

RETINA CENTER OF PENSACOLA'S NOTICE OF PRIVACY PRACTICES  
EFFECTIVE 11/26/2013

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**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.**

If you have any questions about this notice, please contact the Privacy Officer at 850-607-6841.

Each time you visit Retina Center of Pensacola (RCP), information is generated about you and your care. This information is kept in your patient medical record. This Notice of Privacy Practices describes how RCP will use and disclose Protected Health Information (PHI) about you. The Notice will also describe your rights and certain obligations RCP has regarding use and disclosure of PHI.

#### **OUR RESPONSIBILITIES**

RCP is required by law to:

- make sure that PHI that identifies you is kept private;
- give you this notice of our legal duties and privacy practices concerning PHI about you; and
- Follow the terms of the notice that is currently in affect.

#### **HOW THE PRACTICE MAY USE OR DISCLOSE YOUR INFORMATION**

- **Treatment:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, technicians, nursing or medical students or RCP personnel who are involved in taking care of you. For example, we would disclose your information, as necessary, to a pharmacy that would fill your prescriptions. Your medical information also may be shared in order to coordinate prescriptions for glasses. We may also disclose PHI about you to people who may be involved in your medical care such as family members, clergy, nursing homes, etc.
- **Payment:** We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether or not your plan will cover the surgery.
- **Healthcare Operations:** We may use or disclose your PHI in order to support RCP's business activities and quality assessment purposes and to help improve the care we give you. These uses and disclosures are necessary to run our organization and make sure all of our patients receive quality care. For example, we may disclose your PHI to help teach medical school or nursing students that are in our office. We may also use and disclose health information:
  - To business associates we have contracted with to perform the agreed upon service and bill for it;
  - To assess your satisfaction with our services;
  - To tell you about possible treatment options;
  - To tell you about health-related benefits or services;
- **People involved in your care and payment for your care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. We may also release information to someone who helps pay for your care. If you are unable to agree or object to such disclosure, we may disclose such information, as necessary, if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only PHI that is necessary will be disclosed.

#### **SPECIAL NOTICES**

- **Appointment Reminders:** We may call you at home to remind you that you have an appointment. We may also send you appointment reminders in the mail. If you do not want us to do this, please let us know in writing.
- **Sign-In Sheets:** We may use sign-in sheets in our waiting room which will ask you to write down your name and the name of your doctor. We may call your name to tell you when the doctor is ready to see you.
- **Research:** We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

#### **SPECIAL SITUATIONS**

- **As Required By Law:** We may use or disclose your PHI to the extent that the use or disclosure is required by law.

- **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **Organ and Tissue Donation:** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Health Oversight:** We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- **Public Health Risks:** We may disclose medical information about you for public health activities in the following ways:
  - o to prevent or control disease, injury or disability;
  - o to report births and deaths;
  - o to report child/elder abuse or neglect;
  - o to report reactions to medications or problems with products;
  - o to notify people of recalls of products they may be using
  - o to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - o to notify the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Legal Proceedings:** We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, in certain conditions in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement:** We may also disclose PHI, for law enforcement purposes. These law enforcement purposes include:
  - o In response to a court order, subpoena, warrant, summons or similar processes;
  - o To identify or locate a suspect, fugitive, material witness, or missing person;
  - o About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - o About a death we believe may be the result of criminal conduct;
  - o About criminal conduct at Retina Center of Pensacola; and
  - o In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **Coroners, Funeral Directors, and Organ Donation:** We may disclose PHI information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
- **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
- **Workers' Compensation:** Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.
- **Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institute or law enforcement official. This release would be necessary: (1) for the institution to provide you with health care, (2) to protect your health and safety or the health and safety of others, or (3) for the safety and security of the correctional institute.

## OTHER PERMITTED USES AND DISCLOSURES

You have the following rights regarding medical information we maintain about you:

- **Right to a Paper Copy of this Notification:** If asked, we will provide you with a paper copy of this Notice.
- **For All Other Uses and Disclosures:** All other uses and disclosures of information not contained in this Notice of Privacy Practices will not be disclosed without your authorization.
- **Right to Request Confidential Communication:** You may ask us to communicate with you in certain ways. For example, you can ask us not to call you at work, or send appointment reminders to your home. If you wish to

make this request, you must do so in writing. We may ask you to provide us with a different place to contact you. We will agree to reasonable requests.

- **Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must complete an "Authorization to Release Copies of a Medical Record" form. We may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request in writing that the denial be reviewed. Another RCP qualified employee will review your request.
- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to our privacy officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.
- **Right to Amend:** You may ask us to change your PHI. For example, if we recorded the wrong date of birth for you, or the wrong date of service, you may ask us to correct that information in our records. If you would like us to correct something, you must make your request in writing. The law does not require us to agree to your request. If we do not agree to amend your PHI, you can appeal our decision. Your appeal must also be in writing. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by RCP, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for our practice;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.
- **Right to Accounting of Disclosures:** You can ask us to provide a list of people with whom we have shared your PHI. This does not include disclosure for purposes of treatment, payment or healthcare operations, disclosures made pursuant to your valid authorization, disclosures we have made to you, for a facility directory, to family members or friends involved in your care, or disclosures for notification purposes. We are required to keep records of disclosure for six years, beginning on April 14, 2003. We will not have any information about disclosures that took place before April 14, 2003. If you request more than one accounting in a twelve-month period, we may charge you a fee.
- **Right to Restrict Release of Information for Certain Services:** You have the right to restrict the disclosure of information regarding services for which you have paid in full or on an out of pocket basis. This information can be release only upon your written authorization.
- **Right to Breach of Notification:** You have the right to be notified of any breach of your unsecured healthcare information.

## CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our office. This notice will contain on the first page, the effective date. In addition, each time you are seen for treatment or health care services at our office, we will offer you a copy of the current notice in effect.

## COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with Retina Center of Pensacola, please write to the Privacy Officer at Retina Center of Pensacola, 1549 Airport Blvd. Suite 410, Pensacola, FL 32504. **You will not be penalized for filing a complaint.**

## OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you or the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.



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

Date of Birth: \_\_\_\_\_

Medical Record Number: \_\_\_\_\_

### Consent to Use/Disclose Protected Health Information

Your medical information may be used and disclosed to carry out your treatment, bill and receive payment and for health care operations. More specific information pertaining to our practice policies is provided for you in our "Notice of Privacy Practices" statement. You have a right to review this statement prior to receiving health care and prior to signing this consent.

The terms of our "Notice of Privacy Practices" may change at any time. You may contact the office and request a revised policy. Also, if you so choose, you may request that we restrict the use of your health information for the purposes of treatment, payment, and/or health care operations. Our physicians are not required to agree with the restriction. If the physicians believe it is in your best interest to permit use and disclosure of your protected health information, this information will not be restricted.

I understand that I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent

I acknowledge that I have received a copy of the "Notice of Privacy Practices" from Retina Center of Pensacola, and I consent to the above noted terms related to the use and disclosure of my individually identifiable health information for the purposes of treatment, payment and/or health care operations.

\_\_\_\_\_  
Patient name (printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient, parent or legal guardian signature

\_\_\_\_\_  
Relationship to patient of the person signing

**If written acknowledgement is not obtained, please check the reason:**

Notice of Privacy Practices given -patient unable to sign

Notice of Privacy Practices given –patient declined to sign

Reason patient declined to sign: \_\_\_\_\_  
.....

\_\_\_\_\_  
Employee witness

\_\_\_\_\_  
Date