THE Eye CENTER of North Florida

2500 MLK Jr. Blvd.
Panama City, FL 32405
(850) 784-3937

10900 Hutchison
Panama City Beach, FL 32407
(850) 234-1829

528-B Fifth Street
Port St. Joe, FL 32456
(850) 227-7266

1400 Main Street
Chipley, FL 32428
(850) 638-7333

To our Patients

NOTICE OF PRIVACY PRACTICES

This Notice is effective As of April 14, 2003.

THE FOLLOWING DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our practice is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Our practice is required by law to abide by the terms of this Notice.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Our office is required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. To request a revised notice you may call the office and request that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

How We May Use and Disclose your Medical Information.

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered and in order to support the business activities of the practice, including, but not limited to, use by administrative personnel reviewing the quality of the care you receive, employee review activities, training of medical students, licensing, contacting or arranging for other business activities..

We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

Appointment Reminders.

We may contact you to provide appointment reminders.

Treatment Information.

We may contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Disclosure to Department of Health and Human Services.

We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.

Notification.

Unless you object, we may use or disclose your medical information to notify a family member, a personal representative or another person responsible for your care of your location, general condition or death.

Disaster Relief.

We may disclose your medical information to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts.

Health Oversight Activities.

We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.

Abuse or Neglect.

We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.

Legal Proceedings.

We may disclose your medical information in the course of certain judicial or administrative proceedings.

Law Enforcement.

We may disclose your medical information for law enforcement purposes or other specialized governmental functions.

Coroners, Medical Examiners and Funeral Directors.

We may disclose your medical information to a coroner, medical examiner or a funeral director.

Organ Donation.

If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.

Research.

We may use or disclose your medical information for certain research purposes if an Institutional Review Board or a privacy board has altered or waived individual authorization, the review is preparatory to research or the research is on only decedent s information.

Public Safety.

We may use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or to the public.

Workers Compensation.

We may disclose your medical information as authorized by laws relating to workers compensation or similar programs.

Business Associates.

We may disclose your health information to a business associate with whom we contract to provide services on our behalf. To protect your health information, we require our business associates to appropriately safeguard the health information of our patients.

Authorizations.

We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. To request a Revocation of Authorization form, you may contact our Privacy Officer at the address and phone number on the back of this brochure.

Your Rights Regarding Your Medical Information

You have the following rights with respect to your medical information:

You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.

You have the right to receive communications from us in a confidential manner.

Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.

You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.

You have the right to receive an accounting of the disclosures of your medical information made by our practice during the last six years (or following April 14, 2003), except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.

You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.

You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please contact our Privacy Officer at the address and phone number on the back of this brochure.

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact our Privacy Officer at the address and phone number on the back of this brochure.

Revision Of Notice Of Privacy Practices

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at our office and will make paper copies of the revised Notice of Privacy Practices available upon request.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

Date: _____

_____

Patient or Patient's Representative

Print Patient's Name _____

If Signed by Representative, state name of Representative: _____

Relationship to Patient: _____