Effective date of notice: 4/9/2016

NOTICE OF PRIVACY PRACTICES

Office Manager: Sheree Strong

Dr. Gary J. Williams, O.D

293 Main Street

Owego, NY 13827

Phone: 607-687-3391

Fax: 607-687-4226

THIS IS A 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.

OUR PATIENTS AND THEIR RIGHTS AND PRIVACY HAVE ALWAYS BEEN RESPECTED BY THIS OFFICE. THE FOLLOWING IS A WRITTEN NOTICE OF STANDARDS AND PRCATICES ALREADY IN PLACE IN OUR OFFICE.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medication and faxing them to be filled; showing your low vision aids; referring you to another doctor or clinic for eye care or low vision aids services; or getting copies or your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health Core Operations" meant those administrative and managerial functions that we must do in order to run our office. Examples of how we use or disclose your health care information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all these situations will apply to us; some may never come up in our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;

- for public health purposes; such as contagious disease reporting; investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence;
- uses and disclosure for health oversight activities, such as for licensing of doctors; for audits by Medicare of Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of court administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office;
- disclosure to a medical examiner to identify a dead person or to determine a cause of death or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the President or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information (ex: name, no tracking number, no social security number);
- disclosures relating to worker's compensation programs;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your eye care with your family or friends who are helping you with your eye care.

APPOINTMENTS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a postcard and/or leave you a reminder message on your home or work answering machine or with someone who answers your phone if you are not home. To assist us in seeing you in a timely manner, you may be asked to register by signing in when you arrive at our office.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form". The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it is your idea for us to send your information to someone else. Typically, in this situation, you will give us a properly completed authorization form or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make or use the disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

HIV-RELATED INFORMATION AN INFORMATION CONCERNING ALCOHOL AND SUSTANCE ABUSE SERVICES

New York State law includes special protections for HIV-related information. We will not disclose information concerning your HIV status or HIV testing without obtaining a specific written authorization, except under certain circumstances in which such a disclosure is authorized or required by law. For example, we would be permitted to disclose such information to certain agents or employees of your health care providers that are authorized to obtain such information for treatment or payment purposes; to health care facilities staff committees and health care facilities accreditation or oversight organizations; or a public health officer when mandated by law; to your health insures or vision plan for purposes of securing reimbursement if we obtained your general consent to such disclosures; pursuant to a court order and certain purposes.

Health information possessed by federally supported alcohol and substance abuse treatment program is also subject to special protections under federal law. If we receive information about you from one of these programs, we will not re-disclose it without your specific written authorization, except under circumstances in which such a disclosure is authorized by law, such as medical personnel who need this information for the purpose of providing you with emergency treatment; to the Food and Drug Administration for the purpose of identifying potentially dangerous products; for research purposes if approved by our privacy board; to authorized persons conducting onsite audits of our records, subject to the requirement that these persons not remove information from our facilities and agree in writing to safeguard the information; and in response to an appropriate court order.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment, or health care operations. We do not have to agree to this, but if we agree, we must honor the restrictions that you want. To ask for a restriction send a written request to the office contact person at the address or fax number shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address or fax number shown at the beginning of this Notice.
- ask to see or get copies of your health information. By law, there are a few limited situations in which we can refuse to permit access copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or 60 days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation and instructions about how to get the impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address or fax number shown at the beginning of this Notice.
- ask us to amend your health information if you think it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can

write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you ask us to amend your health information, send a written request to the office contact person at the address or fax number shown at the beginning of this Notice.

- Get a list of the disclosures that we have made of your health information within the past six years (or shorter period if you want). By law, the list will not include; disclosures for purposes of treatment, payment, or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to on such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address or fax number shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices up request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, and send a written request to the office contact person at the address or fax number shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that may generate in the future. If we change our Notice of Privacy Practices we will post the new Notice in our office and have copies available in our office.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address or fax number shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT AND GENERAL CONSENT

I ACKNOWLEDGE THAT I RECEIVED A COPY OF Dr. Williams Notice of Privacy Practices.

I further consent to the release of my health information for purposes of treatment, payment, and healthcare operations and as authorized or requested by law under the circumstances described in the Notice Of Privacy Practices.

Patient Name (please print) _____

Signature _____ **Date** _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient: _____ **Print Name:** _____

Source of Authority (if non-parental): _____