



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.

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 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 are: 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 may further use or disclose your health information without your permission if required by law:

- when a state or federal law mandates that certain health information be reported for a 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;
- for disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- for 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;
- for disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- for 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;
- for 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 organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- for uses and disclosures to prevent a serious threat to health or safety;
- for uses or disclosures for specialized government functions;
- for disclosures relating to worker's compensation program;
- for 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 about your care with your family or friends who are helping you with your eye care.

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 that might help you.

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. If we ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization we cannot disclose health information. If you do sign, you may revoke it at any time. Revocations must be in writing to the office contact person named at the beginning of this Notice.

By sending a written request to the office contact person named at the beginning of this Notice you can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations.
- 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 E-mail to your personal E-mail address. We will accommodate these requests if they are reasonable.
- ask to see or to get photocopies of your health information. You will be able to review or have a copy of your health information within 30 days of asking us.
- ask us to amend your health information if you think that it is incorrect or incomplete.
- get a list of the disclosures that we have made of your health information within the past six years and get additional paper copies of this Notice.

We reserve the right to change this notice at any time as allowed by law.

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.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Shida's Notice of Privacy Practices.

Patient Name: _____

Signature: _____

Date: _____