MILLS EYE CARE

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION (PHI) ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Mills Eye Care is permitted to make uses of and disclosers of protected health information for treatment, payment and health care operations, as described in the following examples:
    1. For treatment (Referral to another eye care specialist or physician)
    2. For payment (Submission of claim to third party payer)
    3. For health care operations
2. Mills Eye Care is permitted, or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization.
3. Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization.
4. Mills Eye Care may engage in any of the following activities:
    a. Mills Eye Care may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
    b. Mills Eye Care may contact the Individual / Patient to raise funds for Mills Eye Care; or
    c. A group health plan, or a health insurance issuer or HMO with respect to a group health plan, may disclose protected health information to the sponsor of the plan.
5. The individual has the following rights regarding protected health information:
    a. The right to request restrictions on certain uses and disclosures of protected health information; however, Mills Eye Care is not required to agree to a requested restriction.
    b. The right to receive confidential communications of protected health information, as applicable.
    c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
    d. The right to amend protected health information, as provided in the Privacy Regulation.
    e. The right to receive an account of disclosures of protected health information.
    f. The right to obtain a paper copy of the Notice of Privacy Practices from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.
6. Mills Eye Care is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and Privacy practices with respect to protected health information.
7. Mills Eye Care is required to abide by the terms of the Notice currently in effect.
8. Mills Eye Care reserves the right to change the terms of this Notice. The new Notice provisions will be effected for all protected health information that it maintains.
9. Mills Eye Care will provide individuals with a revised notice by posting it on the company's web site (www.millseyecare.com).
10. Individuals may complain to Mills Eye Care and the Secretary of the Department of Health and Human Services without fear of retaliation by the organization, if they believe their privacy rights or protected health information has been violated. Individuals may file a complaint, submitted in writing, to Mills Eye Care addressed to Office Manager or Compliance Officer.
11. Mills Eye Care's contact person for matters relating to complaints is Kendal Brawley, located at 492 Williamson Rd Mooresville, NC 28117 and at phone number (704)664-9121.
12. This notice is first in effect on April 1, 2003.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I hereby acknowledge that I have received a copy of Mills Eye Care's Notice of Privacy Practices

Printed Name of Patient_____

Signature of Patient / Legal Guardian _____Date: _____

HIPAA Privacy Authorization Form

*Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

AUTHORIZATION

I authorize Mills Eye Care to use and disclose the protected health information described below to the following people:

Name_____Relationship: _____

Name_____ Relationship: _____

Name_____ Relationship: _____

COMMUNICATION PREFERENCE

_____I would prefer to receive communication via text. Text messaging is not secure and could be viewed by third parties. We need your permission to text with you about your health.

_____I would prefer to receive communication via email. Email messaging is not secure and could be viewed by third parties. We need your permission to email with you about your health.

EFFECTIVE PERIOD

____This authorization for release of information covers the period of healthcare from _____ to _____.

OR

____All past, present, and future periods.

EXTENT OF AUTHORIZATION

_____I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDs, and treatments of alcohol or drug abuse).

OR

____I authorize the release of my complete health record with the **exception** of the following information:

_____Mental health records
_____Alcohol / drug abuse treatment
_____Communicable Diseases (including HIV & AIDS
_____Other (please specify): _____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes I may direct.

This authorization shall be in force and effect until _____, at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether or not I sign this authorization.I understand that information used or disclosed pursuant to this authorization may be disclosed to the recipient and may no longer be protected by federal or state law.

Printed Name_____

Signature of patient / legal guardian / personal representative_____

Date_____