

**Please read the following Notice of Health Information Practice carefully, to understand Deer Penick Eye Clinic policies about protection and use of patient health information.**

**Introduction**

At Deer Penick Eye Clinic, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

**Understanding Your Health Record/Information**

Each time you visit Deer Penick Eye Clinic; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- ❖ Basis for planning your care and treatment,
- ❖ Means of communication among other health professionals who contribute to your care,
- ❖ Legal document describing the care you received, and
- ❖ Means by which you or a third-party payer can verify that services billed were actually provided.

**Your Health Information Rights**

Although your health record is the physical property of Deer Penick Eye Clinic, the information belongs to you. You have the right to:

- ❖ Obtain a paper copy of this notice of information practices upon receipt of written authorization from you,
- ❖ Obtain an accounting of disclosures of your health information,

- ❖ Understand that accounting of disclosures of your health information will be provided to your insurance carrier,
- ❖ Understand that your health information will be provided to your referring physician as well as physician, lab, or hospital that you are referred to by Deer Penick Eye Clinic,
- ❖ Understand that your health information and accounting of disclosures of your health information will be provided to your employer if workman's compensation has been initiated by you,
  - ❖ Understand that your health information will not be disclosed to any attorney or any physician that has not referred you to Deer Penick Eye Clinic or to whom Deer Penick Eye Clinic has not referred you without your written authorization, and
  - ❖ Understand that your health information will not be disclosed to a family member or relative without written authorization from you.

**Our Responsibilities**

Deer Penick Eye Clinic is required to:

- ❖ Maintain the privacy of your health information,
- ❖ Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- ❖ Abide by the terms of this notice,
- ❖ Keep current patient records in a secured nursing or physician office(s) at Deer Penick Eye Clinic,
- ❖ Copies of original documentation or billing information obtained for the staff to carry out their assigned duties will be shredded upon completion of use,
- ❖ Computer passwords shall be established, maintained, and distributed to personnel having computer access clearance,
- ❖ Unless we have written authorization, your health information will not be disclosed to a physician or entity that has not referred you to Deer Penick Eye Clinic or to any attorney, and

- ❖ Unless we have written or verbal authorization, your health information will not be disclosed to a family member or relative.

The staff at Deer Penick Eye Clinic is dedicated to your health needs and health information privacy. However, if you feel at any time your privacy rights have been violated, you can file a complaint with the privacy officer at Deer Penick Eye Clinic at 501-224-4701.

We reserve the right to change our practices and make the new provisions effective for all protected effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied to us.

**Final Statement: We will not use or disclose your health information without your authorization, except as described in this notice.**

I acknowledge that I have read and received the Privacy Policy of Deer Penick Eye Clinic.

Signed \_\_\_\_\_

Date \_\_\_\_\_

I elect the person(s) below as my account representative(s). This will allow them access to information regarding my account and medical history:

Name \_\_\_\_\_

Name \_\_\_\_\_

Name \_\_\_\_\_

Name \_\_\_\_\_

Name \_\_\_\_\_

