Inland Empire
CMG
Children's Medical Group

7101 Magnolia Avenue, Suite A • Riverside, CA 92504
Office (951) 682-9780 • Fax (951) 682-9787
www.iecmg.org

NOTICE OF HEALTH INFORMATION PRACTICES (PRIVACY NOTICE)

This notice describes how medical information about you may be used and how you can get access to this information. Please review it carefully.

How we will use your Health Record Information

- Basis for planning your care and treatment
- Means of communicating among other health professionals who contribute to your care
- Legal document describing the care you need
- To ensure accuracy
- To better understand who, what, when, where and why others may access your health information
- Make informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have a right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record
- Amend your health record
- Obtain an accounting of disclosures of your health information
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us. We will not use or disclose your health information without your authorization, except as described in this notice.

PRIVACY NOTICE ACKNOWLEDGEMENT

I understand that as part of my healthcare, this organization originates and maintains health records describing my child's health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's care and treatment
- Means of communication among other health professionals who contribute to my child's care
- A source of information for applying my child's diagnosis and surgical information to my bill
- A means by which third party payer (insurance) can verify that services billed were actually provided
- A tool for routine healthcare operations such as quality and reviewing the competence of healthcare professionals

I understand and have been provided with a notice of privacy practices (privacy notice), which provides a more complete description of information and disclosures. I understand that I have a right to review the notice before signing it. I understand that this organization has the right to change their notice and practice and that prior to implementation will mail a copy of the revised notice to the address that I have provided. I understand that I have the right to restrict as to how my information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this organization is not required to agree to the restrictions requested.

I acknowledge receipt of this organization's privacy practice

Signature:_____ Printed Name:_____

Date:_____

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