

Steven A. Ohlbaum, O.D Michael R. Waterman, O.D.
1 Paris Road New Hartford, NY 13413 (315) 797-9091

HIPAA PRIVACY POLICIES ACKNOWLEDGEMENT AND CONSENT (mandatory)

I acknowledge that I have been offered a copy of the Notice of Privacy Practices for the office of Drs. Ohlbaum and Waterman. I have been given a chance to read these Privacy Practices, I understand them, and I agree to them.

Patient name _____ Date of birth: _____

Signature _____ Date _____

Parent name and signature if patient under 18

(Optional) AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION FOR PURPOSES OTHER THAN TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The purpose of this authorization is obtain consent to release identifying health information for purposes other than treatment, payment, and health care operations that may arise such as research, certain types of marketing of new products, due to a request from a life or disability insurance company, or a request from an employer.

The patient is entitled to give the office of Drs. Ohlbaum and Waterman a detailed description of the information that is to be authorized to be released. The patient may provide a specific list of recipients or class of recipients who may receive this information. The patient is entitled to a statement of the purpose(s) of the release which may be "at the request of the individual." The patient is entitled to provide an expiration date for this authorization.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. We will not receive any direct financial benefit from disclosing health information about you.

I have read and understand this authorization. I am signing it voluntarily. I authorize the disclosure of my health information as described in this form.

Patient/authorized signature _____ Date _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Name (printed) _____
Address _____

Relationship to patient

q patient declined to sign authorization. Comments:

Michael R. Waterman, O.D. Steven A. Ohlbaum, O.D.
1 Paris Road New Hartford, NY 13413 phone (315) 797-9091 fax (315) 797-9124

HIPAA NOTICE OF PRIVACY PRACTICES (3/27/2003)

We understand that your medical information is personal and we are committed to protecting your privacy. In the course of providing service to you, we need to create, receive, and store health information that identifies you. This notice tells you specifically how we use and disclose health information: in order to treat you, to obtain payment for services, and to conduct health care operations. This notice also describes certain unusual situations which could require disclosure of information, your privacy rights, and how you can get access to your medical information. We are required by federal law to notify you of our privacy practices, and we cannot examine you without your signature on this consent form.

Release of Personal Health Information for Treatment, Payment, and 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 eyeglasses, contact lenses, or eye medications. Faxing, calling, or mailing a prescription to be filled; sending a written report by mail or fax, or phoning a verbal report of our exam findings to another doctor, school, or health facility; referring you to another doctor or health facility for eye or health care; recording dictated exam notes and reports which are written in your chart by a member of our staff or typed by an independent transcribing agency outside of our office; getting copies of your health information from another eye or health care provider that you may have seen before us; calling you at home or work, leaving messages on your answering machine or voice mail, writing letters, or sending emails or faxes to communicate information to you about your eyes or your eyecare, or to give you the results of tests that were performed or ordered. Examples of how we use or disclose health information for *payment purposes* are: asking you about your health or vision care plans or other sources of payment; preparing or sending paper, faxed, or electronic (internet) bills or claims to you, your insurance company, or an independent billing agency; collecting unpaid bills through ourselves, an attorney, or collections agency. "*Health care operations*" mean those administrative and managerial functions that we have to do in order to run our office such as: financial or billing audits; internal quality assurance; personnel decisions; participation in insurance plans; defense of legal matters; business planning; and storage of records.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

We may use your health information inside and outside our office for the purposes listed below without any special permission. These uses and disclosures are quite unusual, and will likely never occur. If we need to disclose your health information outside of our office for these reasons, we will not ask you for special written permission unless you give us written notice as to what information may be used. In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Such uses or disclosures are:

- 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;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- 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;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- 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;
- 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 and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for special 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 members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations.
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" such as billing agencies and transcription agencies who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we may also share relevant information about your care at the time of your visit with your family members or friends who accompany you, or who are assisting in your care such as scheduling follow-up appointments, referrals, ordering eyeglasses or contact lenses, medical prescriptions, or payment.

APPOINTMENT REMINDERS & MARKETING

We may call, write postcards or letters, or send email or faxes to remind you of scheduled appointments, or that you are due or overdue for an exam appointment. We may leave a message on your answering machine or voice mail at home or work. We may also call or write to notify you of other treatments, services, or products available at our office that might help you. **We do not and will not give or sell any protected health information to any other company or persons for the purposes of advertising, marketing, or other solicitations.**

OTHER USES AND DISCLOSURES We will not make any other uses or disclosures of your health information unless you sign a written "authorization form for purposes other than treatment, payment, and health care operations."

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. Please send a written request to our office if you wish to ask for any special restrictions or requests as listed below. You can:

- ask us to restrict our uses and disclosures to purposes of treatment, payment, or health care operations. We do not have to agree to this, but if we agree, we must honor the restrictions that you want. We have the right to not agree to your request and decline treatment.

- ask us to communicate with you in a confidential way, such as by phoning you only at a particular location, by mailing health information to a different address, or by using email. We will attempt to accommodate these requests if they are reasonable, and if you pay us for any additional costs.

§ revoke this consent in writing unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent, in which case your revocation of consent would only apply to future visits or future health information generated about you.

§ ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of your request. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension.

- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension.

- get a list of the disclosures that we have made of your health information within the past six years (or shorter period). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can one 30 day extension of time if we notify you of the extension in writing.

- get additional paper copies of this Notice of Privacy Practices upon request.

OUR NOTICE OF PRIVACY PRACTICES

We reserve the right to change our privacy practices at any time. We agree to abide by the terms of this Notice of Privacy Practices at the time of your consent, unless we notify you of any significant changes in our policy, and you sign our new policies. If we change our Privacy Policies, the old policies that you signed will apply to your health information until you sign the new Privacy Policies. If we change our Notice of Privacy Practices, we will post the new notice in our office, and have copies available in our office.

COMPLAINTS: If you think that we have not properly respected the privacy of your health information, we ask that you discuss this problem with us or send us a written complaint so that we can correct the problem. You are also permitted to complain to the US Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint.

WHAT YOUR CONSENT MEANS

When you sign this consent document, you acknowledge that you agree that we can and will use and disclose your health information as described in this notice of privacy practices. **We can and will decline to examine or treat you if you elect not to sign this consent form.** If you have additional questions about our privacy practices you may speak to a member of the staff, your doctor, or the HIPAA privacy officer, Dr. Ohlbaum. I acknowledge that I have been offered a copy of the Notice of Privacy Practices for the office of Drs. Ohlbaum and Waterman. I have been given a chance to read these Privacy Practices, I understand them, and I agree to them.

Patient name _____

Signature _____ Date _____

MORE ABOUT OUR HIPPA PRIVACY POLICIES

The HIPAA (Health Insurance Portability and Accountability Act) federal laws were written to protect individual's rights to privacy of their health information. Effective April 14, 2003 all health care offices with 10 or more employees or any health care office that electronically bills insurance must be compliant with HIPAA rules. Our doctors and staff have been trained in HIPAA privacy policies, and we do everything we possibly can to protect the privacy of your health information.

Please keep in mind:

* We know that the HIPAA documents that we ask you to sign are long, confusing, and overwhelming. Our office did not write the rules for HIPAA; These documents were written almost entirely by the Department of Health and Human Services, with minor modifications specific to our office. All health offices with 10 or more employees or any office that does electronic billing is required to ask you to sign them.

* There are some doctor's offices that are not required to abide by HIPAA policies, and there are also some offices that should be "doing HIPAA" but have chosen not to. If you choose to go to a doctor that does not require you to sign a similar "Privacy Policies" document, then you will be permitting unrestricted use and disclosure of your personal health information.

* You can write down your specific objections to our privacy policies that we will review and consider. If we agree to your objections/restrictions, then we will abide by them. If we do not agree to your objections/restrictions, we will not treat you, and you will have to find another eye doctor that is willing to agree to your objections/restrictions. If this occurs, we will refer you to the telephone book under the headings Optometrists or Physicians, Ophthalmologists.

Objections/Restrictions:

Patient name
Date _____

Patient signature

Doctor's name
Date _____

Doctor's signature