

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 IT CAREFULLY.

THIS NOTICE IS EFFECTIVE September 21, 2016 UNTIL FURTHER NOTICE.

Please review this entire notice for details about the uses and disclosures Designer Eyes may make of your medical information, about your rights and how to exercise them and about complaints regarding or additional information about our privacy practices.

OUR LEGAL DUTY

We use many methods to protect your oral, written and electronic medical information from illegal use or disclosure. We are required by law to: (a) keep your medical information private; (b) provide you with this notice and follow the policies listed here; (c) inform you if we cannot agree to limit how we share your medical information; (d) agree to reasonable requests to contact you by alternative means or at alternative locations; (e) get your written approval to share your medical information for reasons other than those listed above and permitted by law; and (f) notify you of any breaches of your unsecured health information.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. If we make a significant change in our privacy practices, we will change this notice and make available a copy of the notice at our office.

You may request a paper copy of our notice at any time by contacting us using the information at the end of this notice.

USES AND DISCLOSURES OF MEDICAL INFORMATION

We will use and disclose medical information about you for treatment, payment and health care operations. For example:

Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you, or to coordinate or manage your health care and any related services.

For example, we may share information about your eye condition to another health care professional to assist in their treatment of you.

Payment: We may use and disclose your medical information, without your permission, to determine eligibility, process claims or make payment for covered services you receive under your benefit plan.

We may also disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities. For example, we may need to give information about your treatment to your health plan so they will pay us or reimburse you for the treatment.

Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations.

Health care operations include, for example, health care quality assessment and improvement activities and general administrative activities.

Persons Involved in Your Care: Unless you object, we may disclose your medical information to a family member, friend or any other person you involve in your health care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement, and at all times, we will only disclose the minimum necessary information. In addition, we may disclose your medical information to your personal representative (generally, a person who has authority to act on your behalf to make decisions related to your care).

Medical Emergency & Disaster Relief: We may use or disclose your name, location and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your health care in appropriate situations, such as a medical emergency or during disaster relief efforts.

Appointment Reminders & Health-Related Benefits and Services: We may contact you to remind you of appointments. We may use your medical information to communicate with you about health-related products, benefits and services, payment for those products, benefits and services, and treatment alternatives that may be of interest to you.

Additional Uses and Disclosures Without Your Authorization: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and interest activities, judicial and administrative proceedings, law enforcement, research and other

public benefit functions: for public health, including to report disease and vital statistics, child and adult abuse, neglect or domestic violence; to avert a serious and imminent threat to health or safety; to a health oversight agency for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities and fraud prevention enforcement agencies; to the Secretary of the Department of Health and Human Services (“HHS”) for the purpose of investigating or determining our compliance with HIPAA; for research; in response to court and administrative orders and other lawful process; to law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies and identifying or locating suspects or other persons; to coroners and medical examiners to identify a deceased person, determine cause of death, or other lawful duties; to funeral directors as needed to carry out their duties; to organ procurement, banking, or transplantation organizations to assist with organ, eye, or tissue donation and transplantation; to the military regarding individuals who are Armed Forces personnel or foreign military personnel, for activities considered necessary by appropriate military command authorities; to federal officials for lawful intelligence, counterintelligence and national security activities, and correctional institutions and law enforcement regarding persons in lawful custody; and as authorized by state worker’s compensation laws.

Uses and Disclosures With Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. An authorization is required for the following: most uses and disclosures of psychotherapy notes; most uses and disclosures for marketing purposes; and the sale of your medical information.

INDIVIDUAL RIGHTS

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You must make a written request to the contact at the end of this notice to obtain access to your medical information.

Disclosure Accounting: You have the right to a list of instances after

April 13, 2003, in which we disclose your medical information for purposes other than treatment, payment and health care operations, as authorized by you, and for certain other activities. You must make your request to the contact at the end of this notice. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than six years before the date of your request and never for a disclosure that occurred before April 14, 2003.

Amendment: You have the right to request that we amend your medical information. You must make a written request to the contact at the end of this notice and the written request must explain why the information should be amended. We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request, except if you (or someone on your behalf) pay for a health care item or service in full and you request that we not disclose information about the health care to your health plan. If we agree to a restriction request, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You must make a written request to the contact at the end of this notice.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by alternative means or to alternative locations that you specify. You must make a written request to the contact at the end of this notice and your request must represent that the information could endanger you if it is not communicated in confidence as you request. We will accommodate your request if it is reasonable and specifies the alternative means or location for confidential communication.

Right to Obtain a Paper Copy: You are entitled to receive this notice

in written form, even if you receive this notice on our web site or by e-mail. Please contact us using the information at the end of this notice to obtain this notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your medical information, you may complain to us using the contact information at the end of this notice. You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office of Civil Rights' Hotline at 1-800-368-1019. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact us at Dr. Viviani's Total Vision Care
787 Walt Whitman Road
Melville, New York 11747
631-271-3443 fax: 631-271-3606

Dr. Viviani's Total Vision Care

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

Purpose of this form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You May Refuse to Sign This Acknowledgement

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement (Please Specify)
