West Milford Vision Center

Notice of Privacy Practices

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 HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information. We call this information "Protected Health Information," or "PHI" for short, and it includes information that can be used to identify you that we've created or received about your past, present, or future health condition, the provision of health care, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described In this notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

Uses and Disclosures Which Do Not Require Your Authorization.

Treatment. We may disclose your PHI to hospitals, physicians, nurses and other health care personnel who provide you with health care services or are involved in your care.

Payment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you.

Health care operations. We may disclose your PHI in order to operate this practice. For example, we may use your PHI in order to evaluate the quality of health care service that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement. For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence, when dealing with a gunshot or other wound; or when ordered in a judicial of administrative proceeding.

For public health activities. For example, we report information about births, deaths, and various diseases, to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.

For health oversight activities. For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

For purposes of organ donations. We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

For research purposes. In certain circumstances, we may provide PHI in order to conduct medical research.

To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.

For workers' compensation purposes. We may provide PHI in order to comply with the workers' compensation laws.

Appointment reminders and health related benefits or services. We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.

Use and Disclosure Where You Have the Opportunity to Object:

Disclosure to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

All Other Uses and Disclosures Require Your Prior Written Authorization.

In any other situation not described above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action relying on the authorization)

Incidental Uses and Disclosures.

We may make incidental uses and disclosures of your protected health information. Incidental uses and disclosures may result from otherwise permitted uses and disclosures and can not be reasonably prevented. Having your name called allowed by a staff member in our waiting area is an example of incidental disclosure.

WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you to an alternate address (for example, sending information to your work address rather than your home address). We must agree to your request so long as we can easily provide it in the format you requested.

The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we do not have your PHI but know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request copies of your PHI, we will charge you $1.00 for each page. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, to your family, or in our facility directory. The list also won't include uses and disclosures made for national security purposes to corrections or law enforcement personnel, or before April 14, 2003.

We will respond within 60 days of receiving your request. The list we will give you include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you $5.00 for each additional request.

The Right to Correct or Update Your PHI.

If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. We will respond within 60 days of receiving your request in writing. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have don't it, and tell others that need to know about the change to your PHI.

COMPLAINTS

If you think that we may have violated your Privacy Right, or you disagree with a decision we made about access to your PHI, you may file a complaint with our Privacy Officer listed below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W.: Room 615F: Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

CONTACT PERSON

If you have any questions about this notice or any complaints about our Privacy Practices please contact the Privacy Officer, at:

West Milford Vision Center
Dr. Adriana Palumbo
1549 Union Valley Road
West Milford, NJ 07480

EFFECTIVE DATE: This notice is effective as of April 14, 2003.

Office of Dr. Adriana Palumbo, OD

PATIENT HIPPA CONSENT

PATIENT CONSENT FOR USE OF PROTECTED HEALTH INFORMATION

PRIVACY POLICY

Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. The notice contains a "Patient Rights" section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on our prior consent. The practice provides revocation shall not affect any disclosures we have already made in reliance to your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

CONSENT TO RELEASE INFORMATION

By signing this form, I permit the practice to release any medical information to the physicians involved in my care. I consent that the practice may call my house or other designated locations and leave a message on voice mail or in person in reference to appointment reminders and insurance items. In addition, that practice may mail to my home appointment reminders and patient statements.

I designate the following representative(s) who the provider can communicate with on my behalf. If you do not designate anyone, the doctor will be unable to speak to anyone in your family regarding your medical condition.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

SIGNATURE ON FILE

I request that payment of authorization benefits be made on my behalf to Dr. Adriana Palumbo, OD (dba West Milford Vision Center) and/or its providers for services furnished to me. I authorize any holder of medical information about me to release to Empire Medicare Services or any other of my medical carriers any information needed to determine these benefits of the benefits payable for related services. I permit a copy of this authorization to be used in place or original.

Signature of Patient or Legal Guardian _____

Print Patient's Name _____ Date _____

Print Legal Guardian's Name _____