**THE EYE CARE Team, Inc.**

126 N. Washington St.

Spokane, WA 99201

(509)747-6581 Fax (509)747-6354

HIPAA PRIVACY NOTICE TO PATIENTS

Revised 7/2013

**HIPAA** is the acronym for the Health Insurance Portability and Accountability Act that was signed into law on August 21, 1996, Public Law 104-191. This law impacts all areas of the health care industry and was designed to provide insurance portability; to improve the efficiency of health care by standardizing the exchange of administrative and financial data, and to protect the privacy, confidentiality and security of health care information.

**In order to comply** with this legislation, the Eye Care Team, Inc. is required to provide this notice which describes how medical information about you may be used and disclosed and you can get access to this information. Please review it carefully.

The law does **NOT** require that we obtain authorization for use or disclosure of your medical information when we are directly involved in your care, and when the use or disclosure is for purposes of **providing treatment, obtaining payment, or operations of the practice.**

**For Treatment:** Your personal health information may be provided to a physician, specialist or laboratory to whom you have been referred, to ensure they have the necessary information to diagnose, treat or provide you a service.

**For Payment:** Your personal health information may be used to enable us to bill and either collect payment from you, a health plan or third party for treatment and services you receive from us.

**For Health Care Operations:** We may use and disclose your health information to support the business activities of our office. These include but are not limited to, the evaluation of our team members in caring for you, quality assessment, or disclosure of information to physicians, nurses, technicians, students or other authorized personnel for educational and learning purposes.

**Appointment Reminders/Health-Related and Services:** We may use and disclose your information to contact you to remind you that you have a scheduled medical appointment or to advise you of treatment options or health-related benefits and services which may be of interest to you.

**Please let us know if you wish to have kept in confidence** the fact that you have an appointment with us; otherwise in the course of telephone conversations to your home or family, such information may be disclosed.

**Please inform us if you do not want us to leave voice messages at any of the numbers you have provided.**

**As Required by Law:** Our providers may use or disclose protected health information about you for other purposes, without consent, if we are required by local, state, federal or international law to disclose to governmental authorities. Such uses or disclosures may include:

Suspected abuse or child abuse/documented communicable diseases.

Reporting to public health or mandated patient registries.

**Lawsuits and Disputes:** If you are involved in a lawsuit or dispute, we may disclose medical information in response to a court or administrative order. We may also disclose medical information in response to a subpoena, discovery request or other lawful process or to our attorneys in accordance with applicable state law.

**Genetic information:** If we are in possession of any genetic information in your health information, disclosure of genetic information will be made with your written authorization.

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**Our practice** may make other uses and disclosures of your protected health information with your written authorization.

**Marketing & any purposes which require the sale of your information:** These disclosures require your written authorization, except for a face-to-face encounter or a communication involving a promotional gift of nominal value. We are prohibited from selling lists of patients to third parties for marketing activities of the third party without your authorization. We may communicate with you about our own health-related products and services and inform you of value-added items and services, such as discounts and new products.

**You have the right to revoke such authorization.**

**You have other rights regarding your protected health information. You may:**

* Request restrictions on certain uses and disclosures of protected health information; we will make every effort to comply with a requested restriction, but we are not required to do so.
* Request a restriction or limitation of the protected information we use or disclose if it pertains solely to a health care item or service for which the health care provider has been paid out of pocket in FULL. You may request a limit on the protected health information we disclose about you to someone involved in your care or payment of our care. You request must be made in writing. You may not request that we restrict the disclosure of your health information for treatment purposes.
* Request that you receive confidential communication of protected health information. You are responsible for letting us know if this is your desire. We will make all reasonable efforts to see that your protected health information, for purposes other than treatment, payment or operations, are communicated only to you. This may require confirmation of your identity and/or a written signed release form.
* Request a copy of your own protected health information (a copying fee will apply and a signed release form will be requested) OR per HITECH Act, you may request an electronic copy of that Electronic Health Records portion of your Medical Record.
* Request that your information be amended. Your request should be in writing and will be made part of your medical record.
* Request an accounting of disclosures of protected health information made by the practice in the past six years.
* Request a paper copy of this notice.

The practice is required to act on your request within 60 days.

The practice is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.

The practice is required to abide by the terms of this notice and provide individuals with revisions to the notice.

You may complain to the practice or the Secretary of Health and Human Services, if you believe that your privacy rights have been violated. File a complaint in writing to Privacy Officer, the Eye Care Team, Inc., 126 N Washington St., Spokane, WA 99201. No one will attempt to retaliate against you for filing a complaint.

**I have reviewed this notice and believe I understand my right to privacy:**

(or see signature on patient history form)

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**Patient’s name Responsible Party ( if patient is under age 18)**

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**Signature Date**