

# Shepherd Eye Center

## NOTICE of PRIVACY POLICIES

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

### Introduction

At Shepherd Eye Center, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

### Understanding Your Health Record/Information

Each time you visit Shepherd Eye Center; a record of your visit is made. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve. Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

### Your Health Information Rights

Although your health record is the physical property of Shepherd Eye Center, the information belongs to you. You have the right to obtain a copy of this notice of information practices upon request. In addition, if done so in writing, you have the right to request:

- To inspect and copy your health record as provided for in 45 CFR 164.524;
- An amendment of your health record as provided in 45CFR 164.528; (*For an amendment request, we must have a reason for the request in writing*).
- An accounting of disclosures of your health information as provided in 45 CFR 164.528;
- Communications of your health information by alternative means or at alternative locations, per written request;
- A restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and;
- A revocation of your authorization to use or disclose health information except to the extent that action has already been taken.

### Our Responsibilities

Shepherd Eye Center is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and;
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

**We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a REVISED NOTICE on the patient bulletin board at our offices.**

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

### For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer, at 702-731-2088. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is:

#### *Office for Civil Rights*

U.S. Department of Health & Human Services  
200 Independence Avenue, S.W.; Room 509F, HHH Building  
Washington, D.C. 20201

## Examples of Disclosures for Treatment, Payment and Health Operations

### We will use your health information for treatment.

**For example:** Information obtained by a nurse, physician, or other member of our health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you as well as your diagnosis, procedures and supplies used.

### We will use your health information for payment.

**For example:** A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

### We will use your health information for regular health operations.

**For example:** Members of the medical staff, the risk or quality improvement manager or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it.

This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

**Business associates:** There are some services provided in our organization through contacts with business associates. Examples include certain laboratory tests or plan audits performed by some insurance plans. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

**Notification:** We may use or is close information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

**Communication with family:** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

**Research:** We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

**Funeral directors:** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

**Marketing:** Unless you object, we may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Front Desk Sign In For Your Appointment:** ~~UNLESS YOU NOTIFY US THAT YOU OBJECT~~, we acknowledge your appointment by:

#### •Sign In Sheets

•**Announcing your name:** to call you back to see the doctor.

•**Telephone:** We call your home via an automated telephone attendant to remind you of your appointment.

**\*\* Unless you tell us that you object, we may also leave messages on your answer machine regarding appointments, billing, financial matters and/or other general healthcare operations.**

• **Mail:** We may mail letters/postcards to tell you it is time for you to make another appointment.

• **Email:** Unless you tell us you object, we may contact you via your email address for non-medical purposes, i.e., completion of a patient survey via a link to a secured website.

**Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**Workers compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs "established by law."

**Public health:** "As required by law," we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**Law enforcement:** We may disclose health information for law enforcement purposes as "required by law or in response to a valid subpoena." Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

## OPPORTUNITY TO OBJECT

Use this form to notify us of objections you have to ways we MAY use your protected health information. Please detach and mail completed form to the Privacy Officer of Shepherd Eye Center at 3575 Pecos McLeod, Las Vegas, NV 89121. If your objection is reasonable and permitted by law, we will do our best to comply. Certain items noted in this notice CANNOT be objected to, such as Law Enforcement or Public Health. If we cannot, by law or for any other reason comply with your request, we will notify you in writing. Thank you and we sincerely hope that you feel secure in our efforts to protect your privacy.

Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_  
Social Security# \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_