NOTICE OF PATIENTS' PRIVACY RIGHTS

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.

I. **PURPOSE OF THIS NOTICE**

Our Practice is committed to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our Practice concerning your PHI. By federal and state law, we must follow the terms of this Notice of Patient's Privacy Rights ("Notice") currently in use by the Practice.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI;
- Your privacy rights in your PHI; and
- Our obligations concerning the use and disclosure of your PHI.

The terms of this Notice apply to all records containing your PHI that are created or retained by our Practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this Notice will apply to all of your records that our Practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our Practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time. Our Practice will always follow the Notice that is in effect at the time any action related to PHI is taken.

II. **If you have questions about the Notice, please contact:** Katie Ortiz, Chief Operating Officer

III. **DIFFERENT WAYS THE PRACTICE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION:**

A. **Treatment.** Our Practice may use your PHI to treat you. For example, we might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our Practice—including, but not limited to, our doctors, nurses, and technicians—may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, with your authorization, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents, collectively called your "Friends and Family List," as documented by you on your "Patient Authorization for Use and Disclosure of Protected Health Information" form. To let us know with whom you

want your information shared, please be sure to complete this notice. Finally, we may also disclose your PHI to other healthcare providers for purposes related to your treatment.

B. **Payment.** Our Practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such service costs, such as family members. Also, we may use your PHI to bill you directly for service and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts. You have the right to request that our Practice not submit a claim to your insurance company for payment due to privacy concerns. However, you agree to pay for all services in full under the time frame specified by our Practice. Failure to do so constitutes a waiver of this right (see 'Requesting Restrictions' below).

C. **Healthcare Operations.** Our Practice may use and disclose your PHI to operate our business. As examples of the way in which we may use and disclose your information for operations, our Practice may use your PHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our Practice. We may disclose your PHI to other healthcare providers and entities who are involved with your healthcare to assist in their healthcare operations.

D. **Disclosure to You.** Our Practice may disclose your medical information to you or a third party to whom you request us in writing to disclose your medical information.

E. **Release of Information to Family and Friends.** With your authorization, our Practice may release your PHI to a friend or family member that is involved in your care, or who assists in take care of you. Generally, we require written authorization to share your PHI with friends and family members.

F. **Disclosures Required by Law.** Our Practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

G. **Disclosures to Business Associates**. Our Practice may contract or otherwise arrange with other entities to perform services. System may then disclose your medical information to these "Business Associates," and these Business Associates will use or disclose your medical information only to the extent the Practice would be able to do so. These Business Associates are also required to comply with federal law that regulates your medical information privacy.

H. **Limited Data Set**. The Practice may use or disclose your medical information for purposes of healthcare operations, research, or public health activities if the information is stripped of direct identifiers and the recipient agrees to keep the information confidential.

IV. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION IN CERTAIN CIRCUMSTANCES:

A. **Health Oversight Activities.** Our Practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the healthcare system in general.

B. **Lawsuits and Similar Proceedings.** Our Practice may use and disclose your medical information to persons authorized by law to receive the information under a court order, subpoena, discovery request, warrant, summons, or similar process. Requests for your medical information from an attorney involving civil litigation must be accompanied by your signed authorization.

C. **Law Enforcement.** We may release your PHI if asked to do so by a law enforcement official if they need the information to investigate a crime or to identify or locate a suspect, fugitive, material witness, or missing person.

D. **Serious Threats to Health or Safety.** Our Practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

E. **Military.** Our Practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

F. **National Security.** Our Practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials, or foreign heads of state, or to conduct investigations.

G. **Inmates.** Our Practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (1) for the institution to provide healthcare services to you; (2) for the safety and security of the institution; and/or (3) to protect your health and safety or the health and safety of other individuals.

H. **Workers' Compensation.** Our Practice may release your medical information to comply with workers' compensation laws or similar programs providing benefits for work-related injuries or illnesses.

I. **Governmental Agencies.** Our Practice may release your medical information to agencies authorized to receive reports of abuse if you are a victim of abuse, neglect, or domestic violence.

J. **Coroners/Medical Examiners/Funeral Directors**. Our Practice may release PHI after your death to identify you, to determine your cause of death, or as otherwise authorized by law.

K. **Health and Human Services**. Our Practice will release your PHI to the federal agency that investigates compliance with federal privacy law.

V. YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

1. **Right to Confidential Communication.** You have the right to request that our Practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must indicate in writing on the (APPENDIX E) specifying the requested method of contact and/or the location where you wish to be contacted. Our Practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Right to Request Restrictions.** You have the right to request a restriction in our use or disclosure of your medical information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to (APPENDIX K). Your request must describe in a clear and concise fashion:

- The information you wish restricted;
- Whether you are requesting to limit our Practice's use, disclosure, or both; and
- To whom you want the limits to apply.

3. **Right to Inspect and Copy.** You have the right, in most cases, to inspect and copy your medical information maintained by or for the Practice. You must make your request in writing to the Privacy Officer. If the Practice denies your request, you may have the right to have the denial reviewed by a licensed health care professional selected by the Practice. If the Practice (or a licensed health care professional performing the review on behalf of the Practice) grants your request the Practice will provide you with the

requested access. You may request copies of such information; however, but our Practice may charge you a reasonable fee.

4. **Right to Amend.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for amendment. Our Practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (1) accurate and correct; (2) not part of the PHI kept by or for the Practice; (3) not part of the PHI that you would be permitted to inspect; or (4) not created by our Practice, unless the individual or entity that created the information is not available to amend the information.

5. **Right to an Accounting of Disclosures.** (APPENDIX F) You have the right to request a list of disclosures of your medical information that have been made by the Practice. To obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure. The first list you request within a 12-month period is free of charge, but our Practice may charge you for additional lists within the same 12-month period. Our Practice will notify you of other costs involved with additional requests, and you may withdraw your request before you incur any costs. The Practices does not have to list disclosures:

1. for treatment, payment, or healthcare operations;
2. of a limited data set for healthcare operations, research, or public health activities;
3. to you and individuals involved in your healthcare;
4. to authorized federal officials for national security activities;
5. that occur incidentally with other permissible uses and disclosures;
6. made under your written authorization; and
7. law enforcement officials or health oversight agencies.

6. **Right to a Paper Copy of This Notice**. You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact: Medical Record Department

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our Practice's Privacy Officer or with the federal government's Department of Health and Human Services. To file a complaint with our Practice, contact our Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our Practice will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note we are required to retain records of your care. If you have any questions regarding this Notice or our health information privacy policies, please contact our Privacy Officer.

VI. BREACH NOTIFICATIONS

Our Practice makes every effort to secure your health information, including the use of encryption whenever possible. In the event that any of your medical information that has not been encrypted is the subject of a breach, our Practice will provide you with a written or electronic notification about the breach as required by federal law.

Katie Ortiz
Retina Consultants of South Carolina
3801 Commercial Center Dr
Ladson, SC 29456

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM:

I, _____, have received a copy of the Notice of Privacy Practices.

Signature of Patient: _____ Date: _____

Signature of Guardian: _____ Date: _____

APPENDIX E

REQUESTS FOR CONFIDENTIAL COMMUNICATION

Name: _____ Date of birth: _____
Address: _____
Daytime Phone #:_____ Email address:_____

Description of the means by which and/or location to which you want the Office of Employee Benefits to provide you with communications containing Protected Health Information: ____
_____
_____

Description of the medical information to which the confidential communications method will apply (check one): ( ) All medical information pertaining to the patient identified above
( ) Other. Please specify: _____

If this restriction would affect our ability to collect or make payments in connection with your health benefits, please explain how this would be handled under the proposed restriction:
_____
_____

Could disclosure of medical information other than as requested endanger you?
Check one: ( ) Yes ( ) No

Signature: _____ Date: _____

If the request is signed by a legal representative of the patient:

Printed name of legal representative: _____

Representative's authority of act for the patient: _____

If signed by a legal representative of the patient, please note that we must verify that you are this patient's legal representative for the purposes of filing this Request. Please enclose any documents that support this authority (Power of Attorney, Court Order, etc.). As this patient's representative, can you be contacted at the address, e-mail, or phone number listed above? If not, please provide your mailing address, e-mail address and phone number below:
_____

_____

For Practice Use Only

Person processing request: _____

Date request received: _____

Request: ( ) Granted ( ) Denied Date patient notified: _____

Method and destination of notification: _____

APPENDIX K

REQUEST FOR RESTRICTION ON USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Practice recognizes a Patient's right to request the Practice restricts its uses and disclosures of medical information for purposes of payment, health care operations, and certain notification disclosures. As a practical matter, normally the Practice cannot agree to restrictions on use and disclosure of medical information. However, the Practice will consider the special circumstances for which you make your request. If we agree to your request, we will comply with your requested restriction unless either the restriction is terminated, the use or disclosure is necessary for your emergency treatment, or the use or disclosure is legally permissible for reasons other than payment, health care operations, or notification disclosures.

Name: _____ DOB: _____

Address: _____

Daytime Phone #: _____ Email Address _____

Describe the types of medical or payment information you wish to be restricted: _____

_____

_____

To whom do you request this information not be disclosed? _____

_____

_____

Why are you requesting this restriction? _____

_____

_____

If agreement with your request will affect the Practice's ability to receive payment(s) for treatment, what would be a feasible alternative method for us to perform payment operations? _____

_____

_____

Signature: _____ Date: _____

If the request is signed by a legal representative of the patient:

Printed name of legal representative: _____

Representative's authority to act for the patient: _____

If signed by a legal representative of the individual, please note that we must verify that you are

this individual's legal representative for purposes of filing this Request. Please enclose any

documents that support this authority (Power of Attorney, Court Order, etc). As this person's representative, can you be contacted at the address, e-mail, or phone number listed above? If not, please provide your mailing address, e-mail address and phone number below:

For Practice Use Only

Person processing request for restriction: _____

Date request received: _____

Restriction: ( ) Granted ( ) Denied

Date patient/legal representative notified: _____

APPENDIX F

REQUEST FOR AN ACCOUNTING OF CERTAIN DISCLOSURES OF PROTECTED HEALTH INFORMATION

As a patient, you have the right to receive an accounting of certain non-routine disclosures of your identifiable health information made by our Practice. Our request must state a time period that may not be longer than six (6) years. The request an accounting of disclosures made by the Practice; you must submit your request in writing to the Medical Records Department at 3801 Commercial Center Dr, Ladson, SC 29456.

Patient name: _____

Date of birth: _____ Email address: _____

Patient address:

Street/Apt #: _____

City/State/Zip: _____

Daytime Phone#: _____

Time period during which the accounting will cover:

Start Date: _____End Date: _____
Note: The start date cannot be more than 6 years prior to the date this form is signed.

Unless otherwise noted on this form, I understand that the accounting will be mailed to me at the address above. I understand that I am entitled to my first accounting in any 12-month period free of charge but that any additional accounting requested may be subject to a cost-based fee. I also understand that if a fee will be imposed, I will be notified of the amount and will have the opportunity to withdraw or modify my request before receiving the accounting and incurring the fee.

Signature: _____ Date: _____

If the request is signed by a Personal Representative of the patient:

Printed name of Personal Representative: _____

Representative's authority to act for the patient: _____

If signed by a legal representative of the patient, please note that we must verify that you are the patient's legal representative for the purpose of filling this Request. Please enclose any document that supports this authority (Power of Attorney, Court Order, etc.).

As this patient's representative, can you be contacted at the address, email or phone number listed above? If not, please provide your mailing address, email address and/or phone number below:

This form must be addressed to:

Katie Ortiz
Retina Consultants of South Carolina
3801 Commercial Center Dr
Ladson, SC 29456

For Practice Use Only

Person processing request: _____

Date request received: _____

Deadline to respond: _____

Deadline extended? ( ) No
( ) Yes: Reason: _____
New Deadline to respond: _____

Date accounting sent: _____