

## 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**

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

### **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 will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

**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.

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

**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 as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

**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.

### **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 restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

**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.

**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 protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

### **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 a any questions, requests, or complaints, please contact: **Administrator, A Center for VisionCare, 4418 Vineland Avenue, Suite 106, North Hollywood, CA 91602 (818) 762-0647**  
**Effective Date:** February 15, 2003

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:** \_\_\_\_\_