

NOTICE OF PRIVACY PRACTICES

GRAND RAPIDS EYE CARE 2820 PLLC
2820 East Beltline Lane, NE
Grand Rapids, MI 49525
Phone: (616) 363-5413
Fax: (616) 363-4211
Office contact person: Kelly Boos

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

USES AND DISCLOSURES OF HEALTH INFORMATION

We routinely use your health information inside our office for treatment (such as sending your medical record information to a specialist physician as part of a referral), to obtain payment for treatment (such as sending billing information to a health insurance plan), for administrative purposes and to evaluate the quality of care that you receive (such as comparing patient data to improve treatment methods). If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, abuse or neglect reporting, auditing purposes, research studies, funeral arrangements and organ donation, workers' compensation purposes, and emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. We may also contact you about appointment reminders or treatment alternatives. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in our office and on our Web site. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed above.

INDIVIDUAL RIGHTS

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you \$0.20 (20 cents) for each page. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You have the right to request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. If this notice was sent to you electronically, you may obtain a paper copy of the notice.

You may request in writing that we not use or disclose your information for treatment, payment, or administrative purposes or to persons involved in your care except when specifically authorized by you, when required by law or in emergency circumstances. We will consider your request but are not legally required to accept it.

COMPLAINTS

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. Under no circumstances will you be retaliated against for filing a complaint.

OUR LEGAL DUTY

We are required by law to protect the privacy of your information, provide this notice about our information practices and follow the information practices that are described in the notice.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGMENT OF RECEIPT

Please sign this form below under the heading "Acknowledgment of Receipt" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of Grand Rapids Eye Care's Notice of Privacy Practices.

Patient Name (please print)

Signature of Patient or legal guardian

Date: _____

For office use only

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgment:

An emergency situation prevented the patient from signing the Acknowledgment.

Office Personnel (signature)

Office Personnel (print name)

Date: _____