EYEDENTITY
2176 HILLSBORO ROAD SUITE 100
FRANKLIN, TN 37069

THIS NOTICE DESCRIBES HOW OPTOMETRIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Uses & Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1. Your optometrist or a staff member may have to disclose your health information, including all of your clinical records, to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment or treatment of your health condition.
2. Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3. Your optometrist and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practices.

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

Permitted Uses and Disclosures Without Your Consent or Authorization

Under federal law, we are also permitted or required to use or disclose your health information in these following circumstances:

1. We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
2. We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
3. We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
4. We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.

Other than the circumstances described in the preceeding four examples, any other use of disclosure of your health information will be made with your written authorization.

Your Right To Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request.

1. If we have already released your health information before we receive your request to revoke your authorization.
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization please write us at:

William Y. Cuthbertson OD, FAAO
Eyedentity 2176 Hillsboro Road
Suite 100 Franklin, TN 37069

Your Right To Limit Uses Or Disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing.

Your Right To Receive Confidential Communication Regarding Your Health Information

We normally provide information about your health to you in person at the time you receive optometric services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your Right To Inspect And Copy Your Health Information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

Your Right To Amend Your Health Information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your Right To Receive An Accounting Of The Disclosures We Have Made Of Your Records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

1. Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
2. Those disclosures made to you.
3. Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
4. Those disclosures for national security or intelligence purposes.
5. Those disclosures made to correctional officers or law enforcements officers.
6. Those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12 month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your Right To Obtain A Paper Copy Of This Notice

If you have agreed to receive privacy notices by e-mail,you may request a paper copy of this notice at any time.

Our Duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the person to whom we provide information and may be protected by the federal privacy rules.

Your Right To Complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

William Y. Cuthbertson OD, FAAO
Eyedentity
2176 Hillsboro Road Suite 100
Franklin, TN 37069

To Contact Us

If you would like further information about our privacy policies and practices please contact:

William Y. Cuthbertson OD, FAAO
Eyedentity 2176 Hillsboro Road,
Suite 100 Franklin, TN 37069

This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

Patient Name (Printed) _____ Date _____

Patient Signature _____

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APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your optometrist and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. By signing this form, you are giving us authorization to contact you with these reminders and information. This contact may be made by phone, e-mail, postal services, or private carriers such as UPS or Federal Express. If this contact is made by phone and you are not at home or at work, a message will be left on your answering machine.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder of other information and may be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (S164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____
Patient Name (Printed) Date

_____ _____
Patient Signature Authorizing Provider Representative

_____ _____
Personal Representative (Printed) Personal Representative Signature

Please list persons (family, etc.) who are to have access to your medical information.