



Ludwick Eye Center

Chambersburg • Hagerstown • Waynesboro

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 READ IT CAREFULLY.

OUR RESPONSIBILITIES:

We are required by law to maintain the privacy of your health information. In addition, we are to provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you and seek your acknowledgement of receipt of this notice. We must abide by the terms of this Notice of Privacy Practices, 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 alternate locations. We reserve the right to change the terms of our notice at any time. At your request, we will provide you with a revised Notice of Privacy Practices at your next appointment. We will not use or disclose your health information without your written authorization, except as described in this notice.

YOUR RIGHTS:

Unless otherwise required by law, your health record is the physical property of our office. You have the right to request a restriction on certain uses and disclosures of your information. This includes the right to obtain a paper copy of the Notice of Privacy Practices relating to your health information, to request communications of your health information by alternative means or at alternate locations and to revoke your authorization to use or disclose your health information except to the extent that action has already been taken. We are not required to agree to the requested restriction(s).

You have the right to request a copy of your health information by submitting a Request to Inspect & Copy PHI Form. If your request is denied, you may ask that the denial be reviewed. The person reviewing the denial will not be the same person who denied your request.

You have the right to ask us to amend your health information if you believe it is incorrect or incomplete. You must complete and submit a Request for correction or Amendment of PHI Form.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- A) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- B) Is not part of the health information that we keep.
- C) You would not be permitted to inspect or copy.
- D) Is accurate and complete.

You have the right to request a restriction of the health information we may disclose. You may complete and submit the Request for Limitations and Restrictions of PHI Form. If we do agree, we will comply unless the information is needed to provide you emergency treatment.

ACCOUNTING OF DISCLOSURES:

You have the right to request an “accounting of disclosures.” To obtain this list, you must submit your request in writing. It must state a time period which may not be longer than six years and may not include dates before April 14, 2003. We may charge you for the cost of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

CHANGES TO THIS NOTICE:

We reserve the right to change or revise this notice at any time and at our discretion, which will be effective for information we already have about you as well as any information we receive in the future. You are entitled to a copy of the notice currently in effect.

EXAMPLES OF DISCLOSURES FOR:

1. **Treatment:** Information obtained by your doctor will be recorded in your record and used to determine the course of treatment that should work best for you. We may use your health information to contact you as a reminder that you have an appointment for treatment or testing at our office. Your health information may be provided to another doctor to whom you have been referred to ensure that the doctor has the necessary information to diagnose or treat you. Different personnel in our office may share information about you to people who do not work in our office in order to coordinate care, such as phoning in prescriptions to your pharmacy and communicating with other healthcare providers to coordinate your care.
2. **Payment:** A bill may be sent to you or your insurance. The information on the bill may include information that identifies you as well as your diagnoses and procedures. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, etc.
3. **Healthcare Operations:** Members of our staff may use information in your health record in an effort to continually improve the quality and effectiveness of the care and service we provide. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer and how we can become more efficient. Other activities include but are not limited to internal auditing of records.

OTHER USES OF YOUR HEALTH INFORMATION MADE WITH YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your health information will be made only with your written authorization, unless otherwise permitted or required by law. You may submit a completed Authorization for Disclosure Form. You may revoke this authorization at any time, in writing, except to the extent that the practice has taken action in reliance on the use or disclosure indicated in the authorization. You have the opportunity to agree or object to the use or disclosure of all or part of your health information. If this is not possible, your doctor will use professional judgment to determine whether the disclosure is in your best interest. In this case, only the health information that is relevant to your health care will be disclosed.

OTHER USES OF YOUR HEALTH INFORMATION MADE WITHOUT YOUR WRITTEN AUTHORIZATION

We may use or disclose your health information in the following situations without your consent or authorization, subject to all applicable legal requirements and limitations:

When required by law, public health risks, communicable diseases, health oversight activities, abuse or neglect, Food and Drug Administration, legal proceedings, law enforcement, criminal activity, worker’s compensation, organ or tissue donation, research national security, medical examiners and family or friends (only if we obtain your verbal agreement or if we give you an opportunity to object to such a disclosure and you do not raise an objection or you are not capable of giving your verbal consent).

Please be assured that everyone at Ludwick Eye Center has always placed your confidentiality and privacy as a top priority. We value your trust and confidence in our staff.

OUR NOTICE OF PRIVACY PRACTICES WILL BE PROMINENTLY POSTED IN THIS OFFICE WHERE REGISTRATION OCCURS. PATIENTS WILL BE PROVIDED A HARD COPY.

If you believe your privacy rights have been violated, you may file a written complaint with our Privacy Officer at the address below or call the Secretary of the Department of Health and Human Services/Office of Civil Rights at 1-866-OCR-PRIV. You will not be penalized for filing a complaint. You must file your complaint within 180 days of knowing or perceived knowing that the act or omission occurred, unless the time limit is waived by the Secretary of DHHS for good cause shown.

Effective Date: April 14, 2003
Last Revision: November 1, 2006