

HIPAA Omnibus Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003

[Pajka Eye Center](#)
[855 W. Market St. Suite A. Lima, OH 45805](#)
[\(419\) 228-7432](#)

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 of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising

activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the 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.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right

to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Pajka Eye Center Ohio HIPAA Release of information

AUTHORIZATION FORM

I, _____ hereby authorize Pajka Eye Center, Inc. and its affiliates, its employees and agents to release to

_____ **[Insert full name of person/organization]**
my personal health information maintained by Pajka Eye Center, Inc. (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) **except** the following information about me:

_____ **[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]** for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of _____ **[INSERT DATE/EVENT UPON WHICH THIS AUTHORIZATION EXPIRES]** or the date my coverage ends on _____.

I understand that I have a right to revoke this authorization by providing written notice to Pajka Eye Center, Inc. However, this authorization may not be revoked if Pajka Eye Center, Inc., its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Member: _____

Signature of Member: _____

Date: _____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____

Pajka Eye Center
Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

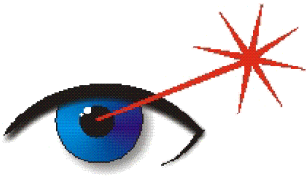
Please call my home my work my cell Number: _____

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

Signed: _____ Date: ____/____/____



Pajka Eye Center Patient Access to Protected Health Information Policy Handout

Policy

- The policy of Pajka Eye Center, Inc. is to protect individually identifiable health information and the system components that such data resides in under HIPAA, among other laws, rules, and regulations.
- The policy of Pajka Eye Center, Inc. is to provide patients access to their protected health information (“PHI”) under HIPAA, among other laws, rules, and regulations.

Procedure

- **Request for access to PHI.**
 - A patient who has or is receiving services from Pajka Eye Center, Inc. a parent of a minor, and a personal representative or legal guardian of a patient should request in writing for access to inspect or receive copies of PHI except in those instances covered by federal regulations and outlined in the Pajka Eye Center, Inc. Notice of Privacy Practices acknowledged at admission and must further specify the exact information requested for access. This policy does not mean that an Pajka Eye Center, Inc. provider cannot give a patient a copy of the patient’s test results, preventive measures, care instructions, or information to assist the patient’s understanding of the diagnosis during the delivery of health care without a written release.
- **Denial of Access**
 - Pajka Eye Center, Inc. may deny the patient access to PHI if the information requested makes reference to someone other than the patient and a health care professional has determined that the access requested is reasonably likely to cause death or serious bodily harm to that other person.
 - Pajka Eye Center, Inc. may deny a request to receive a copy or inspect PHI by a personal representative of the patient if the facility has a reasonable belief that the patient has been or may be subjected to domestic violence, abuse, or neglect by such person; or treating such person as the personal representative could endanger the individual; and the facility, exercising professional judgment, decides that it is not in the best interest of the patient to treat that person as the patient’s personal representative.
 - Pajka Eye Center, Inc. may deny the patient access to PHI if the information requested makes reference to someone other than the patient and a health care professional has determined that the access requested is reasonably likely to cause death or serious bodily harm to that other person.
 - Requests for access to PHI may be denied provided that the individual is given a right to have the denial reviewed, except as follows.
 - Requests for access to PHI may be denied without a right to review as follows:
 - If the information conforms to one of the following categories:
 - Psychotherapy notes.
 - HIV testing information.

- Information compiled for use in civil, criminal, or administrative actions or proceedings.
 - Information that would be prohibited from use or disclosure under the Certified Laboratory Information Act (“CLIA”) laws and regulations.
 - If the patient is participating in research-related treatment and has agreed to the denial of access to records for the duration of the study.
 - If access is otherwise precluded by law.
 - If the information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.
 - If the facility has been provided a copy of a court order from a court of competent jurisdiction that limits the release or use of PHI.
 - If a licensed health care professional based on an assessment of the particular circumstances, determines that the access requested is reasonably likely to endanger the life or physical safety of the patient or another person.
- **Appeal and Review of Denial of Requests**
 - A patient, parent of a minor, or guardian of a patient has the right to appeal the decision to withhold portions or all of the record for safety or confidentiality reasons.
 - The appeal shall be submitted in writing through the HIPAA Compliance Officer to the Medical Director, who will designate a licensed health care professional to review the denial of access.
 - The designated licensed health care professional that did not participate in the original decision to deny access shall review the record and the request for access to the patient’s record. The reviewer must determine whether access meets an exception as described above.
 - If the reviewer determines that the initial denial was appropriate, the patient must be notified in writing, using plain language that the review resulted in another denial of access. The notice must include the reasons for denial and must describe the process to make a complaint to Pajka Eye Center, Inc.’s complaint official and/or to the Secretary of DHHS.
 - If the denial was not appropriate, the licensed health care professional who acts as the reviewer shall refer the request to the Pajka Eye Center, Inc. HIPAA Compliance Officer for action.
 - If access is denied to any portion of the PHI, access must still be granted to those portions of the PHI that are not restricted.
 - Pajka Eye Center, Inc. is bound by the decision of the reviewer.
- **Provision of Access and Fees**
 - If Pajka Eye Center, Inc. provides a patient or legal representative access, in whole or in part, to protected PHI, Pajka Eye Center, Inc. must comply with the specifications as outlined in federal regulations to the extent of Pajka Eye Center, Inc. capabilities and as identified in Pajka Eye Center, Inc.’s Notice of Privacy Practices.
- **Release of Protected PHI of a Deceased Patient.** Upon request to obtain information, the Billing Manager or Medical Records Department shall ask for a copy of the probate court

order, letters of administration, or other necessary documentation appointing the requester executor or administrator of the estate. [If state law permits disclosure to the next-of-kin, verify that the requester is the next-of-kin.]

09/06/13

Pajka Eye Center Access to Protected Health Information Request Form

Use this form to request access to or to receive a copy of your protected health information that Pajka Eye Center, Inc. maintains regarding you.

Name: _____ Phone number: _____

Address: _____
Street City State Zip Code

Date of birth: _____ Date of request: _____

Description of records requested (please describe specific information or records requested and include time period):

Scope of request:

There is a cost-based charge for copying records as follows: The first copy is free, and there is a cost-based charge for copying records thereafter as follows: Pages 01-10: \$2.50/pg, pages 11-50: \$0.51/pg, Pages 51+: \$0.20/pg.

- I would like to inspect the requested records.
- I would like to obtain a copy of my requested records.
- I would like both to inspect and to obtain a copy of the requested records.
- Other:

Signature of individual or personal representative: _____ Date: _____

If personal representative, describe authority and provide documentation and proof of identity:

For Pajka Eye Center, Inc. Privacy Officer Use Only:

Identity of individual or personal representative verified: Yes No

- Request approved.
- Request denied.
- Response delayed.

Response due date: _____

Comments:

Signature of Privacy Officer

Date

Pajka Eye Center Access to Protected Health Information Request Form

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Address: _____
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- Other:

Signature of individual or personal representative: _____ Date: _____

If personal representative, describe authority and provide documentation and proof of identity:

For Pajka Eye Center, Inc. Privacy Officer Use Only:

Identity of individual or personal representative verified: Yes No

- Request approved.
- Request denied.
- Response delayed.

Response due date: _____

Comments:

Signature of Privacy Officer

Date

Pajka Eye Center Ohio Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided the Pajka Eye Center, Inc. Notice of Privacy Practices (“Notice”):

- It tells me how Pajka Eye Center, Inc. will use my health information for the purpose of my treatment, payment for treatment, and Pajka Eye Center, Inc.’s, healthcare operations.
- The Notice explains in more detail how Pajka Eye Center, Inc. may use and share my healthcare information for other than treatment, payment, and health care operations.
- Pajka Eye Center, Inc. will also use and share my health information as required/permitted by law.

Patient’s Complete Legal Name: _____
(Please Print)

Patient’s DOB _____ Date _____

Signature: _____
(Patient or legal representative)