

# **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.**

## **I. Who We Are**

This Notice describes the privacy practices of **Network Eye Care FL PLLC** (“we” or “us”), including:

- All healthcare professionals allowed to enter or access information in your medical record
- All employees with access to your medical or billing records or health information about you (“**Protected Health Information**”).

## **II. Our Privacy Obligations**

We understand that your health information is personal and we are committed to protecting your privacy. In addition, we are required by law to maintain the privacy of your Protected Health Information, to provide you with this Notice of our legal duties and privacy practices with respect to your Protected Health Information, and to notify you in the event of a breach of your unsecured Protected Health Information. When we use or disclose your Protected Health Information, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

## **III. Permissible Uses and Disclosures Without Your Written Authorization**

In certain situations, which we will describe in Section IV below, we must obtain your written authorization in order to use and/or disclose your Protected Health Information. However, unless the Protected Health Information is Highly Confidential Information (as defined in Section IV.B below) and the applicable law regulating such information imposes special restrictions on us, we may use and disclose your Protected Health Information without your written authorization for the following purposes:

A. Treatment. We use and disclose your Protected Health Information to provide treatment and other services to you--for example, to provide Diabetic Retinopathy screening or retina therapy for Diabetic Retinopathy or Macular Degeneration or to consult with your physician about your retina disease or therapy. We may use your information to direct or recommend alternative treatments, therapies, health care providers, or settings of care to you or to describe a health-related product or service. We may also disclose Protected Health Information to other providers involved in your treatment.

B. Payment. We may use and disclose your Protected Health Information to obtain payment for health care services that we provide to you--for example, disclosures to

claim and obtain payment from Medicare, Medicaid, your health insurer, HMO, or other company or program that arranges or pays the cost of your health care (“**Your Payor**”) to verify that Your Payor will pay for the health care. We may also disclose Protected Health Information to your other health care providers when such Protected Health Information is required for them to receive payment for services they render to you.

C. Health Care Operations. We may use and disclose your Protected Health Information for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use Protected Health Information to evaluate the quality and competence of our health care professionals.

D. Disclosure to Relatives, Close Friends and Other Caregivers. We may use or disclose your Protected Health Information to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if: (1) we obtain your agreement or provide you with the opportunity to object to the disclosure and you do not object; or (2) we reasonably infer that you do not object to the disclosure.

If you are not present for or unavailable prior to a disclosure (e.g., when we receive a telephone call from a family member or other caregiver), we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information under such circumstances, we would disclose only information that is directly relevant to the person’s involvement with your care.

E. As Required by Law. We may use and disclose your Protected Health Information when required to do so by any applicable federal, state or local law.

F. Public Health Activities. We may disclose your Protected Health Information: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to a government authority authorized by law to receive such reports; (3) to report information about products under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

G. Victims of Abuse, Neglect or Domestic Violence. We may disclose your Protected Health Information if we reasonably believe you are a victim of abuse, neglect or domestic violence to a government authority authorized by law to receive reports of such abuse, neglect, or domestic violence.

H. Health Oversight Activities. We may disclose your Protected Health Information to an agency that oversees the health care system and is charged with responsibility for

ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

I. Judicial and Administrative Proceedings. We may disclose your Protected Health Information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

J. Law Enforcement Officials. We may disclose your Protected Health Information to the police or other law enforcement officials as required by law or in compliance with a court order.

K. Decedents. We may disclose your Protected Health Information to a coroner or medical examiner as authorized by law.

L. Organ and Tissue Procurement. We may disclose your Protected Health Information to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

M. Clinical Trials and Other Research Activities. We may use and disclose your Protected Health Information for research purposes pursuant to a valid authorization from you or when an institutional review board or privacy board has waived the authorization requirement. Under certain circumstances, your Protected Health Information may be disclosed without your authorization to researchers preparing to conduct a research project, for research or decedents or as part of a data set that omits your name and other information that can directly identify you.

N. Health or Safety. We may use or disclose your Protected Health Information to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

O. Specialized Government Functions. We may use and disclose your Protected Health Information to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

P. Workers' Compensation. We may disclose your Protected Health Information as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

#### **IV. Uses and Disclosures Requiring Your Written Authorization**

For any purpose other than the ones described above in Section III, we only use or disclose your Protected Health Information when you give us your written authorization.

A. Marketing. We must obtain your written authorization prior to using your Protected Health Information for purposes that are marketing under the HIPAA privacy rules. For example, we will not accept any payments from other organizations or individuals in exchange for making communications to you about treatments, therapies,

health care providers, settings of care, case management, care coordination, products or services unless you have given us your authorization to do so or the communication is permitted by law.

We may provide refill reminders or communicate with you about a drug or biologic that is currently prescribed to you so long as any payment we receive for making the communication is reasonably related to our cost of making the communication. In addition, we may market to you in a face-to-face encounter and give you promotional gifts of nominal value without obtaining your written authorization.

B. Sale of Protected Health Information. We will not make any disclosure of Protected Health Information that is a sale of Protected Health Information without your written authorization.

C. Uses and Disclosures of Your Highly Confidential Information. Federal and state law requires special privacy protections for certain health information about you (“**Highly Confidential Information**”), including Alcohol and Drug Abuse Treatment Program records and other health information that is given special privacy protection under state or federal laws other than HIPAA. **[We generally do not maintain any Highly Confidential Information.]** However, in order for us to disclose any Highly Confidential Information for a purpose other than those permitted by law, we must obtain your authorization.

D. Revocation of Your Authorization. You may revoke your authorization, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Privacy Office identified below.

## **VI. Your Individual Rights**

A. For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your Protected Health Information, you may contact our Privacy Office. You may also file written complaints with the Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of your Protected Health Information (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction unless the request is to restrict our disclosure to a health plan for purposes of carrying out payment or health care operations, the disclosure is not required by law and

the information pertains solely to a health care item or service for which you (or someone on your behalf other than the health plan) have paid us out of pocket in full. If you wish to request additional restrictions, please obtain a request form from our Privacy Office and submit the completed form to the Privacy Office. We will send you a written response.

C. Right to Receive Communications by Alternative Means or at Alternative Locations. You may request, and we will accommodate, any reasonable written request for you to receive your Protected Health Information by alternative means of communication or at alternative locations.

D. Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from the Privacy Office and submit the completed form to the Privacy Office. If you request copies, we may charge you a reasonable copy fee.

E. Right to Amend Your Records. You have the right to request that we amend your Protected Health Information maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Privacy Office and submit the completed form to the Privacy Office. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

F. Right to Receive An Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your Protected Health Information made by us during any period of time prior to the date of your request provided such period does not exceed six years. If you request an accounting more than once during a twelve (12) month period, we may charge you a reasonable fee for the accounting statement.

G. Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically.

## **VII. Effective Date and Duration of This Notice**

A. Effective Date. This Notice is effective on December 1, 2021.

B. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all your Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in our waiting room and on our Internet site at [www.networkkeyecare.com](http://www.networkkeyecare.com). You also may obtain any new notice by contacting the Privacy Office.

## **VIII. Privacy Office**

You may contact the Privacy Office at:

Privacy Office

**NETWORK EYE CARE FL PLLC (C/O Jeremy Kirsch)**

**1875 K St NW**

**Washington, DC 20006**

Telephone Number: **1-877-362-3937** E-mail: [privacy@networkeyecare.com](mailto:privacy@networkeyecare.com)

By signing below, I hereby acknowledge receipt of the Notice of Privacy Practices of **Network Eye Care FL PLLC** and consent to the uses and disclosures described in the Notice of Privacy Practices.

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Signature of Patient (or Personal Representative)

\_\_\_\_\_, 20\_\_

Date of Signature

\_\_\_\_\_

Patient Name

\_\_\_\_\_

Relationship of Personal Representative to Patient

*(if applicable)*