

**OPHTHALMOLOGY ASSOCIATES
NOTICE OF PRIVACY PRACTICES
COMPREHENSIVE VERSION**

The protection of your health information is important to us at Ophthalmology Associates. We have available to you a comprehensive version of our Notice of Privacy Practices if you wish to read it in its entirety.

During the appointment check-in process you will be asked to sign a medical record document acknowledging receipt of the Notice of Privacy Practices. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement. If you have any questions about the Notice of Privacy Practices, please notify an Ophthalmology Associates physician or staff member.

Ophthalmology Associates is committed to treating and using protected health information about me responsibly. In using this information, this office will comply with all state and federal laws pertaining to your privacy rights, including the Privacy and Security protections provided to you by the Health Insurance Portability and Accountability Act ("HIPAA").

It is important to understand that your **health record** is the physical and legal property of Ophthalmology Associates, even though the information belongs to you. You may have access to inspect, amend or obtain a copy of your health information. Costs may be incurred for copies of your records, and appointments must be made with the Privacy Officer to inspect, access, or amend your health information.

Ophthalmology Associates is required to maintain the privacy of your health information. Ophthalmology Associates will require your authorization to release your health information to outside sources with the **exception** of disclosures for purposes of **Treatment, Payment, and Healthcare Operations**. Your authorization will need to be in writing and it will be specific to the disclosure requested. Your authorization for use and disclosure of information, with the exceptions as referenced above, may be revoked in writing at any time. Please notify this office if you ever decide to revoke your consent.

If you believe that your privacy rights have been violated, you may submit a written complaint to our HIPAA Privacy Officer at the address below:

Ophthalmology Associates
1201 Summit Avenue
Fort Worth, TX 76102
Attn: My Le, Privacy Officer

AVISO DE PRÁCTICAS DE PRIVACIDAD DEL PACIENTE

La protección de su información de salud es importante para nosotros en Ophthalmology Associates. Tenemos a su disposición una versión completa de nuestro Aviso de Prácticas de Privacidad si desea leerlo en su totalidad. Durante el proceso de registro de entrada en el nombramiento, se le pedirá que firme un documento de registro médico confirmando la recepción de la Notificación de Prácticas de Privacidad. La entrega de sus servicios de atención de salud de ninguna manera ser condicionado a su reconocimiento firmado. Si usted tiene alguna pregunta acerca de la Notificación de Prácticas de Privacidad, por favor notifique a un médico Ophthalmology Associates o miembro del personal.

Por favor, lea las siguientes

Se me ha proporcionado la oportunidad de leer el Aviso de Prácticas de Privacidad en Ophthalmology Associates.

Entiendo que Ophthalmology Associates se compromete a tratar y utilizar la información de salud protegida sobre mí de manera responsable. En la utilización de esta información, esta oficina se cumplen todas las leyes estatales y federales relativas a sus derechos de privacidad, incluyendo la privacidad y la protección de seguridad que le ha proporcionado la portabilidad de seguro de salud y Accountability Act ("HIPAA").

Entiendo que mi expediente médico es propiedad física y jurídica de Ophthalmology Associates, pero la información que me pertenece. Puede que tenga acceso para inspeccionar, modificar u obtener una copia de mi información médica. Los costos incurrirán por las copias de mis discos, y las citas deben ser hechas con el Oficial de Privacidad para inspeccionar, acceso o modificar mi información de salud.

Entiendo que Ophthalmology Associates está obligado a mantener la privacidad de mi información de salud. Ophthalmology Associates requerirá mi autorización para divulgar mi información de salud a fuentes externas, con la excepción de las divulgaciones para fines de tratamiento, pago, y servicios sanitarios. Su autorización tendrá que ser por escrito y será específica para la divulgación solicitada. Su autorización para el uso y divulgación de información, con las excepciones que se hace referencia anteriormente, puede ser revocado por escrito en cualquier momento. Por favor notifique a esta oficina si alguna vez decide revocar su consentimiento.

Si usted cree que sus derechos de privacidad han sido violados, usted puede presentar una queja por escrito a nuestro Oficial de Privacidad HIPAA a la dirección siguiente :

Associates Oftalmología
1201 Summit Avenue
Fort Worth, TX 76102
A la atención de : My Le, Oficial de Privacidad

Notice Revision Date: January 30, 2018



Your Information.
Your Rights.
Our Responsibilities.

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.**

YOUR RIGHTS

WHEN IT COMES TO YOUR HEALTH INFORMATION, YOU HAVE CERTAIN RIGHTS.

This section explains your rights and some of our responsibilities to help you.

ASK US ABOUT HOW TO REGISTER FOR OUR PATIENT PORTAL

You have the right to:

- **Get an electronic or paper copy of your medical record**
 - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
 - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your medical record**
 - You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
 - We may say “no” to your request, but we’ll tell you why in writing within 60 days.
- **Request confidential communications**
 - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
 - We will say “yes” to all reasonable requests.
- **Ask us to limit what we use or share**
 - You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
 - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.
- **Get a list of those with whom we’ve shared information**
 - You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
 - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Get a copy of this privacy notice**
 - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you**
 - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
 - We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated**
 - You can complain if you feel we have violated your rights by contacting us.
 - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
 - We will not retaliate against you for filing a complaint.

YOUR CHOICES

FOR CERTAIN HEALTH INFORMATION, YOU CAN TELL US YOUR CHOICES ABOUT WHAT WE SHARE.

If you have a clear preference for how we share your information in the situations described below, talk to us.

Tell us what you want us to do, and we will follow your instructions.

- **In these cases, you have both the right and choice to tell us to:**
 - Share information with your family, close friends, or others involved in your care about your condition
 - Share information in a disaster relief situation
 - Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- **In these cases we never share your information unless you give us written permission:**
 - Marketing purposes
 - Sale of your information
 - Most sharing of psychotherapy notes
- **In the case of fundraising:**
 - We may contact you for fundraising efforts, but you can tell us not to contact you again.

HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION?

We may use and share your information as we:

- **Treat You**
 - We can use your health information and share it with other professionals who are treating you.
 - **Example: A doctor treating you for an injury asks another doctor about your overall health condition.**
- **Run our organization**
 - We can use and share your health information to run our practice, improve your care, and contact you when necessary.
 - **Example: We use health information about you to manage your treatment and services.**
- **Bill for your services**
 - We can use and share your health information to bill and get payment from health plans or other entities.
 - **Example: We give information about you to your health insurance plan so it will pay for your services.**

How else can we use or share your health information? We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- **Help with public health and safety issues**
 - We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety
- **Do Research**
 - We can use or share your information for health research.
- **Comply with the law**
 - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **Respond to organ and tissue donation requests**
 - We can share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director**
 - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Address workers' compensation, law enforcement, and other government requests**
 - We can use or share health information about you:
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services.
- **Respond to lawsuits and legal actions**
 - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

CHANGES TO THE TERMS OF THIS NOTICE - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our web site.

www.fortworth2020.com

This notice is effective February 16, 2017

FOR MORE INFORMATION SEE: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html