

This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

NOTICE OF INFORMATION PRACTICES

Patty Vision Center 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. Patty Vision Center is required by law to abide by the terms of this Notice.

1. Patty Vision Center may use and disclose protected health information for treatment, payment, and healthcare operations. Examples of these include, but are not limited to, requested preschool, or sports physicals, referral to nursing homes, foster care homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; collection agencies. Healthcare operations include, but is not limited to, internal quality control and assurance including auditing records.
2. Patty Vision Center is permitted or required to use or disclose protected health information without individuals written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.
3. Patty Vision Center will not make any other use or disclosure of a patient's protected health information without the individuals written authorization. Such authorization may be revoked at any time. Revocations must be written.
4. Patty vision Center will abide by the terms of this notice currently in effect at the time of the disclosure.
5. Patty Vision Center reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Patty Vision Center will provide each patient with a copy of any revisions of it's Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.
6. Any patient, guardian or personal representative has the right to object to the use of their health information for directory purposes.
7. Any patient, guardian or personal representative has the right to inspect and obtain copies of their medical record.
8. Any patient, guardian or personal representative has the right to request amendments be made to their medical record.
9. Any patient, guardian or personal representative has the right to request a six-year accounting of all disclosures or their medical record. The history will be provided with 60 days of the request and a reasonable charge may be assessed for any copies after the first requested in a 12-month period.
10. Any patient, guardian or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Practice is not required to agree to the restrictions requested, but if the Practice does agree, the Practice must abide by those restrictions.
11. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy may have been violated. To file a complaint with the practice, please contact the Privacy Officer at the following address and/or phone number Patty Vision Center 2326-A South Church Street, Burlington, NC 27215, Telephone: 336-513-0073 Fax: 336-513-0204. All complaints will be addressed and the results will be reported to the Privacy Officer.
12. It is the policy of Patty Vision Center that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

CONSENT FORM

Disclaimer: Contents are informational and not intended as legal advice. NCRIC MSO, Inc. and its subsidiaries, its employees, agents and staff, make no representation, guarantee or warranty, express or implied, that these forms are error-free or that the use of this information will prevent differences of opinion or disputes with any other party, and will bear no responsibility or liability for the results or consequences of its use.

For Use and Disclosure of Protected Health Information for Treatment, Payment or Healthcare Operations)

I understand that as part of my healthcare, Patty Vision Center originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care and treatment. I also understand this information serves as:

1. A basis for planning my care and treatment
2. A means of communication among the many health professional who contribute to my care
3. A source of information for applying my diagnosis and surgical information to my bill
4. A means by which a third party payer can verify that services billed were actually provided
5. And a tool for routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the Practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment of healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

With this consent, Patty Vision Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, Patty Vision Center may e-mail to me appointment reminders and patient statements. I have the right to request that Patty Vision Center restrict how it uses or disclose my PHI to carry out TPO. However, the practice is not required to agree my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Patty Vision Center to use and disclose my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, Patty Vision Center may decline to provide treatment to me.**

Print Patient Name: _____
Account Number: _____

Signature of Patient or Legal Guardian: _____

Date: _____

PERMISSION TO DISCUSS PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

I hereby give my permission to the person(s) listed below to receive information about the care of the above named patient:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Patient, Parent, or Guardian

Date

In order to obtain information by telephone, the party calling the practice must share the patient identifier with the staff.

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