# NOTICE OF PRIVACY PRACTICES

This notice describes how Galiani Ophthalmology Associates, PC may use and disclose your personal Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are required or permitted by law. "Protected Health Information" is personal information including demographic information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

## PHI (Protected Health Information)

Uses & Disclosures of PHI :

- Treatment, Payment and Healthcare Operations (unless paid in full by patient/person on behalf of patient other than healthcare plan)
- Patient or designated representative
- Legal Purposes
- Marketing Purposes with written permission
- Fundraisers with written permission

Unauthorized Disclosure is permitted:

- as Required by Law
- for Public Health Issues and Communicable Diseases
- for investigation of claims or audits
- to protect victims of abuse, neglect or domestic violence
- when Judicial and Administrative Proceedings are necessary
- for Law Enforcement purposes or specialized Government functions
- to Coroners and Funeral Directors
- for Research
- to avert a serious threat or criminal activity
- for Disability documentation
- for Workers' Compensation
- for Inmates

Permitted Disclosures will only be released with your written consent or the written consent of a parent or guardian of a minor patient, unless noted above for Unauthorized Disclosure as permitted by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Safeguards for the Protection of PHI:

- Patient paper records and Electronic Health Records (EHR) are stored in a secure location. EPHI is protected in accordance with the administrative, physical and technical safeguards of the HIPAA Security Rule.

Patients' Rights:

- Our patients have the right to privacy and respect regarding their personal information.
- You have the right to inspect and copy your protected health information with reasonable notice.

- You have the right to receive care without discrimination due to age, sex, race, color, religion, sexual orientation, income, education, national origin, marital status, culture, language, disability, gender identity or ancestry.
- You have the right to restrict your protected health information if the service was paid in full by patient or patient representative.
- You have the right to request a restriction on how your personal protected health information is used.
- You have the right to have your physician amend your protected health information.
- You have the right to receive confidential communications from us by alternative means or at an alternative location.
- You have the right to receive an accounting of certain disclosure we have made of your protected health information.
- You have the right to file a complaint if you believe that our safeguards and procedures have not been followed. Any privacy issues complaints should be directed to the Privacy Officers of Galiani Ophthalmology Associates PC. to the Practice Administrator.

## Acknowledgement of Receipt of Notice of Privacy Practices

I have received the Notice of Privacy Practices of Galiani Ophthalmology Associates, PC and have been provided the opportunity to review it at my leisure.

_________________________________________________  ______________________
(Patient or if minor Parent or Guardian Signature)  (Date)

**Patient Record of Disclosures**

In general, the HIPAA privacy rules give the individual the right to request restriction on uses and disclosures of the protected health information (PHI) for the purpose of continuity of my care or to adjudicate my account. This authorization does not take place of our standard "Release of Records Authorization".

I authorize my PHI to be disclosed to the following individuals:

__________________________________________  ______________________  ______________
(Name)  (Relationship)  (Date)

__________________________________________  ______________________  ______________
(Name)  (Relationship)  (Date)

__________________________________________  ______________________  ______________
(Name)  (Relationship)  (Date)

**** Uses and disclosures for treatment may be permitted without prior consent in an emergent situation.****

**We reserve the right to change the terms of this notice. You have the right to object or withdraw. As provided in this notice.**

**(Signature)** **(Date)**

**Revised September 2013**