JAY C. GROCHMAL, M.D., P.A.

Ophthalmology & Optometry

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND IS CLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

EFFECTIVE DATE OF THIS NOTICE: April 14, 2003

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health Informaiton. This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information, payment, or Health Care Operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information (PHI). PHI is information about you, including demographic information, that may identify you and relates to your past, present, or future physical or mental health condition and related health care services. At **Jay C. Grochmal, M.D., P.A., the privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it.**

We are required by law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will effective for all Protected Health Information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. Our practice will also post a copy in our office in a visible location at all times.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care/services you receive at this office. It also reviews the ways in which your health information may be disclosed to other entities and it describes your rights and our obligations in managing the privacy and integrity of your care. We are required by law to give you this notice and to help you understand its intent. You must signify your understanding and agreement by signing in the appropriate spaces and initialing each page. You may opt out of this agreement at any time by presenting this office with written notice of your wishes.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For your treatment requirements, we may use your health information to provide you with medical treatment and necessary services. In addition, we may need to disclose your health information to physicians and other caregivers such as nurses, technicians, and office or other personnel who are involved in your health care and medical requirements. For example, you physician may be treating you for a condition that requires health information from other health care experts who may have already cared for you or are requires to be consulted in the full scope of providing you with the most complete care for your particular condition(s). Thus, the doctor team may best decide what alternatives are optimal for you. However, for personal health information to be sent to another office that is outside the treatment endeavors of this office, your written consent will be required.

Different personnel in our office may share information about you and disclose information to healthcare personnel who are not located in our office, but still involved in your immediate care. For example, prescriptions may be telephoned to a pharmacy, or laboratory studies and x-rays may be ordered as part of your immediate care. Designated family members and other healthcare providers may require information about you as well, such as surgical supply houses, case managers and social workers, or perhaps visiting nurses.

For payment purposes we may be requires to disclose health information about you such as diagnoses and treatment modalities in order for this office to be reimbursed for the services we provide to you. Other personal health and identifying information may be appropriately disclosed such as social security numbers, banking information, drivers license numbers so relevant plans can settle all or a portion of your account with this office. We may also share information with your health plan concerning the treatment recommended in order to receive their prior approval.

Health Care Operations

We may use and disclose health information about you in order to evaluate our office operations and monitor the quality of our care. For example, we may use your health information to evaluate the performance and quality of our staff provide in servicing your needs. Such information may also be used to determine what additional services we can and must offer to increase the effectiveness of treatment.

PATIENT'S RIGHT TO REVIEW PERSONAL HEALTH INFORMATION

You may, and are encouraged, to review your entire health care record maintained in this office by making an appointment with our administrator. Please feel free to discuss and put in writing any discrepancies you feel may be present so that we can resolve any issues or questions of care and service.

APPOINTMENT REMINDERS

Our practice may use and disclose your PHI to contact you and remind you of an appointment, to discuss billing issues, or to inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. By consenting to our Notice of Privacy Practices, you are hereby giving us permission to mail documents to you residence in your name that may include PHI or to call you regarding issues about your healthcare services provided by us. If you do not

wish us to leave messages on your voicemail or answering machine, it is your responsibility to inform us in writing (at the address on the top of this notice) as to how you would like us to contact you.

SITUATIONS REQUIRING RELEASE OF PERSONAL HEALTH INFORMATION (PHI)

1. In emergency treatment situations, if we try to obtain consent as soon as possible after treatment;
2. Where significant barriers to communicating with you exist and we determine that the consent is clearly inferred from the situation;
3. Where we are required by law to provide treatment and we are unable to obtain consent;
4. Where the use or disclosure is required by law;
5. For certain public health activities such as reporting births, deaths, diseases, etc.
6. Where we reasonably believe you are a victim of abuse, neglect, or domestic violence to a government agency authorized to receive abuse, neglect, or domestic violence reports;
7. Health care oversight activities such as audits, investigations, or licensing purposes;
8. Certain legal administrative proceedings in response to a court administrative order;
9. Certain legal enforcement purposes in response to a subpoena, warrant, or summons, subject to all applicable legal requirements;
10. To coroners, medical examiners, and funeral directors;
11. For organ, eye, or tissue donation purposes, to facilitate such donation, if you are an organ donor;
12. For certain research purposes that are subject to a special authorization process signed and reviewed by you;
13. To avoid a serious threat to public health and safety;
14. For specialized government functions if you are or were a member of the armed forces, or part of the national security or intelligence communities;
15. For Workers' Compensation purposes in the case of a work related injury or illness.
16. To a family member, friend, or other person you choose who may assist in your care or payment for care.

We will not use or disclose your health information for any purpose other that those identified in the previous sections without your specific written authorization. We must obtain your authorization separate from any consent we may have obtained from you. If you give use authorization to use or disclose health information about you, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back and uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you, (different for the *Authorization and Consent* mentioned above). In order to disclose these types of records for purposes of treatment, payment or Health Care Operations, we will have to have both your signed consent and a special written authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDINGHEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain concerning you:

1. Inspect and copy protected health data by submitting a written request to our privacy officer.
2. Amend protected health information, if you believe it's incorrect, by submitting a written request to our privacy officer.
3. Receive a list of disclosures made of your protected health data. To obtain this list of disclosures, you must submit your request in writing to our privacy officer. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at any time before any costs are incurred.
4. Request restrictions on certain uses and disclosure of facts about you. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you may have had. However, we are not required to agree to the request restrictions. To request restrictions, you must submit a written request to our privacy officer.
5. Receive confidential communication of protected health data by giving us a specific means of communication. For example, you can request that we only contact you at work or via U.S. mail. Please submit such a request in writing to our privacy officer.
6. Obtain a paper copy of this notice upon request, if you agreed to originally accept this notice via e-mail or facsimile.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our privacy officer. You will not be penalized for filing a complaint.