

HIPAA Notice of Privacy Practices

PEDIATRIC OPHTHALMOLOGY ASSOCIATES, P.C.
515 N. 98TH STREET
OMAHA, NE 68114, 402-399-9400, FAX 402-399-8170

**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**

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) TO CARRY OUR TREATMENT, PAYMENT OF HEALTH CARE OPERATIONS (TOP) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or conditions and related health care services.

USES AND DISCLOSURES OF PROTECT HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. FOR EXAMPLE: We would disclose your protected health information, as necessary, to a home health agency that provides care to you. FOR EXAMPLE: Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. FOR EXAMPLE: Obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPTIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians' practice. These activities include but are not limited to quality assessment activities, employee review activities, training or medical students, licensing and conducting or arranging for other business activities. FOR EXAMPLE: We may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may also disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: As Required by Law, Public Health issues as required by Law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements. Legal Proceedings: Law Enforcement, Coroners, Funeral Directors, and Organ Donation Research: Criminal Activity, Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES will be made only with our Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization at any time, in writing except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS: The following is a statement of your rights with respect to your protected health information:

YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION. Under the federal law, however you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of or use in a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR HEALTH INFORMATION. This means you may ask not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request to receive confidential communications from us by alternate means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to receive an account of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaints. **WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.**

This notice was published and became effective on or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (402) 399-9400.

Signature below is only acknowledgment that you received this Notice of our **PRIVACY PRACTICES:**

PRINT NAME

DATE

SIGNATURE

