NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

We may use or disclose your medical information for the purposes listed on this notice. Examples of use are provided but not every use or disclosure is listed.

Medical Treatment. We will disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are involved in taking care of you.

Payment. We may use and disclose your medical information for services and procedures so they may be billed and collected from you, an insurance company or any other third party including workmen's compensation. This may include information needed to preauthorize treatment. You may request that no information be provided to insurers if you are paying in full for the service.

Health Care Operations: We may use and disclose your medical information so that we can run our Practice more efficiently. We may also disclose information to doctors, nurses, technicians, medical students and residents and other personnel for review and learning purposes.

Appointment and Patient Recall Reminders: We may ask you to sign in writing at the reception desk, contact you by phone, in writing, by e-mail or otherwise. This may involve leaving a message on e-mail, an answering machine or by postcard which could be received or intercepted by others.

Emergency Situations: We may disclose your medical information in an emergency so that your family can be notified about your condition and location.

Research: We may use and disclose medical information about you for research purposes. Before we use or disclose medical information for research, the project will have been approved through a research approval process and we will obtain an Authorization from you before using any individually identifiable information.

Other Uses and Disclosures: We may disclose your medical information when required by law, to report public health risks, to facilitate organ and tissue donations, for government oversight programs and licensure. If you are involved in a lawsuit or dispute we may disclose your information in response to a court or administrative order, subpoena, discovery request or other lawful process. We may also use such information to defend ourselves or any member of our Practice in any actual or threatened action.
We may release medical information if required to do so by a law enforcement official, funeral directors, medical examiners and correctional institutions if applicable.
Uses and disclosures not covered by a category listed including marketing or fund raising will only be made with your written permission, following Pennsylvania requirements for authorization..

This consent allows the practice to disclose my information to the following people.

Spouse ________________________ Parents ________________________________

Children ____

Other ____
(Please print names of individuals)

Patient or Representative Signature ____

Relationship (if other than patient) ____

Date _________________________ Witness ___________________________________

COMPLAINTS

You will be notified of any breach of you privacy that violates this policy. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice contact our compliance officer, Kathleen Santa Maria at 302-798-5777 ext 16. All complaints must be submitted in writing to her at Neuro-ophthalmologic Associates, 1304 Society Drive, Claymont DE 19703. All complaints will be investigated without repercussion to you.

PATIENT RIGHTS

You have the right to inspect and obtain a copy your medical information. If the office maintains your record electronically you may request an electronic copy. You must submit your request in writing using appropriate language as required by Pennsylvania State Law. A copy of the request form is available in our office. A minimal copying fee may be charged as permitted by law. You will be notified in advance of any fees. We may deny your request for access if it is determined it would be detrimental to your life or physical safety. You may appeal the decision by requesting a review by an independent licensed health care professional chosen by the Practice. We will comply with the outcome from that review

You have the right to request an amendment or correction to your medical record. The request must be made in writing and include a reason that supports your request. We may deny your request if you ask us to amend information not created by us or if we are asked to make something inaccurate or incomplete.

You have the right to request an accounting of disclosures we made about you to others. You must make the request in writing and may not include dates before April 14, 2003 or a date more than 6 years prior to the request.

You have the right to request a restriction on the medical information we use or disclose about you for treatment, payment or health care operations or set a time limit on the information we disclose. You have the right to restrict disclosure of your information to health plans if you have paid for the services. We are not required to agree to your request and we may not be able to comply with your request. Your request must be in writing and be specific about the restriction you are requesting.