

FLORIDA EYE AND LASER INSTITUTE
NOTICE OF PRIVACY PRACTICE

THIS NOTICE, EFFECTIVE 4-14-03, DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit a physician, hospital, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing related information. Your record represents Protected Health Information.

We are committed to treating and using Protected Health Information about you responsibly. This notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information. This Notice applies to all Protected Health Information, as defined by federal regulations, that is generated by our office.

THE FOLLOWING CATEGORIES DESCRIBE EXAMPLES OF THE WAY WE USE AND DISCLOSE HEALTH INFORMATION

For Treatment: We may use your health information to provide you with medical treatment or services. We may disclose medical information about you to other health professionals who contribute to your care (such as doctors, nurses, technicians, or other personnel who are involved in taking care of you.)

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company, or a third party payer. For example, we may need to give your insurance company information about your treatment so they will pay us for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Healthcare Operations (Business Associates): There are some services provided in our office through contacts with business associates. Examples include transcription of your health information, a copy service making copies of your health records, and off site storage of medical records. When services such as these are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information.

For Research: We may disclose information to researchers when an institute review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

Communication with Family or Friends: We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

We may also use and disclose medical information to/for the following:

- * to remind you that you have an appointment.
- * Public Health Authorities
- * to assess your satisfaction with our services
- * Workers Compensation Agents
- * Food and Drug Administration
- * Legal Authorities
- * Organ and Tissue Donation Organizations
- * Military Command Authorities
- * Health Oversight Agencies
- * National Security & Intelligence Agencies
- * Funeral Directors, Coroners, Medical Directors
- * Proactive Services for the President
- * to notify or assist in notifying a disaster relief entity so that your family can be notified about your health status
- * for law enforcement purposes as required by law or in response to a subpoena

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of this office, you have the right to:

Inspect a Copy: You have the right to view your Protected Health Information, obtain a copy of the information, or both. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We are allowed to charge you for these copies.

Amend: If you feel that medical information is incorrect or incomplete, you may ask to amend (not change) the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You may have the right to request a list of certain disclosures we make of your medical information for purposes other than treatment, payment, or healthcare operations.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you. We are not required to agree to your request. If we do agree to the request restriction, it will be honored with the exception of permitted disclosures, including emergency treatment, public health authority, Food and Drug Administration, work related injury, and OSHA compliance.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location (for example, at work, or by U.S. Mail). We will grant this request only if it is submitted in writing. We reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.

A Paper Copy of This Notice: You may ask us to give you a copy of this Notice.

If you have any questions about this Notice, please contact our Privacy Officer at 941-883-2020.

We reserve the right to change this notice and to make the new provisions effective for all Protected Health Information we maintained from the first date of your health record. The current notice will be posted and include this effective date.

If you believe your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer in our office at 3195 Tamiami Trail, Port Charlotte, Florida 33952. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You may revoke your permission to use or disclose medical information about you, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

**Acknowledgment of Receipt of Notice of Privacy Practices, Office of :
Florida Eye & Laser Institute**

By signing this document, I acknowledge that I have read a copy of this office's Notice of Privacy Practices.

PRINT Name

Signature

Date