ALAMEDA EYE Physicians

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NOTICE OF PRIVACY PRACTICES (SUMMARY)

Our Duties: We are required by law to maintain the privacy of your health information and to give you this notice describing our legal duties and privacy practices.

Our policy is not to use or disclose your health information without your authorization **except** in the following situations:

1. Treatment: We will provide health information for another medical provider who is a part of your health care team in order to provide, coordinate, and manage your health care.
2. Payment: We will submit information needed to obtain compensation or reimbursement from your health plan.
3. Health Care Operations: Share information within our own organization to manage our business and assess quality of care.
4. Business Associates: Provide information for services provided to our organization such as billing services. They are required to take precautions to protect your information.
5. Notification/Communication with family: We may disclose information to notify a family member or your designated person of your general condition and health information relevant to that person's involvement in your care.
6. Research: Provide information consistent with applicable law when researcher's project has been approved by an institutional review board to ensure the privacy of your health information.
7. Funeral Director, Coroner, and Medical Examiner: Consistent with applicable law.
8. Organ Procurement Organizations: Consistent with applicable law.
9. Food and Drug Administration: Relative to adverse events, product defects, recalls, etc.
10. Public Health: If necessary to control disease, injury, including child abuse and neglect.

We will not make any other use or disclosure of your personal health information without your written authorization.

Individual Rights

You have many rights concerning the confidentiality of your health information. You have the right to the following:

1. To request restrictions on the health information we may use and disclose for treatment and payment with health care operations. We are not required to agree to these requests. To request restrictions, please send us a written request.
2. To inspect or copy your health information. You must submit your request in writing.
3. To amend health information you believe to be incorrect and/or incomplete. You must submit your request in writing.
4. To receive an accounting of disclosures of your health information.
5. To receive a paper copy of this notice upon request. You may obtain a copy of this notice at our website: www.sfbayeye.com.

Authorizations

I give my permission for Alameda Eye Physicians to communicate information regarding my health, care and progress to the individual(s) listed here:

1. _____ Relationship _____

2. _____ Relationship _____

☐ I decline to designate a specific individual for sharing information with.

Signature _____ Date _____

Complaints

If you believe that your privacy rights have been violated you have the right to submit a written complaint to our office and receive a response back.

Acknowledgement

I have read and understand the above policies related to my personal information.

_____	_____	_____
Patient Name Printed	Patient Signature	Date