



NOTICE OF PRIVACY PRACTICES IN COMPLIANCE WITH HIPPA

This notice describes how your protected medical information may be used, disclosed and retrieved.
Please review it carefully. This notice is effective January 28, 2018.

As a patient, you have the right to notice of privacy practices of your protected health information. Under the Health Insurance Portability and Accountability Act (HIPPA), Ossining Family Optometry can use your protected health information for the following reasons:

1. We may use and disclose your health information for treatment purposes such as setting up an appointment, faxing prescriptions, or referring you to a physician or other healthcare provider.
2. We may use and disclose your health information for payment purposes such as asking about your health or vision plans, preparing and sending bills or claims, and collecting unpaid amounts ourselves or through a collection agency or attorney.
3. We may use and disclose your protected health information in connection with our healthcare operations such as reminding you of scheduled appointments via telephone, mail or email, internal quality assurance, participation in managed care plans, conducting training programs, accreditation, certification, licensing or credentialing activities.

The law also allows or requires us to use or disclose your health information without a specific authorization for other reasons. Not all of the situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

1. When a state or federal law mandates that certain health information be reported for a specific purpose;
2. 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;
3. To governmental authorities about victims of suspected abuse, neglect or domestic violence;
4. 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;
5. For judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
6. 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;
7. 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 organizations that handle organ or tissue donations;
8. To prevent a serious threat to health or safety;
9. 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 member of the foreign service;
10. For purposes of worker's compensation programs;
11. Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
12. Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information

We routinely use your health information inside our office for those purposes and with other health care providers, insurers, and administrative entities when necessary in order to provide appropriate treatment, secure payment, insurers, and administrative functions. We ask for your consent to the disclosure of your health information for the purposes of treatment, payment and health care operations by signing the "Acknowledgement of Receipt and General Consent" on the next page and returning it to us. Uses and disclosures that do not fall under the previous instances will require your written authorization. Upon signing, you may revoke your authorization in writing through our practice at any time.

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

1. Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. The request for restriction may be denied if the information is required for treatment, payment or health care operations. To ask for a restriction, send a written request to the office.
2. Ask us to communicate with you in a confidential way, such as by phoning you at work rather than as home, by mailing health information to a different address, or by using Email to your personal Email address. If you want to ask for confidential communications, send a written request to the office.
3. Inspect and copy your protected health information, amend your protected health information by written request, receive an account of disclosures of your protected information and obtain a paper copy of this notice of privacy practices.

Ossining Family Optometry, PLLC is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. For further information about our privacy policies, please contact us at (914) 923-0300.

ACKNOWLEDGEMENT OF RECEIPT

By signing below, I acknowledge that I have read and agree with all terms of the Notice of Privacy Practices put forth by Ossining Family Optometry as stated in the above document.

Signed: _____

Date: _____