THE RETINA CARE CENTER

NOTICE OF PRIVACY PRACTICES SUMMARY
Acknowledgement of Receipt

This is only a summary of our Notice of Privacy Practices. Please review the full Notice to learn how we use and disclose medical information about you and your rights concerning these uses and disclosures. The full Notice is available upon request.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

Treatment, Payment, and Health Care Operations. We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; and for the general operation of our business.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment or that you should schedule an appointment. If you are not home, we may leave this information in a telephone message or a message left with the person answering the phone.

Marketing, Fundraising, and Sale of Protected Health Information (PHI). We will obtain your prior written authorization before sending you certain marketing communications. We may use or disclose your demographic information in order to contact you for our fundraising activities, but you have the right to opt out of such communications. We will not sell your health information without your prior written authorization.

We may use your PHI as otherwise authorized or required by law for such purposes as:

- public health reporting and oversight activities
- judicial, administrative, or law enforcement proceedings
- complying with workers' compensation laws
- communicating with your family or caregivers

INDIVIDUAL RIGHTS REGARDING MEDICAL INFORMATION

You have the right to:

- Request certain restrictions on our use and disclosure of your PHI
- Request communications from us by specific means or locations
- Inspect and copy your medical record
- Ask us to correct the information in your medical record
- Receive an accounting of disclosures of your PHI by our practice
- Be notified in the case of a breach of unsecured PHI

I have reviewed the Summary of Notice of Privacy Practices and acknowledge that a copy of the full Notice of Privacy Practices will be provided to me upon request. I understand my rights regarding my protected health information and hereby authorize The Retina Care Center to obtain or release all pertinent information regarding my medical care as described in the HIPAA Compliant Notice of Privacy Practices. This authorization remains in effect until revoked.

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Print Patient Name

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Signature of Patient or Responsible Party Date