Effective Date: Nov 1st 2016
Revision Date: TBD

Right to Notice: As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information under the Health Insurance Portability and Accessibility Act (HIPAA).

Eminence Family Eyecare can use your protected health information as described below.

Treatment - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. This includes faxing, emailing, or phoning your prescription for medicine or medical devices to providers of these services.

Payment - We may use and disclose your health information to obtain payment for services we provide to you.

Health care operations - We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. Most uses and disclosures that do not fall under treatment, payment, or health care operations will require your written authorization. You may revoke your authorization in writing through our practice at any time, except under the circumstances listed below.

Emergency Situations - In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

Required by Law - We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect - We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

National Security - We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders - We may use or disclose your health information to provide you with appointment reminders via phone, email, or mail.

Your Rights as a Patient: You have the right to restrict the disclosure of your protected health information in writing. The request for restriction may be denied if the information is required for treatment, payment, or health care operations. You have the right to receive confidential communications regarding your protected health information. You have the right to inspect and copy your protected health information. You have the right to amend your protected health information. You have the right to receive an account of disclosures of your protected health information. You have the right to a paper copy of this notice of privacy practices.

Legal Requirements: Stratford Eye Care Optometry is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are available within our office.

For Law Suites and Disputes: If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. In response to a subpoena discovery or other lawful process by someone else involved on the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting that information.

For Specialized Government function: (1) if you are a member of the armed forces, as required by military command authorities; (2) if you are an inmate or in lawful custody, to a correctional facility or law enforcement official; (3) In response to a request from law enforcement, if certain conditions are satisfied; (4) For national security reasons authorized by law; and (5) To authorized federal officials to protect the president, other authorized persons or head of state.

For Workers' Compensation or other similar programs

Organ and Tissue Donation: To organ procurement or similar organizations for the purposes of donation or transplant.

Coroners or Funeral Directors: To a coroner or medical examiner, for example, to determine cause of death. To funeral directors consistent with applicable law to enable them carry out their duties.

Personal Representatives: To a person legally authorized to act on your behalf, such as parents, legal guardian, administrator, or executor of your estate, or other individual authorized under applicable law.

Data Breach: To provide legally required notices and reports and otherwise respond to unauthorized access to disclosure of your health information.

Complaints: If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint. For further information about Stratford Eye Care Optometry privacy policies, please contact our office at the address or phone number listed above.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

Patients Name: ____

Signature ________________________________ Date:_________________

OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:
DATE:___________________ INITIALS:___________ REASON:____