



**OPHTHALMIC CONSULTANTS OF THE CAPITAL REGION**

**SUMMARY OF PRIVACY PRACTICES**

This summary of our privacy practices is contains a condensed version of our Notice of Privacy Practices. Our full-length Notice follows this summary.

Date of Last Revision: 9/23/13

Effective Date: Immediately

*This information is made available on request by a patient*

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.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.



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You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential Communications

For more information about these rights, please see the detailed Notice of Privacy Practices that follows this summary.



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## **OPHTHALMIC CONSULTANTS OF THE CAPITAL REGION NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY  
BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS  
INFORMATION**

**PLEASE READ IT CAREFULLY**

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that 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, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

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

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

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

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

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and 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.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

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

This notice is effective as of 9/23/13 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer, Nancy Shipley for more information, in person or in writing.

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## OPHTHALMIC CONSULTANTS OF THE CAPITAL REGION

### WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of \_\_\_\_\_. I hereby acknowledge receipt of Ophthalmic Consultants of the Capital Region's Notice of Privacy Practices.

Name [please print]: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

OR

I am a parent or legal guardian of \_\_\_\_\_ [patient name]. I hereby acknowledge receipt of Ophthalmic Consultants of the Capital Region's Notice of Privacy Practices with respect to the patient.

Name [please print]: \_\_\_\_\_

Relationship to Patient:       Parent                       Legal Guardian

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## OPHTHALMIC CONSULTANTS OF THE CAPITAL REGION

### AUTHORIZATION FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Specific description of the information to be used or disclosed, including the specific purpose:

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Individuals who may use or disclose this information: \_\_\_\_\_

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Individuals who may receive and use the disclosed information: \_\_\_\_\_

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Expiration date of this authorization: \_\_\_\_\_

The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

To the extent that this form authorizes the sale of your Protected Health Information, such a disclosure will result in remuneration to the Practice.

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By signing this form, you authorize the Practice to use and disclosure Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

This authorization was signed by: \_\_\_\_\_  
Printed Name – Patient or Representative

In front of \_\_\_\_\_  
Printed name – Practice representative

Witness: \_\_\_\_\_ / / \_\_\_\_\_ By: \_\_\_\_\_  
Name Date Patient or Representative

Relationship to Patient (if other than patient): \_\_\_\_\_

Date: \_\_\_\_\_ / / \_\_\_\_\_





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## OPHTHALMIC CONSULTANTS OF THE CAPITAL REGION REQUEST FOR ACCESS TO MEDICAL INFORMATION

Our Notice of Privacy Practices provides information about our use of a patient's protected health information. The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect, and copy protected health care information used to make decisions about them.

The Practice will only include information used to make decisions about the patient. The Practice may limit access to information generated only by this Practice. Under some circumstances, such as increased risk of harm or injury, the Practice may withhold the requested information. The Privacy Officer of this Practice will evaluate this Request and notify the patient of our decision within fifteen (15) days of this Request. If the Request is approved, the Practice will provide the information within thirty (30) days or within sixty (60) days if such an extension is necessary. Reasonable costs will be charged for the Request. Costs will be submitted to the patient upon approval of the Request. The Practice may provide a summary of the requested information if you are agreeable.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Name: \_\_\_\_\_

Health Care Information requested. Please provide dates, diagnosis, treatment, or any other indications of the specific information you desire: \_\_\_\_\_

Is a summary of the information acceptable? \_\_\_\_\_

Do you wish to:

    Arrange an appointment to inspect the requested information?

    Receive a copy of the information?

Instructions regarding copies:

    I will pick the copies

    Please mail the copies to me at the following address: \_\_\_\_\_

This Request was signed by: \_\_\_\_\_

Printed Name – Patient or Representative

Relationship to Patient (if other than patient): \_\_\_\_\_

    Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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## OPHTHALMIC CONSULTANTS OF THE CAPITAL REGION

### REQUEST TO AMEND MEDICAL INFORMATION

Our Notice of Privacy Practices contains a Patient Rights section describing your rights under the law. Patients have the right to request amendment of protected health care information used to make decisions about them if they believe the information is inaccurate or incomplete, and we still maintain their file. We are generally required to review and respond to your request within sixty (60) days. If you believe that your information is inaccurate or incomplete, please complete and submit this form. We will then respond to your request within the required time period.

Patient Name: \_\_\_\_\_

Health Care Information that you wish to amend: Please provide dates, diagnosis, treatment, or information in your file that you believe is inaccurate or incomplete and that you wish to amend:

\_\_\_\_\_

Please indicate the inaccuracy or incomplete aspect of the information in your file: \_\_\_\_\_

\_\_\_\_\_

Please indicate the amendment you wish to make: \_\_\_\_\_

\_\_\_\_\_

This Request was signed by: \_\_\_\_\_

Printed Name – Patient or Representative

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Representative's Authority to Sign for Patient: \_\_\_\_\_

(e.g. parent, guardian, legal representative)



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## OPHTHALMIC CONSULTANTS OF THE CAPITAL REGION PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of Ophthalmic Consultants of the Capital Region not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: _____	_____ yes	_____ no
Parent: _____	_____ yes	_____ no
Other: _____	_____ yes	_____ no
_____	_____ yes	_____ no
_____	_____ yes	_____ no

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PRINTED NAME** \_\_\_\_\_

Patient/Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**FOR OFFICE USE**

Changes to above authorized by patient over phone:

Change	Date	Staff Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____

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