Pa Retina Specialists, P.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE SUMMARIZES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. IT IS NOT THE COMPLETE NOTICE AS REQUIRED BY LAW. IT IS ONLY A SUMMARY. OUR COMPLETE NOTICE IS POSTED IN OUR OFFICE AND AVAILABLE UPON REQUEST.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you a notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. You may request a copy of our full notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use or disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorizations: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.
To Your Family and Friends: We must disclose your health information to you, as described in the patient rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with the payment for your healthcare, but only if you agree that we may do so.
Persons Involved In Your Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosures of your heath information, we will provide you with the opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, medical supplies, x-rays, or other forms of health information.
Marketing Health-related Services: We will not use your health information for marketing communications without your written authorization
Required by Law: We may 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 possible victim of other crimes. We may disclose your health information to the extent necessary to avert serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters)

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge:

- Actual mailing and delivery fees
- Pages 1-20 $1.11 per page
- Pages 21-60 $ .84 per page
- Pages 61 and beyond $.29 per page

If you request an alternative format, and we are able to comply, we will charge a cost-based fee for providing your health information in that format. There are various exceptions and provisions of state and federal statutes that govern the control of, and charging for medical records. We cannot possibly note them all here. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do so, we will abide by our agreement (except in an emergency).
Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (You must make your request in writing). We are not required to agree to the request. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request
Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.
QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Pa Retina Specialists, P.C, PRIVACY OFFICER
220 Grandview Avenue, Suite 200 Camp Hill, PA 17011-1740
Telephone: (717) 761-8688 or Facsimile: (717) 761-5604

PA RETINA SPECIALISTS, P.C.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

Regulations require that we make a "Good Faith" effort to provide you with a copy of our Privacy Notice. You are not required to accept the Notice.

I acknowledge that I received or had the opportunity to review The Notice of Privacy Practices for PA Retina Specialists, P.C.

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

I consent to leaving appointment message on:			Leave other medical information on:		
Home Phone (incl Auto Call)	Y	N	Home Phone	Y	N
Cell Phone (incl Auto Call)	Y	N	Cell Phone	Y	N
Send Via Mail	Y	N	Send Via Mail	Y	N

Leave appointment message with and/or share patient information with another person? Y N

If you answered YES to allowing us to discuss your appointment and/or medical information with another person, please list their name(s), relationship(s) and phone # below:

NAME	RELATIONSHIP	HOME PHONE #	CELL PHONE #
_____	_____	(____)_____-_____	(____)_____-_____
_____	_____	(____)_____-_____	(____)_____-_____
_____	_____	(____)_____-_____	(____)_____-_____

HIPAA Contact Special Instructions: _____

_____

_____

Name of Patient

_____ _____

Signature of Patient Date

(or patient's personal representative)

Personal representative information (if applicable-Family Member or POA)

_____ _____

Name of Personal Representative Relationship to Patient

POA Papers Provided Y N