authorization. You may give us written authorization to use and/or disclose PHI to anyone for any purpose. If you authorize us to use or disclose such information, you may revoke that authorization in writing at any time.

VI. Uses and Disclosures in Which You Have An Opportunity to Object

Use or Disclosure for Directory of Patients We may include your name, location in the hospital, general health condition and religious affiliation in a patient directory without receiving your written authorization unless you tell us you do not want your information in the directory. Information in the directory may be shared with anyone who asks for you by name or with members of the clergy; however, religious affiliation will only be shared with members of the clergy.

Disclosure to Relatives, Close Friends and Your Other Caregivers. We may share your PHI with your family member/relative, a close personal friend, or another person who you identify if we (1) first provide you with the chance to object to the disclosure and you do not object; (2) infer that you do not object to the disclosure; or (3) obtain your agreement to share your PHI with these individuals. If you are not present at the time we share your PHI, or you are not able to agree or disagree to our sharing your PHI because you are not capable or there is an emergency circumstance, we may use our professional judgment to decide that sharing the PHI is in your best interest. We may also use or share your PHI to notify (or assist in notifying) these individuals about your location and general condition.

Fundraising Communications. We may share with our fundraising staff limited demographic information about you (e.g., name, address, other contact information, age, gender, date of birth), including the dates on which we provided health care to you, department of service information, treating physician, outcome information, and health insurance status without your written authorization. We may contact you with information about the importance of contributions to Nationwide Children's Hospital and invite you to participate. If you do not want to receive any fundraising communications in the future, you may opt out of receiving such communications by contacting the Privacy Office at the contact information below.

Health Information Exchange. We participate in the State of Ohio's approved health information exchange ("HIE"), and may electronically share your health information for treatment, payment and healthcare operations purposes with other authorized participants in this HIE. HIEs allow your health care providers to access and use your pertinent medical information necessary for treatment and other lawful purposes. Only authorized individuals may access and use your health information from the approved HIE. The State of Ohio's approved HIE maintains appropriate administrative, physical and technical safeguards to protect the privacy and security of your health information. Upon request, you may "opt-out" of HIE participation, in full or in part. The opt-out form is available by calling 614-355-0777 to request a copy. If you do not opt out, we may provide your health information to an approved HIE in which we participate in accordance with applicable law. Your decision to opt-out of participation in the approved HIE, in full or in part, may result in a health care provider not having access to information that is necessary for the provider to render appropriate care to you.

VII. Other Specific Uses and Disclosures Which We Are Required to or Permitted to Make

When Legally Required. We will disclose your PHI when required by any Federal, State or local law.

A. Public Health Activities. We are required or are permitted by law to report PHI to certain government agencies and others. For example, we may share your PHI for the following:
   a. to report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability;
   b. to report known or suspected abuse or neglect to the appropriate public child protective services agency, as we are required to do by law;
   c. to report information about products and services to the U.S. Food and Drug Administration;
   d. to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of developing or spreading a disease or condition;
   e. to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance; and
   f. to prevent or lessen a serious and imminent threat to a person for the public's health or safety or to certain government agencies with special functions such as the State Department.

B. Health Oversight Activities. We may share your PHI with a health oversight agency that oversees the health care system and ensures the rules of government health programs, such as Medicaid, are being followed.

C. Judicial and Administrative Proceedings. We may share your PHI in the course of a judicial or administrative proceeding in response to a court order or other lawful process.

D. Law Enforcement Purposes. We may share your PHI with the police or other law enforcement officials as required or permitted by law or in compliance with a court order or warrant.

E. Correctional Facilities. We may share your PHI if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

F. Decedents. We may share PHI with a coroner or medical examiner as authorized by law.

G. Organ and Tissue Procurement. Consistent with applicable law, we may share your PHI with organizations that facilitate organ, eye, or tissue procurement, banking, or transplantation.

H. Research. We may use your PHI for research. Before we disclose any of your PHI for such research purposes in a way that you could be identified, the project will be subject to an extensive review and approval process.

I. Workers' Compensation. We may share your PHI as permitted by or required by state law relating to workers' compensation or other similar programs.

J. As required by law. We may use and share your PHI when required to do so by any other law not already referred to above.

VIII. Uses and Disclosures Requiring Your Written Authorization

We will not use or disclose your PHI without authorization, except as described in this Notice. You may give us written authorization to use and/or disclose health information to anyone for any purpose. Our use or disclosure will be consistent with such written authorization. If you authorize us to use or disclose such information, you may revoke that authorization in writing at any time.

In certain other situations, we must have your written authorization to use and/or share your PHI.

A. Marketing. We must obtain your written authorization prior to using your PHI for marketing materials, except if the communication is in the form of a face-to-face communication made by us to an individual, or a promotional gift of nominal value provided by us. If the marketing involves financial payment to us from a third party, the authorization will state that such payment is involved. However, we may communicate with you about products or services related to your treatment, case management or care coordination, or alternative treatments, therapies, health care providers, or care settings without your permission.

B. Sale of PHI. We must obtain your written authorization prior to selling your PHI, or in the instance that disclosure of your PHI will result in remuneration to us.

C. Uses and Disclosures of Your Highly Confidential Information. Federal and state law requires special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including any portion of your PHI that is: (1) kept in psychotherapy notes; (2) about mental health and developmental disabilities services; (3) about alcohol and drug abuse prevention, Treatment and referral; (4) about HIV/AIDS testing, diagnosis or Treatment; (5) about sexually transmitted disease(s); (6) about genetic testing; (7) about child abuse and neglect; (8) about sexual assault; or (9) Invitro Fertilization (IVF). For any of the foregoing, we must obtain your written authorization for any use or disclosure, except to carry out certain treatment, payment, or health care operations. Before we share your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

IX. Patient Rights

A. You have the right to be informed of our privacy practices. Our practices related to protecting the privacy of your health information are described in our Notice of Privacy Practices (NOPP). The NOPP describes how we use your information to provide treatment to you, to obtain payment for that treatment and for our internal business operations. You will be given the opportunity to obtain a paper copy of the NOPP anytime you visit. When you first become our patient, we will obtain your acknowledgement indicating that you have been given the opportunity to review and/or obtain a paper copy of our NOPP. A current version of our NOPP can also be viewed on our website at www.nationwidechildrens.org.

B. Right to a Personal Representative. You may identify persons to us who may serve as your authorized personal representative, such as a court-appointed guardian, a properly executed and specific power-of-attorney granting such authority, a Durable Power of Attorney for Health Care if it allows such person to act when you are unable to communicate on your own, or other method recognized by applicable law. We may, however, reject a representative if, in our professional judgment, we determine that it is not in your best interest.

C. You have the right to request access to your health information.

a. You have the right to see and obtain a copy of health information that may be used to make decisions about you, such as nurse's notes, lab tests, prescriptions, and treatment plans. You also may in some cases receive a summary of this health information. You must make a written request to inspect and copy your health information. The request form is available by mail at the address below, can be downloaded from our website, or you may call 614-355-0777 to request a copy. We may charge a reasonable fee for any copies.

b. In certain limited circumstances, we may deny your request to inspect and copy your health information. For example, you may not read or be given a copy of psychotherapy notes; information collected for use in a civil, criminal, or administrative action, or court case; and certain PHI that is protected by law. In some situations, you may have the right to have this decision reviewed. Please contact the Health Information Management Department at 614-355-0777 if you have questions about access to your medical record.

D. You have the right to request that we disclose your health information to others.

a. If you would like some of your health information sent to someone else, for example to another physician or to your employer, you will need to complete our authorization form indicating that you agree to our disclosing (providing) the information to the others you select. The authorization form is available by mail at the address below, can be downloaded from our website, or you may call 614-355-0777 to request a copy.

b. Once you authorize us to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time, in writing, by mailing or emailing your revocation to the address below, except if we have already acted based on your authorization.

c. If we maintain an electronic health record containing your health information, when and if we are required by law, you will have the right to request that we send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.

E. You have the right to request to amend your health information.

a. You have the right to ask to amend health information we maintain about you if you believe the health information is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. The amendment form is available by mail at the address below, can be downloaded from our website, or you may call 614-355-0711 to request a copy. Fax, e-mail or mail your request to the address listed below. We will review the information as requested and either make the correction or let you know why we think our information is correct. If we deny your request, you may give us a written statement disagreeing with our decision that we will keep with your health information.

F. You have the right to request to receive communications related to your health in another way or at other locations.

a. We normally send your healthcare information to the address and phone numbers you have provided. However, if you would like to have the information sent elsewhere to protect your privacy, you may do so. We will not ask you to explain why you are making the request. We will agree to reasonable requests. To carry out the request, we will ask you for another address or another way to contact you, for example, mailing to a post office box. The confidential communication form is available by mail at the address below, can be downloaded from our website, or you may call 614-355-0711 to request a copy. Mail or email your request to the address listed below or turn in your completed form at any Patient Registration location.

G. You have the right to request restrictions on the use and disclosure of your health information.

a. You have the right to ask to restrict uses or disclosures of your health information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. Although we may consider your request, please be aware that we are under no obligation to accept it or abide by it unless the request concerns a disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full. The restriction request form is available by mail at the address below, can be downloaded from our website, or you may call 614-355-0711 to request a copy. Mail or email your request to the address listed below.

b. If you pay out of pocket in full for specific services, you may request that PHI about that service not be disclosed to your health plan. The "Do Not Bill Insurance" form is available by mail at the address below, can be downloaded from our website, or you may call 614-355-0711 to request a copy. Turn in your completed form at any Patient Registration location.

c. We may also have policies on minors that permit your minor child to request certain limits on your access to their health information.

H. You have the right to request an accounting of people to whom we have disclosed your health information. You have the right to receive an accounting of certain dis closures of your health information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; (iii) to correctional institutions or custodial law enforcement officials; (iv) for our patient directory or to person's involved in your care; and (iv) other disclosures for which federal law does not require us to provide an accounting. The accounting request form is available by mail at the address below, can be downloaded from our website, or you may call 614-355-0711 to request a copy. Mail or email your request to the address listed below.

I. You have the right to express concerns or to ask questions. If you have any concerns about the privacy of your health information or if you have questions about our procedures, you may contact our Privacy Officer at:

Nationwide Children's Hospital
Attention: Nationwide Children's Hospital ACE Privacy Officer
700 Children's Drive
Columbus OH 43205
PrivacyOffice@NationwideChildrens.org
(614) 355-0711

J. You have the right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above. You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint at: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html.

We will not take any action against you for filing a complaint.