

NOTICE OF PRIVACY PRACTICES

How We Use your Health Information

TREATMENT

Your information will only be used to provide optimal health care. This includes administration of scheduling and coordination of care between the optometrist and office staff. Health information may also be shared with referring physicians, clinical or pathology laboratories, pharmacies or other health care providers involved in your treatment.

BILLING

Your health information may be included when insurance forms are filed or when we bill you directly. We work with insurance companies that are committed to keeping your information secure as well.

QUALITY ASSURANCE

It is possible that health care information may be shared during audits by insurance companies or government agencies as part of their routine compliance reviews. This also applies to the routine processes of certification, credentialing and licensing.

CAREGIVERS, FAMILY, AND EMERGENCIES

With your permission, we may share health information with those whom you have named to assist you with medical treatment and prevention. If there is an emergency, and you cannot give consent, we will rely on professional judgment to inform those who will necessarily participate in your care. The law may also require us to share health information with coroners, funeral directors or medical examiners to determine cause of death.

ABUSE OR NEGLECT

We will inform the appropriate authorities as required by law, ethical standards, or with a patient's consent, if abuse, neglect, or domestic violence is suspected.

LAW ENFORCEMENT

Health information may be shared with the state or federal government according to the laws regarding criminal acts.

PUBLIC SAFETY

Federal or military authorities can obtain your health information for the purpose of maintaining public health or national security. Prevention of epidemics or investigating new side effects of medical treatment is examples of this.

AUTHORIZATION

For your protection, any circumstances requiring your personal health information other than those explained in this notice will require a written release from you.

We are committed to confidentiality of your health information. Please feel free to ask any questions regarding this notice or to request a personal copy. Please sign below to acknowledge the receipt of this notice.

Thank you for taking the time to review our policy.

Signature _____ Date _____