

**Notice of Privacy Practices**

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

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for health care services with our practice. Specifically, PHI is information about you, including demographic information (i.e. name, address, phone, etc.), that may identify you and relates to your past, present, or future physical or mental health condition and related health care services.

Cascade Pediatrics is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other health care professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI and purposes for which we may use and disclose your PHI. Regarding use of information for health care law, be aware that our office records and transmits health information, including prescription information, electronically. Health information is shared and protected electronically through local, state, and national health information exchanges (HIE's) and clinically integrated networks (CIN's) and these HIE's and CIN's have strict rules on how this information is accessed.

Cascade Pediatrics may disclose your medical information for the following purposes, as well as other purposes that are permitted or required by law. Any information pertaining to treatment related to reproductive health care **cannot** be used or disclosed to investigate or impose liability for seeking lawful reproductive health care.

**Treatment** – We may share information about you to providers and other office personnel who are involved in providing your health care treatment.

**Payment** – We may share information about you to bill and collect payment from your insurance carrier, a third party or to obtain authorization for payment.

**Health Care Operations** – We may share information about you to manage our health care operations. These uses and disclosures are necessary to run our office and make sure that all our patients receive quality care.

**Your Rights Under the Privacy Rule** - Following is a statement of your rights, under the Privacy Rule, in reference to your PHI, please feel free to discuss any questions with our staff.

**You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices** - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. Upon your request, we will provide you a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice.

**You have the right to authorize other use and disclosure** - This means you have the right authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your health care provider, or our practice has taken action in reliance on the use or disclosure indicated in the authorization.

**You have the right to request an alternative means of confidential communication** - This means you have the right to ask us to contact you about medication matters using an alternative method (i.e. email or telephone), and to a destination (i.e. cell phone number, alternative address, etc.) designated by you, You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

**You have the right to inspect and copy your PHI** - This means you may inspect, and obtain a copy of your complete health record. We have the right to charge a reasonable fee for paper as established by professional, state, or federal guidelines.

**You have the right to request restriction of your PHI** - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. If we agree to the requested restrictions, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

**You may have the right to request an amendment to your protected health information** - This means you may request an amendment of you PHI for as long as we maintain this information. In certain cases, we may deny your request.

**You have the right to request a disclosure of accountability** - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

**You have the right to receive a privacy breach notice** - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, or would like a more in-depth copy of our privacy policy please feel free to contact our Compliance Officer.

*You may file a complaint with us by notifying our Compliance Officer at 616.940.3168. We will not retaliate against you for filing a complaint.*

**Cascade Pediatrics, LLP**  
**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing below I acknowledge that I have received a copy of Cascade Pediatrics' Notice of Privacy Practices Form revised 02/2025 for the children named below:

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient / Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

**Documentation of Failure to Obtain Signed Acknowledgement**

On \_\_\_\_\_, \_\_\_\_\_ presented this Acknowledgement  
(date) (staff member's name)  
of Receipt of Notice of Privacy Practices Form to \_\_\_\_\_.  
(patient's name)

The Patient refused to provide a signature when requested.

\_\_\_\_\_  
Staff Member's Signature

\_\_\_\_\_  
Date