

Date: _____

Name: _____

Birth Date: _____

MEDICAL HISTORY

FAMILY HISTORY (Ages 5 Years and Older)

Mother: _____ Birth Date: _____

Health: _____

Father: _____ Birth Date: _____

Health: _____

Siblings (Name/Date of birth/Health): _____

Family Health Problems (Check appropriate items):

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Heart attack or stroke at age less than 60 | <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sudden Death | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other _____ |

CHILD'S HEALTH HISTORY

Pregnancy and Birth Problems _____

Hospitalizations/Surgery: _____

Are immunizations up to date? _____ Allergies to medication: _____

Current medications: _____

Check appropriate items child has had in part:

- | | | |
|---|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Urinary Infection |
| <input type="checkbox"/> Bronchiolitis/Bronchitis | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Frequent Abdominal Pains |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Other: _____ | | |

Has your child had any problems in his/her development? _____

School: _____ Grade: _____ School Performance/Problems: _____

Former Pediatrician and other Specialists who has seen your child (name/location): _____

NORTH FULTON PEDIATRICS - FORM PACKET FOR AGES 5 YEARS AND OLDER

PATIENT INFORMATION

PATIENT _____

TODAY'S DATE _____

ADDRESS _____

BIRTHDATE _____

S.S. # _____

PHONE # _____

PARENT INFORMATION

FATHER'S NAME _____

MOTHER'S NAME _____

S.S. # _____

S.S. # _____

ADDRESS (CHECK IF SAME AS PATIENT ____)

ADDRESS (CHECK IF SAME AS PATIENT ____)

HOME PHONE # _____

HOME PHONE # _____

WORK PHONE # _____

WORK PHONE # _____

CELL PHONE # _____

CELL PHONE # _____

EMPLOYER _____

EMPLOYER _____

EMPLOYER'S ADDRESS _____

EMPLOYER'S ADDRESS _____

INSURANCE CO. _____

INSURED'S NAME _____

I.D. # (S.S. #) _____

CLAIM ADDRESS _____

GROUP # _____

I authorize the release of any medical or other information necessary to process my child's insurance claim. This includes the release of medical information to other doctors or insurance companies for referrals or continuing medical care. I authorize payment of medical benefits to North Fulton Pediatrics, P.C. for services rendered and agree to the below stated method of payment and terms of payment.

SIGNATURE OF INSURED _____ DATE _____

NEAREST RELATIVE OR PERSON TO CONTACT IN CASE OF AN EMERGENCY:

NAME _____ PHONE _____

ADDRESS _____

HOW DID YOU HEAR OF NORTH FULTON PEDIATRICS?

FRIEND _____ PHYSICIAN _____

YELLOW PAGES _____ INSURANCE COMPANY _____ OTHER _____

METHOD OF PAYMENT: CASH _____ CHECK _____ OTHER _____ MEDICAID _____

WE RESERVE THE RIGHT TO CHARGE INTEREST IN THE AMOUNT OF 1.5% MONTHLY (18% ANNUALLY) AS PROVIDED BY THE STATE LAW ON ALL ACCOUNTS UNPAID 60 DAYS AFTER SERVICE IS PROVIDED.

Date: _____

Name: _____

Birth Date: _____

MEDICAL HISTORY

FAMILY HISTORY (Ages 5 Years and Older)

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Health: _____

Father: _____ Birth Date: _____

Health: _____

Siblings (Name/Date of birth/Health): _____

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|---|---------------------------------------|---------------------------------------|
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| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sudden Death | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other _____ |

CHILD'S HEALTH HISTORY

Pregnancy and Birth Problems _____

Hospitalizations/Surgery: _____

Are immunizations up to date? _____ Allergies to medication: _____

Current medications: _____

Check appropriate items child has had in part:

- | | | |
|---|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Urinary Infection |
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| <input type="checkbox"/> Other: _____ | | |

Has your child had any problems in his/her development? _____

School: _____ Grade: _____ School Performance/Problems: _____

Former Pediatrician and other Specialists who has seen your child (name/location): _____

NORTH FULTON PEDIATRICS, P. C.
FINANCIAL POLICY

Thank you for choosing North Fulton Pediatrics as your health care provider. Please understand that payment of your bill is considered a part of your care. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

Due to frequent changes in health insurance coverage, we require that you provide proof of insurance coverage at each visit. If you do not have insurance, are unable to provide proof of insurance coverage, or are on a plan in which we do not participate, full payment is required at the time of your visit.

All co-payments and deductibles are due at the time of service. These fees cannot be waived. For your convenience, we accept cash, check, Visa/MasterCard (including debit cards), American Express and Discover.

NON-CONTRACTUAL INSURANCE

For those plans with which we do not have a relationship, you will be responsible for your entire bill at the time of service. We will provide you with a copy of your bill, at each visit, so you will be able to file your claim with your insurance company.

CONTRACTUAL INSURANCE

If we are a participating provider, all co-pays and co-insurance amounts are due at the time of service. In the event that your insurance coverage changes to a plan for which we are not a participating provider, we will provide you with a bill so you will be able to file the claim with your insurance company. The full amount will then be due at the time of service.

Please be aware that some of the services provided may be non-covered services and not considered reimbursable under your insurance plan. You are personally responsible for these services.

We will routinely file your insurance claim for each visit. Should there be a dispute with your insurance company we will attempt to resolve it with you. During this time a statement will be mailed to you each month your account shows a balance due. For all insurance other than HMO's, if your insurance has not paid within 90 days; the balance may be transferred to your personal balance, which must be paid upon receipt. Your insurance policy is a contract between you and your insurance company; therefore, your balance is your responsibility.

VACCINES FOR CHILDREN (VFC) PROGRAM

Children who are not insured, or are insured but do not have vaccine coverage, are enrolled in Medicaid, or are American Indian or Native Alaskan qualify for the Vaccines For Children program. The vaccines are provided free of charge, but there is an administration fee, which is your responsibility. If your child qualifies and you would like to participate in the VFC program, it is required that the nurse be told at the beginning of your child's visit. We cannot implement this program retroactively.

INTEREST

We reserve the right to charge interest in the amount of 1.5% monthly (18% annually) as provided by the state law on all past due account balances.

ADMINISTRATIVE FEE

Participation forms for camp, school, and sports, etc. will be charged a \$10.00 processing fee payable in advance. Any 2nd request for state forms will be charged a \$10.00 fee payable in advance.

PATIENTS WHO ARE NOT ACCOMPANIED BY A PARENT OR GUARDIAN

All patients under the age of 18 years old must be accompanied by a parent or guardian. Only patients for emergency treatment will be seen without a parent or guardian.

RETURN CHECK FEES

A \$25.00 processing fee will be charged for checks returned as insufficient funds, stop payment on an issued check and checks drawn on a closed account. This charge is applied to your personal account balance and must be paid within 14 days of notification to avoid further action. Any family account that has a history of more than two returned checks for insufficient funds will require cash or approved credit card payments for all visits thereafter.

DELINQUENT ACCOUNTS

If a large bill is anticipated and financial arrangements need to be made, a payment program may be arranged with our Practice Administrator prior to your visit. Failure to resolve any past due accounts including any returned checks will result in referral to a collection agency. In the event your account is sent to a collection agency, a 30% collection fee will be added to your outstanding account balance.

North Fulton Pediatrics may need to disclose to a collection agency personal health information related to receiving payment for services rendered in the event your account is delinquent.

Any family whose account is forwarded to a collection agency will be dismissed from our practice. At this point, if you have a PCP assigned to you then you must contact your insurance company and request to be assigned to another office.

TRANSFERING OF MEDICAL RECORDS

Because there are frequent changes in health insurance coverage and participating providers, it is often necessary for patients to ask that their medical records be transferred to another physician’s office. An immunization record, growth chart, and problem list can be provided at no charge. Otherwise, there will be an administration fee charged in accordance with the State regulations for the copying of medical records.

NURSE FEE

Any procedures performed by the lab nurse (strep screens, lab work, hearing and vision, etc.) that do not require a face-to-face visit with the physician will incur a nurse fee in addition to the procedure performed. All appropriate co-payments will apply.

All patients are asked to please check out before leaving the office. It is unlawful to intentionally walk out without satisfying your financial obligations after treatment has been rendered.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read and understand this Financial Policy.

Signature of Parent or Guardian

Date

Patient Name

North Fulton Pediatrics

Receipt of Notice of Privacy Practices Written Acknowledgement Form

Patient Name: _____ Date of Birth: _____

I, _____, have had the opportunity to review a copy of North Fulton Pediatrics Notice of Privacy Practices.

Signature of Patient/Parent/Guardian

Date

Relationship to patient

FOR INTERNAL USE ONLY

Patient/Parent/Guardian refused to sign _____

Date

Initials

I hereby grant permission to North Fulton Pediatrics to contact me and/or leave a message at either my home or workplace. These numbers are on file and can be used to confirm an appointment, to notify me that test results are available, to notify me that a form or prescription is ready for pick-up, or to conduct any other relevant business that is deemed necessary.

Personal or detailed information will not be left on an answering machine or voice mail.

Signature of Patient/Parent/Guardian

FOR INTERNAL USE ONLY

Patient/Parent/Guardian refused to sign _____

Date

Initials

Declaration of Patients' Rights

Physicians are required to post a declaration of the patient's rights to file a grievance with the Board concerning a physician, staff, office or treatment received.

The patient has the right to file a grievance with the Composite State Board of Medical Examiners, concerning the physician, staff, office and treatment received. The patient should either call the board with such a complaint or send a written complaint to the board. The patient should be able to provide the physician or practice name, the address and the specific nature of the complaint.

Complaints may be reported to the Board at the following address or telephone number:

Composite State Board of Medical Examiners
Attn. Complaints Unit
No. 2 Peachtree Street, N.W., 36th Floor
Atlanta, GA 30303
(404) 656-3913

North Fulton Pediatrics, PC - Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR CHILD'S INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI).

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your child's individually identifiable health information (IIHI). In conducting our business, we will create records regarding your child and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies your child. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information: (1) How we may use and disclose your child's IIHI; (2) Your privacy rights in your child's IIHI; and (3) Our obligations concerning the use and disclosure of your child's IIHI.

The terms of this notice apply to all records containing your child's IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your child's records that our practice has created or maintained in the past, and for any of the records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: Jodi M. Greenwald, MD, HIPAA Compliance Officer, North Fulton Pediatrics, PC, 1285 Hembree Road, Suite 100, Roswell, Georgia 30076. The telephone number is 770-442-1050.

C. WE MAY USE AND DISCLOSE YOUR CHILD'S INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your child's IIHI.

1. Treatment. Our practice may use your child's IIHI to treat him/her. For example, we may ask he/she to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your child's IIHI in order to write a prescription, or we might disclose your child's IIHI to a pharmacy when we order a prescription for him/her. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your child's IIHI in order to treat him/her or to assist others in your child's treatment. Additionally, we may disclose your child's IIHI to others who may assist in his/her care, such as your spouse, children, or parents. Finally, we may also disclose your child's IIHI to other health care providers for purposes related to his/her treatment.

2. Payment. Our practice may use and disclose your child's IIHI in order to bill and collect payment for the services and items he/she may receive from us. For example, we may contact your health insurer to certify that your child is eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your child's treatment to determine if your insurer will cover, or pay for, his/her treatment. We also may use and disclose your child's IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your child's IIHI to bill you directly for services and items. We may disclose your child's IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your child's IIHI to operate our business. As examples of the way in which we may use and disclose your child's information for our operations, our practice may use your child's IIHI to evaluate the quality of care he/she received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your child's IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your child's IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your child's IIHI to inform you of potential treatment operations or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your child's IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your child's care, or who assists in taking care of him/her. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

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8. Disclosures Required by Law. Our practice will use and disclose your child's IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR CHILD'S IIHI IN CERTAIN SPECIAL CIRCUMSTANCES:

The following categories describe unique scenarios in which we may use or disclose your child's individually identifiable health information:

1. Public Health Risks. Our practice may disclose your child's IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the parent/guardian agrees or we are required or authorized by law to disclose this information
- notifying your child's employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. Health Oversight Activities. Our practice may disclose your child's IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your child's IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your child's IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- concerning a death we believe has resulted from criminal conduct
- regarding criminal conduct at our office
- in response to a warrant, summons, court order, subpoena or similar legal process
- to identify/locate a suspect, material witness, fugitive or missing person
- in an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your child's IIHI to organizations that handle organ, eye or tissue procurement, or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if he/she is an organ donor.

7. Research. Our practice may use and disclose your child's IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your child's IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to his/her privacy based on the following: (a) an adequate plan to protect the identifiers from improper use and disclosure; (b) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (c) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your child's IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

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9. Military. Our practice may disclose your child's IIHI if he/she is a member of U.S. or foreign military forces and if required by the appropriate authorities.

10. National Security. Our practice may disclose your child's IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your child's IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your child's IIHI to correctional institutions or law enforcement officials if he/she is an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to him/her, (b) for the safety and security of the institution, and/or (c) to protect your child's health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your child's IIHI for workers' compensation and similar programs.

E YOUR RIGHTS REGARDING YOUR CHILD'S IIHI:

You have the following rights regarding the IIHI that we maintain about your child:

1. Confidential Communications. You have the right to request that our practice communicate with you about your child's health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Jodi M. Greenwald, MD., HIPAA Compliance Officer**, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction on our use and disclosure of your child's IIHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your child's IIHI to only certain individuals involved in your care or the payment for his/her care, such as family members and friends. **We are NOT required to agree to your request**, however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat him/her. In order to request a restriction in our use or disclosure of your child's IIHI, you must make your request in writing to **Jodi M. Greenwald, MD, HIPAA Compliance Officer**. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both; and (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about your child, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Jodi M. Greenwald, MD, HIPAA Compliance Officer** in order to inspect and/or obtain a copy of your child's IIHI. Our practice may charge a fee for the costs of inspecting, copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your child's health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Jodi M. Greenwald, MD, HIPAA Compliance Officer**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our parents/guardians have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your child's IIHI for non-treatment, non-payment or non-operational purposes. (Non-TPO) Use of your child's IIHI, as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your child's information to file his/her insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Jodi M. Greenwald, MD, HIPAA Compliance Officer**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosures and may not include dates before April 14, 2003. The first list you request within a 12 month period is free of charge, but our practice may charge you for additional lists within the same 12 month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Jodi M. Greenwald, MD, HIPAA Compliance Officer**.

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7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Jodi M. Greenwald, MD, HIPAA Compliance Officer**. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your child's IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your child's IIHI for the reasons described in the authorization. Please note, we are required to retain records of your child's care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Jodi M. Greenwald, MD, HIPAA Compliance Officer, North Fulton Pediatrics, PC, 1285 Hembree Road, Suite 100, Roswell, GA 30076**.