

---

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.

---

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

#### **TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low-vision aids; referring you to another Doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons we usually will not ask for special written permission.

#### **USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION**

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative procedures, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organize handling of organ or tissue donations;
- uses or disclosures for health related research
- uses or disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the President or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosure of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information with your family or friends who are helping you with your eyecare.

#### **APPOINTMENT REMINDERS**

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a postcard, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not at home.

## **OTHER USES AND DISCLOSURES**

We will not make any other uses or disclosures of your health information unless you sign a written “authorization form”. The content of an “authorization form” is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it is your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance with it. Revocations must be in writing and may be mailed directly to the office or brought in person.

## **YOUR RIGHTS REGARDING YOUR HEALTH CARE INFORMATION**

The law gives you many rights regarding your health care information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions you want. To ask for a restriction, send a written request to our office address, fax or Email address shown on page one of this notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using Email to your personal Email address. We will accommodate these requests if they are reasonable, and if you pay for any extra cost. If you want to ask for confidential communications, send a written request to the office at the address, fax or Email shown on page 1 of this notice.
- Ask to see or get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part you will be able to review or have a copy of your health information within 30 days of asking us (or 60 days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of your denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office address, fax or Email shown on page 1.
- Ask us to amend your health information if you think it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment, if we notify you in writing, of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office address, fax or Email. On page 1 of this notice.
- Get a list of the disclosures that we have made of your health care information in the last 6 months (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have a 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office address, fax or Email. On page 1 of this notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request, including your reasons for the amendment, to the office address, fax or Email. On page 1 of this notice.

## **OUR NOTICE OF PRIVACY PRACTICES**

- By law, we must abide by these terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

## **COMPLAINTS**

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint, to the office address, fax or Email. On page 1 of this notice

## **FOR MORE INFORMATION**

If you want more information about our privacy practices, call or visit the office at the address or phone number shown at the beginning of this notice.



Carl O. Myers, O.D., FCOVD  
10343 Dawsons Creek Blvd. Suite B Building 6  
Fort Wayne IN 46825  
Tel: (260) 497-7973 Fax: (260) 497-7986  
[ivdc@indianavisiontherapy.com](mailto:ivdc@indianavisiontherapy.com)  
[indianavisiontherapy.com](http://indianavisiontherapy.com)

**ACKNOWLEDGEMENT OF RECEIPT**

Effective Date of Notice: January 1, 2010

I acknowledge that I have been offered and/or received a copy of Dr. Carl O. Myers notice of Privacy Practices as required by Federal Law.

\_\_\_\_\_  
**Patient Name or Legal Guardian Signature**

\_\_\_\_\_  
**Date**

Declined \_\_\_\_\_

Received \_\_\_\_\_

Staff Initial \_\_\_\_\_

**Authorization to Discuss Your Information with Family or Caregivers**

To comply with the new HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your case with anyone else including your spouse, children, family members, caregivers, friends, etc. By authorizing this, we will be able to, without your presence, discuss your case, answer questions, leave detailed messages, and contact, in the event of an emergency, the person (s) listed below. **If you would like us to answer questions or discuss your case with anyone other than yourself, you must include them below.** This authorization is optional and can be withdrawn at any time.

Name \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Relationship \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

Name \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Relationship \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_