

# **HIPAA Notice of Privacy Practices**

## **Family Eye Care of Topeka**

**1107 SW Gage Blvd #200**

**Topeka, KS 66604**

**785-271-8989**

**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.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations (TPO) 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 or (PHI) 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.

### **Uses and Disclosure of Protected Health Information**

Your protected health information may be used and disclosed by your healthcare provider, our office staff and others outside of our offices who are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the health care provider's practice and other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the healthcare provider has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for outpatient cataract surgery may require that your relevant protected health information be disclosed to your health plan to obtain approval for the outpatient surgery.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of Family Eye Care of Topeka. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to professional students that see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you. We may contact you to remind you of your appointment, and may leave this information on your answering machine or voicemail. We may contact you regarding care and medical treatment at your home or work.

**WE MAY NOT** use or disclose psychotherapy notes or protected health information for marketing purposes without your authorization.

**WE MAY NOT** sell protected health information without your authorization.

**WE MAY** use or disclose your protected health information in certain situations without your authorization. These situations pertain to the following: as required by law, Public Health Issues, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration Requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, National Security, Workers' Compensation and Inmates. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

**OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES NOT DESCRIBED IN THIS NOTICE** will be made only with your consent, authorization or opportunity to object unless required by law.

**YOU MAY revoke this authorization** at any time, in writing, except to the extent that your healthcare provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**YOUR RIGHTS:** The following is a statement of your rights with respect to your protected health information:

**You have the right to inspect and copy your protected health information.** Under federal law however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means that you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members, significant other or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

**You have the right to restrict certain disclosures of PHI to your health plan. You may be responsible for out of pocket costs related to the restriction of PHI disclosures to your health plan.** Your healthcare provider is not required to agree to a restriction that you may request. If your healthcare provider believes it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. You may then have the right to use another healthcare professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**

**You have the right to obtain a paper copy of this notice from us upon request,** even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your healthcare provider amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. **You then have the right to object or withdraw as provided in this notice.**

**You have the right to be notified following a breach of your unsecured Protected Health Information (PHI).**

**You have the right to opt out of any communication regarding fundraising activities sponsored by this practice.**

**Complaints:** If you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer at 785-271-8989. You may also contact the Secretary of Health and Human Services at 877-696-6775. **We will not retaliate against you for filing a complaint.**

This notice was published and became effective on/or before October 21st, 2023 to comply with the FINAL RULE.

We are required by law to maintain the privacy of our patients' Protected Health Information and provide our patients with this notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any questions regarding this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 785-271-8989.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Patient Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_

Parent/Guardian Signature if Patient is a Minor: \_\_\_\_\_ Date: \_\_\_\_\_