

NOTICE OF PRIVACY PRACTICES – A CENTER FOR VISIONCARE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE UPON REQUEST.

PATIENT HEALTH INFORMATION

To appropriately treat you and receive payment for the services we provide, we need to obtain information from you including your full name and address, insurance company, family medical history, current medical history, and current medical condition. We will use and disclose this information and other information we collect in the ways described below. To help you understand how we will use and disclose your information we have put the different uses and disclosures into categories and give examples of each. All of the ways we use or disclose your information will fit into one of the categories listed below, but we cannot list all of the uses and discloses in each category.

HOW WE USE YOUR PATIENT HEALTH INFORMATION

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluations of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS EXAMPLES

TREATMENT: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and the family members who are helping with your care.

PAYMENT: We may use and disclose your information to receive payment for the services and treatment provided to you. We use your information to create a bill and disclose your information when we send the bill to your insurance company, you, or a third party. The individual or entity paying the bill may request more information to determine whether the bill is covered by your insurance. We may tell your health plan about a treatment you are going to receive to get approval for payment or to determine whether your health plan will cover the treatment.

HEALTH CARE OPERATIONS: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to

assess the care and outcomes of your case and others like it.

SPECIAL USES

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

OTHER USES AND DISCLOSURES

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

REQUIRED BY LAW: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

PUBLIC HEALTH PURPOSES: We disclose to health agencies as required by law for preventing or controlling disease. Examples are reporting of sexually transmitted, communicable, and infectious diseases.

RESEARCH: We may use or disclose information for approved medical research.

HEALTH OVERSIGHT ACTIVITIES: Your health information may be disclosed to governmental agencies and boards for investigations, audits, licensing, and compliance purposes.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We may disclose information in response to an appropriate subpoena or court order.

LAW ENFORCEMENT PURPOSES: Subject to certain restrictions, we may disclose information required by law enforcement officials.

DEATHS: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

SERIOUS THREAT TO HEALTH OR SAFETY: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

MILITARY AND SPECIAL GOVERNMENT FUNCTIONS: If you are a member of the armed forces we may release information about you as required by military command authorities. We may also release information about foreign military personnel to the appropriate foreign military authority.

INMATES: If you are an inmate of a correctional institution or under the custody of a law enforcement official. This release must be necessary (1) for the institution to provide you with healthcare; (2) to protect

your health and safety or the health and safety of others; or (3) for the safety or security of the correctional institution.

ORGAN & TISSUE DONATION: If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ bank, as necessary to facilitate organ or tissue donation.

WORKERS COMPENSATION: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

SPECIALIZED GOVERNMENTAL FUNCTIONS: We may release information about you to authorized Federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

INDIVIDUAL RIGHTS

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

REQUEST RESTRICTIONS: You may request a restriction on how information about you is used and disclosed. If you want to request a restriction of a use or disclosure of your information, contact our Privacy Officer at the number listed at the end of this form. We are required to agree to request for a restriction related to disclosure of information to your health plan for payment or healthcare operations where you pay for the service in full. **We are not otherwise required to agree to any restriction on the use or disclosure of your information.**

CONFIDENTIAL COMMUNICATIONS: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

INSPECT AND OBTAIN COPIES: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

AMEND INFORMATION: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

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ACCOUNTING OF DISCLOSURES: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

OUR LEGAL DUTY

We are required by law to maintain the privacy of PHI and to provide individuals with this Notice of our legal duties and privacy practice regarding health information. We are required to notify you if there is a breach of your unsecured PHI. We are required to follow the terms of the current Notice. We may change the terms of this Notice and the revised Notice will apply to all health information in our possession. If we revise this Notice, a copy of the revised Notice will be posted and a copy may be requested from our Privacy Officer at the number listed at the beginning of this form.

CHANGES IN PRIVACY PRACTICES

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

COMPLAINTS

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

CONTACT PERSON If you have any questions, requests, or complaints, please contact: **Administrator, A Center for VisionCare, 2031 W. Alameda Avenue, Suite 300, Burbank, CA 91506 (818) 762-0647**
Effective Date: June 1, 2016

I, _____
Hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____

Date: _____

If not signed, reason why acknowledgement was not obtained:

Witness: _____

Date: _____