Ophthalmology Associates
1201 Summit Avenue
Fort Worth, Texas 76102

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.

This Notice of Privacy Practices describes how Ophthalmology Associates may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for your purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This notice was published and becomes effective on/or before September 1, 2012.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
Your protected health information may be used and disclosed (in paper or electronic form) by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. Except for the following purposes, we will use and disclose your protected health information only with your written permission. You may revoke such permission at any time by writing to:

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Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a surgery may require that your relevant protected health information be disclosed to your health plan to obtain approval for the surgery.

Healthcare Operations
We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to externs who observe patient exams at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation, research, criminal activity, military activity and national security, Worker's Compensation,

inmates, required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your c onset, authorization or opportunity to object unless required by law.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Following is a statement of your rights with respect to your projected health information. Such requests should be in writing and addressed to:

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You have the right to inspect and copy your protected health information

You have the right to inspect a copy of your medical record, in paper or electronic form. By Texas Law (HB 300), you may request an electronic or paper copy, and we must provide that within 15 days. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of or use in a civil, criminal or administrative action or proceedings, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information

This means that you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. you have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

Changes to this notice

We may change this notice and make it effective for medical information we already have about you, as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice at any visit or by written request.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received Ophthalmology Associates Notice of Privacy Practices.

_____ Account# _____
Patient Signature

_____
Date

_____
Patient Refusal to Sign / Employee / Date

Who may we give information to regarding your condition, treatment or diagnosis?

Name **Phone** **Relationship**

_____

_____

_____

_____

_____

Is there anyone who should <u>never</u> have this information:

_____

May we contact you at:

Home number _____ May we leave a message YES NO

Answering Machine _____May we leave a message YES NO

Work number _____ May we leave a message YES NO

Cell Phone _____ May we leave a message YES NO

May we send you emails related to patient information or appointments YES NO

Email address _____