

KOZOL VISION CENTER
NOTICE OF PRIVACY RIGHTS & PRACTICES
(Effective April 14, 2003)

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.

As of April 14th, 2003, we are required under the Health Insurance Portability and Accountability Act (HIPAA) and currently under Massachusetts law to maintain the privacy of your health information, and to provide *you* with this Notice of Privacy Rights & Practices.

This document explains in detail how *we* use your Protected Health Information (PHI) which is any information about you that could identify you, your past, present, or future physical or mental health condition(s). Your acknowledgement of receipt of this document will be required the first time you receive services after April 14th, 2003.

Examples of how we can use and disclose your information without your authorization include:

- Treatment — we keep a record of each visit. These records may include your test results, diagnoses, medications or other therapies. These records are used and disclosed to allow doctors, nurses and other health care and clinical staff providers to offer high quality care to meet your needs.
- Payment — we maintain a record of and may use and disclose information related to, services and supplies you receive at each visit, so that we can be paid by you, an insurance company, or a third party. We may tell your health plan and other payors about an upcoming treatment or service, which requires their prior approval and authorization.
- Health Care Operations - we use and disclose your medical information to improve the services we provide, to train staff and students, for business management, and for customer service purposes.

Your information may be shared amongst. Other Health organizations, other health care providers, third party payors, and our Business Associates to facilitate treatment, payment or health care operations.

ADDITIONAL USES AND DISCLOSURES:

I. There are additional **times** when we are permitted **OR** required to use and/or disclose medical information without your permission.

These circumstances are listed below:

- In emergency treatment situations • If required by law
- To assist incommunicative patients • For law enforcement
- So protect victims of abuse, neglect or domestic violence • For public health activities such as tracking diseases
- For organ donations • For health oversight activities such as fraud investigations
- To Workers' Compensation if you are injured **at** work • For certain judicial or administrative proceedings
- To coroners, medical examiners and funeral directors • For govt functions such as national security & intelligence
- To a correctional institution if you are an inmate • To avert serious threat to public health or safety

II. We may also use your information without your permission to:

- Recommend treatment alternatives
- Tell you about health benefits and/or services
- Send or call you with appointment reminders
- Ask you to make a charitable gift
- To communicate with those involved in your care

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Except as otherwise permitted by law, all other uses and disclosures not described above will require your signed authorization. You may revoke any authorization you provide at any time by delivering a written statement directly to the Privacy Officer, except to the extent that we have already taken action in reliance on your authorization. III. Please know that federal and state law requires special privacy protections for certain highly confidential information about you, including but not limited to:

- Psychotherapy notes
- Mental health and developmental disabilities services
- Alcohol and drug abuse prevention, treatment and referral
- HIV/AIDS testing, diagnosis or treatment
- Venereal disease(s)
- Genetic testing
- Child abuse and neglect
- Domestic abuse of an adult with a disability
- Sexual assault.

In order for-us to disclose your highly confidential information for a purpose other than those permitted by law, we must obtain your written authorization.

Your Rights under HIPAA, you have the right to request in writing:

- Restrictions on how we use or disclose your medical information.
- Confidential communications to an alternate phone or address other than your home.
- Access to your medical information to review and obtain a copy, subject to federal and state laws (fees may apply).
- An amendment to your medical information if you feel you or your health care provider needs to make additions or corrections.
- An accounting of disclosures of your medical information for purposes other than treatment, payment, health care, operations, or made pursuant to an authorization.
- A paper copy of this notice even if you have received it electronically.
- A revocation of any specific authorization obtained in connection with your privacy, such as for marketing and research.

While we will consider all requests for privacy restrictions carefully, we are not required to agree to any requested restrictions.

Our Responsibilities: We are required by law to maintain the privacy of your medical information, to provide you with this written Notice of Privacy Rights and Practices, and to abide by the terms of the Notice currently in effect. We reserve the right to change this Notice and our privacy practices and make the new provisions effective for all information we maintain. Revised Notices will be posted in our offices, and will be available from your direct treatment provider.

For More Information: If you would like further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact our Privacy Officer at the address or phone number below. You may also file written complaints with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy officer will provide you with the correct address of the Director. We will not retaliate against you if you file a complaint with the Director on us.

Kozol Vision Center and its employees are committed to protecting your patient privacy.

Signed: _____ Date: _____

OPTOS WAIVER

This is to certify that I have agreed to pay **\$39.00** out of pocket for OPTOS photography. I understand that my insurance does not cover this service and I agree not to request reimbursement from my insurer either through direct billing or by non covered allowance.

OPTOS photography might be reimbursable through flex benefits frequently offered by employers.

Patient Signature: _____ **Date:** _____