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HIPAA 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.

If you have any questions about this notice, please contact our Privacy Officer. at 847.299.0700

OUR OBLIGATIONS:

We are required by law to:

1. Maintain the privacy of your Protected Health Information (PHI)
2. Give you this notice of our legal duties and our policy on privacy practices regarding your PHI
3. Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE YOUR PHI:

The following describes the ways we may use and disclose your PHI, which identifies you. Except for the purposes described below, we will use and disclose your PHI only with your written permission. You may revoke such permission at any time by writing to the Retina Consultants, Ltd. Privacy Officer.

For Treatment. We may use and disclose your PHI for your treatment and to provide you with treatment-related health care services. For example, we may disclose your PHI to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose your PHI so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health insurance plan information about you so that they will pay for your treatment.

We may use and disclose your PHI for health care operations purposes. These uses and disclosures are necessary make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure that your primary care physicians records are up to date. (Continued on reverse side)

We also may share information with other entities that have a relationship with you (for example, your health insurance plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose your PHI to contact you, in order to remind you that you have an appointment with us. We also may use and disclose PUI to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share your PHI with person(s) involved in your medical care or payment for your care, such as your family or your Personal Healthcare Representative(s). We also may notify your family or Personal Healthcare Representative(s) about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose your PHI for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose your PHI for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any PHI.

SPECIAL SITUATIONS

As Required by Law. We will disclose your PHI when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose your PHI to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release your PHI to organizations that handle organ procurement or other entities engaged in procurement, storage or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release your PHI as required by military command authorities. We also may release your PHI to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your PHI for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; report person(s) who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to an appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure when required or authorized by law.

Health Oversight Activities. We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We also may disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release your PHI if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release your PHI to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release your PHI to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. (Continued on reverse side)

Protective Services for the President and Others. We may disclose your PHI to an authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution

or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND DECIDE NOT TO PARTICIPATE

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your PHI will be made only with your written authorization:

1. Uses and disclosures of your PHI for marketing purposes; and

2. Disclosures that constitute a sale of your PHI and other uses and disclosures of your PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to: Retina Consultants, Ltd., Attn: Privacy Officer 2454 E. Dempster St., Suite #400, Des Plaines, IL 60016 and we will no longer disclose your PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS

You have the following rights regarding PHI we have about you:

Right to Inspect and Copy. You have a right to inspect and copy your PHI that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy your PHI, you must make your request, in writing, to Retina Consultants, Ltd., Attn: Privacy Officer, 2454 E. Dempster St., Suite #400, Des Plaines, IL 60016. We have up to 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to

another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If your PHI is not readily producible in the form or format you request your record will be provided in either our standard electronic format or in a readable hard copy form. We may charge you a reasonable, cost-based fee for transmitting the electronic medical record or making hard copies

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured PHI.

Right to Amend. If you feel that your PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to: *Retina Consultants, Ltd., Attn: Privacy Officer, 2454 E. Dempster St., Suite #400, Des Plaines, IL 60016.*

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of your PHI for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing to: *Retina Consultants, Ltd., Attn: Privacy Officer, 2454 E. Dempster St., Suite #400, Des Plaines, IL 60016.*

Right to Request Restrictions. You have the right to request a restriction or limitation on your PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your PHI we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing to: *Retina Consultants, Ltd., Attn: Privacy Officer 2454 E. Dempster St., Suite #400, Des Plaines, IL 60016.*

We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request. (Continued on reverse side)

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing to: *Retina Consultants, Ltd., Attn: Privacy Officer 2454 E. Dempster St., Suite #400, Des Plaines, IL 60016.*

Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this

notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.retinaconsultants.md, or at one of our offices.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to your PHI we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date at the left bottom corner of each page

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, please contact our *Privacy Officer, 2454 E. Dempster St., Suite #400, Des Plaines, IL 60016.*

All complaints must be made in writing. **You will not be penalized for filing a complaint**.

Effective Date. This Notice of Privacy Practices Policy is effective on October 1, 2013.

Revisions to the Notice. Retina Consultants, Ltd., will promptly revise and provide this Notice of Privacy Practices Policy, (Policy), whenever there is a material change to the uses or disclosures, the individual's rights, the covered entity's legal duties, or other privacy practices stated in this Policy, except when required by law. Any material change to any of the terms of this Policy will not be implemented prior to the revision date of the Policy in which such material change is reflected.

DOCUMENTATION

Retina Consultants, Ltd., documents compliance with this Policy by retaining a sample copy of each revision of the Policy. A signed copy of the acknowledgment form, the “Receipt of Notice of Privacy Practices” will be maintained in each patient’s medical record file. Copies of materials will be retained as required under section §164.630(j) for a period of six years from the date of creation or last use, whichever is later.

Retina Consultants, Ltd
Receipt of Notice of Privacy Practices Form

I, _____, hereby acknowledge receipt of the
(Patient's Name)

Physician's Notice of Privacy Practices Policy. The Notice of Privacy Practice Policy, (Policy), provides detailed information about how Retina Consultants, Ltd. may use and disclose my confidential information.

I understand that Retina Consultants, Ltd. has reserved a right to change its privacy practices that are described in the Policy. I also understand that a copy of a revised Policy will be provided to me or made available on line at www.retinaconsultants.md, or at one of our offices.

Signed: _____ Date: _____
(Patient signature only)

Only the patient can sign this form. Name and relationship of anyone helping to fill out this form

_____.

Patient File #:_____

Retina Consultants, Ltd

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, _____, hereby give my consent to *Retina Consultants, Ltd.* to use
(Name of Patient or Authorized Agent)

or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.
(Patient's Name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information on how Retina Consultants, Ltd. may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available *www.retinaconsultants.md*.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my Protected Health Information. Written revocation of consent must be sent to the physician's office.

Signed: _____ Date _____
(Patient signature only)

Only the patient can sign this form. Name and relationship of anyone helping to fill out this form

_____.

Patient File #:_____

Retina Consultants, Ltd
Request for Confidential Communication

I, _____, hereby request ***Retina Consultants, Ltd t***o keep
(Name of Patient or Authorized Agent)

communications regarding my Protected Health Information confidential. To accomplish this request please adhere to the following requests:

Phone: You can contact me by phone at _____

Leave messages on answering machine: ____Yes ____ No

Leave message with any other person: ____Yes ____ No

Mail: Contact me at the following address: _____

_____

_____

FAX: Contact me by FAX at_____

Other Requests for Confidential Communications:

_____

This request may be changed or revoked by filing a new request or revoking this one in writing.

Signed: _____ Date: _____
(Patient signature only)

Only the patient can sign this form. Name and relationship of anyone helping to fill out this form

_____.

Patient File #:_____

Retina Consultants, Ltd

Notice of Personal Healthcare Representative Designation Form

Federal law says that Retina Consultants, Ltd., (the Practice), cannot share your Protected Health Information without your permission except in certain situations. If you sign this form, you are giving the Practice permission to share your Protected Health Information with those person(s) you name as your Personal Healthcare Representative, and.

- You can name more than one person as your Personal Healthcare Representative.
- The Personal Healthcare Representative designation will last until you tell the Practice you do not want the person named below as your Personal Healthcare Representative any longer.
- Right to Revoke: If you decide you do not want the Practice to treat any of the person(s) below as your Personal Healthcare Representative, please request a Restrict Access Form and give this form to the Practice. Any revocation can only apply on and after the date the Practice receives the Revocation. The Practice cannot cancel disclosures it made to a Personal Healthcare Representative before it received the Revocation.
- You can keep a copy of this Personal Healthcare Representative form, and can contact Retina Consultants' Privacy Officer to get an additional copy.

I, _____ hereby give my consent to Retina Consultants Ltd.,
(Print Name of Patient)

to treat the following person(s) as my Personal Healthcare Representative(s):

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

(***Add other Personal Healthcare Representatives to the reverse side of this document)***

I acknowledge receipt of the physician's Notice of Privacy Practices which provides details about how Retina Consultants, Ltd., may use and disclose my confidential information

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the Practice. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my Protected Health Information. Written revocation of consent must be sent to Retina Consultants, Ltd, 2454 E Dempster St., Suite 400, Des Plaines, IL, 60004.

Signed _____Date: _____
(Patient signature only)

Only the patient can sign this form. Name and relationship of anyone helping to fill out this form

_____.

Patient File #:_____