PRIVACY NOTICE

"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."

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- understanding of what is in your record and how your health information is used to help you to:
    - * ensure its accuracy
    - * better understand who, what, when, where, and why others may access your health information
    - * make more informed decisions when authorizing disclosures to others

Your Health Information Rights

Although your health record is the physical property of the health care facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

This practice is required:

- by law to maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction

We reserve the right to change our privacy practices and apply the revised practices to protected health information previously created. We will provide you with a revised notice.

We also reserve the right to:

- call you to provide appointment reminders
- call you to provide changes in your appointment date and time

The Practice also will:

- use your health information for treatment
- use your health information for payment
  - * A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.
- use your health information for regular health operations
  - * The physician may use information in your health record to assess the care and outcome in your case. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

There are some services provided in our practice through contacts with Business Associates (i.e. Transcriptionist, Billing Service). When these services are contracted, we may disclose your health information to our Business Associates so they can perform the job we've asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If you believe your privacy rights have been violated, you can file a complaint with our Privacy Officer, Janet Neil, or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Effective Date: April 1, 2003

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of this practice's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) Concerning the use of my personal medical information:

_____ _____

_____ _____

_____ _____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to Costello Eye Physicians and Surgeons, PLLC. Regulations pertaining to medical assignment of benefits apply.

Signed:_____

Date:_____

If not signed by patient, please indicate relationship to patient (e.g. spouse)

Relationship:_____ __

Witnessed by:_____

IF PATIENT REFUSES TO SIGN, INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW.

[ ] Patient refused to sign this Acknowledgement.

Date:_____ Time:____am ____pm

Employee Name:_____