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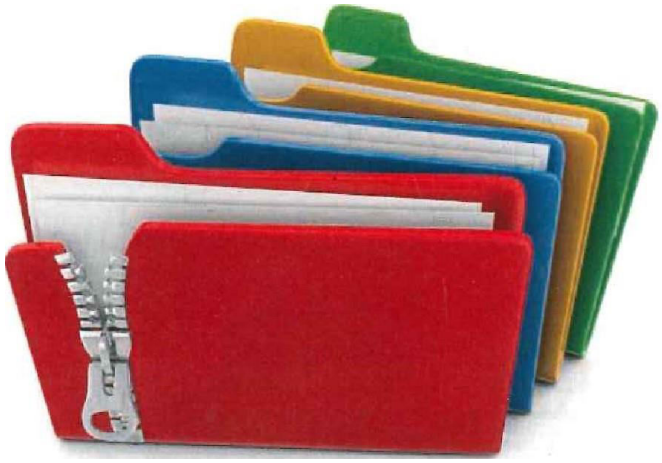
Retinal Consultants of San Antonio
Expert Care of the Retina, Macula and Vitreous

Notice of Privacy Practices



Your Information.

Your Rights.

Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and our responsibilities to help you.

Get an electronic or paper copy of medical record	• You may see or obtain an electronic or paper copy of your medical record and other health information. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable fee.
Ask us to correct your medical record	• You may ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we will tell you why in writing within 60 days.
Request confidential communications	• You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

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Your Rights *continued*

Ask us to limit what we use or share	• You may ask us not to use or share your health information. We are not required to agree to your request, if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we have shared information	• You may ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You may ask for a paper copy of this notice at any time, and we will provide you a copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person may exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You may complain if you feel we have violated your rights. • You may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to: 200 Independence Avenue, S.W., Washington, D.C. 20201, Calling 1-877-696-6775 Visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**. • We will not retaliate against you for filing a complaint.

SUMMARY OF PATIENT PRIVACY PRACTICES
(Revision January of 2018)

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Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

To Treat you	We may use your health information and share it with other professionals who are treating you.	***Example:*** A doctor treating you for an injury asks another doctor about your overall health condition.
For Operational Purposes	We may use and share your health information for operational purposes, to improve your care, and contact you when necessary.	***Example:*** We use health information about you to manage your treatment and services.
To Bill for your services	We may use and share your health information to bill and obtain payment from health plans or other entities.	***Example:*** We provide information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	We can share health information about you for certain situations: Preventing disease Helping with product recalls Reporting adverse reactions to medications Reporting suspected abuse, neglect, or domestic violence Preventing or reducing a serious threat to anyone's health or safety
Do research	We can use or share your information for health research.
Comply with the law	We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
Respond to organ and tissue donation requests	We can share health information about you with organ procurement organizations.

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Work with a medical examiner or funeral director	We can share health information with a coroner, medical examiner, or funeral director when an individual is no longer living.
Address, workers' compensation, law enforcement, and government requests	We can use or share health information about you: For workers' compensation claims For law enforcement purposes or with a law enforcement official With health oversight agencies for activities authorized by law For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have	Share information in a disaster relief situation.
Both the right and choice	Share information with your family, close friends, or others involved in your care
To tell us to:	Include your information in a hospital directory
	Contact you for fundraising efforts
	If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:	Marketing purposes Selling your information Most sharing of psychotherapy notes We may contact you for fundraising efforts, but you may tell us not to contact you again.

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Our Responsiblity

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We reserve the right to change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

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PATIENT PRIVACY PRACTICES CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protecteed health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you in used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about. You have the right to revoke this Consent, in writing. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease

X_____ _____ /_____ /_____ _____ /_____ /_____

Print name of patient or legal representative **Date of Birth** **Date**

X_____ **X**_____

Signature of patient or legal representative **If signed by legal representative, relationship to patient.**

X_____

Witness Signature

SUMMARY OF PATIENT PRIVACY PRACTICES
(Revision January of 2018)