NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU ("your child") MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use or disclose your protected health information and with whom we may share that information. Such "protected health information" is individually identifiable health information. Such information may include, for example, your age, address, or e-mail address, and how it relates to your past, present and future physical or mental health or condition and related health care services. It is information that you have given to us or that we have learned about you when you were a patient. This Notice also describes your rights and our legal duties to this information.

I. ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE You will be asked to provide a signed acknowledgement of your receipt of this Notice to ensure that you are aware of the possible uses and disclosures of your protected health information and privacy rights. Delivery of your health care services is not conditioned upon your signature. If you decline to provide a signed acknowledgement, we will continue to provide treatment to you and will use and disclose your protected health information for treatment, payment and health care operations as necessary.

II. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

A. Treatment, Payment and Health Care Operations. The following describes different ways we use and disclose your protected health information for treatment, payment and health operations, including examples of each.

i. Treatment-We may use or disclose your Protected Health Information to provide medical treatment and/or services in order to manage and coordinate your medical care. For example, we may share your medical information with other physicians and health care providers, DME vendors, surgery centers, hospitals, rehabilitation therapists, home health providers, laboratories, nurse case managers, workers compensation adjusters, ect, to ensure that the medical provider has the necessary medical information to diagnose and provide treatment to you.

ii. Payment. We may use or disclose your health information so that we can bill and collect payment from you, an insurance company, or someone else of the health care services you receive from us. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether the plan will pay for the treatment. For example, we may need to give your health plan information about a planned drug screening so your health plan will pay us or reimburse us for the screening.

iii. Health Care Operations. We may use and disclose your Protected Health Information to manage, operate and support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you may be asked to sign your name. We may also call you by name in the waiting room when your exam room is ready. We may use or disclose your Protected Health Information, as necessary, to contact you, to remind you or your appointment and to inform you about treatment alternatives or other health related services.

iv Minors: Protected Health Information of minors will be disclosed to their parents or legal guardians, unless prohibited by law.

B Other uses and Disclosures of Health Information Without Authorization. In addition to uses and disclosures of your health information for treatment, payment and health care operations, we may also use or disclose health information without authorization in the following circumstances:

i. To you, the patient.

ii If required by law or ordered by a court. We will use or disclose your Protected health Information when required to do so by local, state, federal and international law.

iii For health oversight activities such as, for example, internal and external investigations, inspections or licensure actions.

iv. Abuse, neglect and domestic violence. Your Protected Health Information will be disclosed to the appropriate government agency if there is belief that a patient has been or is currently the victim of abuse, neglect or domestic violence and the patient agrees or it is required by law to do so. In addition, your information may also be disclosed when necessary to prevent a serious threat to your health or safety or the health and safety of others to someone who may be able to help prevent the threat.

V. Public Health: Your Protected Health Information may be disclosed and may be required by law to be disclosed for public heath risks. This includes reporting to the Department of Health reportable medical conditions, including certain sexually transmitted diseases, reporting of reactions of medications or immunizations, and reporting of a person who may have been exposed to a disease.

Vi. Business Associates: We may disclose your Protected Health Information to our business associates who provide us with services necessary to operate and function as a medical practice, We will only provide the minimum information necessary for the associate to perform their functions as it relates to our business operations. All of our business associates are obligated to comply with the same HIPPAA privacy and security rules in which we are obligated.

vii. Communication with family and/or individuals involved in your care or payment of your care. Unless you object, disclosure of your Protected Health Information may be made to a family member, friend, or other individual involved in your care or payment of your care in which you have identified.

III. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION ONLY WITH AUTHORIZATION

A. Except for the purposes defined and listed above, we will not use or disclose your health information for any purpose unless you give us your written authorization. Circumstances that may require written authorization include use of disclosure of psychotherapy notes, for marketing purposes, and for the sale of your health information.

B Revocation of Authorization: If you give us authorization, you can withdraw or amend this written authorization at any time. To withdraw your authorization, deliver a written revocation to 167 Bluffton Rd, Suite G, Bluffton, SC 29910, e-mail to seaside@seasideped.net or fax to 843-815-3849. If you revoke your authorization, except to the extent that we have already relied on your authorization.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

The following are a statement of your rights, subject to certain limitations, with respect to your Protected Health Information:

I Right to Inspect and Copy. You have the right to inspect and get a copy of the health information that we use to make decisions about your care. For the portion of your health record maintained in an electronic health record, if any, you may request we provide that information to or for you in an electronic format. If you make such a request, we are required to provide that information to you electronically. We may deny your request to inspect and/or copy in certain limited circumstances, and if we do this, you may ask that the denial be reviewed.

ii Right to Amend. You have the right to amend your health information maintained by or for us, or used by us to make decisions about you. We will require that you provide a reason for the request, and we may deny your request for an amendment if the request is not properly submitted, or if it asks us to amend information that (a) we did not create unless the source of the information or is no longer available to make the amendment, (b) is not part of the health information that we keep; (c) is of a type that you would not be permitted to inspect and copy; and (d) is already accurate and complete.

iii Right to an Accounting of Disclosures. You have the right to request a list and description of certain disclosures by us of your health information.

iv Right to Request Restrictions. You have the right to request a restriction or limitation on the protected health information we use or disclose about you (a) for treatment, payment, or health care operations, (b) to someone who is involved in your care or the payment for it, such as a family member or friend, or (c) to a health plan for payment of health care operations purposes when the item or service has been paid for out of pocket in full by you or someone on your behalf (other than the health plan). For example, you could ask that we not use or disclose information about a laboratory test ordered or a medical device prescribed for your care. Except for the request noted in (c) above, we are not required to agree to your request. Any time we agree to such a restitution, it must be in writing and signed by our Privacy Officer or his designee.

V Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain place. We will accommodate reasonable requests. For example, you can ask that we only contact you at work or by mail.

Vi. Right to be Notified of a Breach. You have the right to be notified if there is a breach (a) compromise to the security or privacy of your health information due to your health information being unsecured. We are required to notify you within 60 days of discovery of a breach.

V. Revisions to this Notice. We have the right to change this Notice and make the revised or changed Notice effective for health information we already have about you, as well as any information we receive in the future. Except when required by law, a material change to any term of the Notice may not be implemented prior to the effective date of the Notice in which the material change is reflected.

Vi. Financial Information Privacy Notice: We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, personal financial information means information, other than health information, about an insured or applicant for

coverage that identifies the individual, is not generally publicly available, and is collected from the individual in connection with providing coverage. We do not disclose personal financial information about our insureds or former insureds to any third party, except as required or permitted by law.

Vil Questions or Comments. If you have any questions about this Notice, please contact our Privacy Officer at 843-757-8663. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer. You will not be penalized for filling a complaint. This Notice tells you how we may use and share health information about you. If may keep this copy of the Notice.

ACKNOWLEDGEMENT AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices from Seaside Pediatrics. I am aware of the possible uses and disclosures of my protected health information and privacy rights.

Name of patient ____

Name of parent (if under 18 years)____

Signature of parent (if patient under 18 years)____

Signature of patient 18 years and older______________________________

Date____________________