HOLLAND EYE CENTER, P.C.

Notice of Privacy Practices

Effective Date: August 2010

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.

The Health Insurance Portability and Accountability Act of 1966 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

A. How the Practice May Use or Disclose Your Health Information

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **TREATMENT** means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include performing diagnostic tests in our office.

- **PAYMENT** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **HEALTH CARE OPERATIONS** include the business aspects of running the Practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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

There are times we may be required by law to disclose information for law enforcement or public health reasons without additional authorization from the patient.

B. When the Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, the Practice will not use or disclose health information which identifies you without your written authorization. If you do authorize the Practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. We are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

C. Your Health Information Rights

You have the following rights with respect to your protected health information ("PHI"), which you can exercise by presenting a written request to the Privacy Officer using Practice forms:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of PHI from us by alternative means or at alternative locations.

- The right to inspect and copy your PHI.

- The right to amend your PHI.

- The right to obtain a paper copy of this Notice from us upon request.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI.

D. Changes to this Notice of Privacy Practices

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PHI that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from the Practice.

E. Complaints

If you believe there has been a problem with our collection, use or disclosure of your PHI, you have the right to file a complaint with our Privacy Officer. If we do not respond to your compliant in a satisfactory manner, you may file a complaint with the U.S. Office of Civil Rights. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint contact:

The U. S. Department of Health & Human Services
Office of Civil Rights
61 Forsyth Street, SW, Suite 3B70
Atlanta, GA 30303-8909
Telephone (404)562-7886; (404) 331-2867 (TDD)
FAX: (404) 562-7881
www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintpackage.pdf

HOLLAND EYE CENTER, P.C.
Patient Acknowledgement Form for

Patient Name: _____
(Please Print)

When you visit the Practice, it is very important that you feel safe in telling your physician personal information that may be required to fully diagnose or treat a problem. The Practice has strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. The Health Insurance Portability and Accountability Act ("HIPAA") rules require that the Practice provide all of our patients with the attached Notice of Privacy Practices on their first visit. The Notice describes how the medical information we receive from you may be used or disclosed by the Practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of our Notice to review. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer. Thank you for your cooperation.

Please Tell Us How to Contact You to Discuss Your Medical Care

It is our policy to not release a patient's confidential and/or unauthorized information by telephone or voice mail except for appointment confirmation. Whenever returning phone calls, we do not leave a message in voice mail if the name or telephone number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself, please complete the following:

I authorize the Holland Eye Center, P.C. to leave medical information pertaining to my care by the following methods and will assume responsibility to notify the Practice, in writing, whenever this information changes.

Home telephone: yes____ no____ Cell phone: yes___ no____
Voice Mail/Answering machine: yes____ no____ Work phone: yes____ no____
Pager: yes___ no____
May we fax medical records for referrals? yes____ no____
Please list names of people with whom we can discuss your medical care:
Spouse Name_____
Parent Name_____
Other Name (s) & Relationship _____
_____
Please list a "unique identifier" as a way to confirm your identity when calling the office. This "unique identifier" must be given before any information can be disclosed.

Unique Identifier:_____
(last four digits of your social security number or mother's maiden last name)

I also acknowledge that I have received a copy of the Practice's Notice of Privacy Practices and have been given an opportunity to ask questions.

Signature of Patient or Personal Representative:

_____ **Date:**_____

If Personal Representative, give relationship to patient:

_____