Retina Specialists *of Michigan*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form will be retained in your medical record.

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for Retina Specialists of Michigan.

I hereby designate the following individual's to receive communications from Retina Specialists of Michigan that may include health information about me:

_____

_____

I authorize Retina Specialists of Michigan to leave voice mail messages concerning my health information (i.e., lab results, appointment instructions, etc.) at the following number:

Phone ( ) _____ (patient initials) _____

_____

Signature of patient (or personal representative) **Date**

If this acknowledgment is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

FOR OFFICE USE ONLY

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____

_____

Employee Name Date

Consent For Treatment

1. I consent to the making of videotapes and photographs before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.
2. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I give consent to allow **Retina Specialists of Michigan, P.C.** to obtain my personal medical history and/or necessary medical records for the purpose of carrying out my treatment, payment and health care operations.

Patient's Signature _____ Date_____

Parent / Responsible Party's Signature _____Relationship to Patient _____

Notice of Privacy Practices Effective April 14, 2003

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.

Our goal is to take appropriate steps to attempt to safeguard any medical and personal information that is provided to us. By law, we are required to maintain the privacy of medical information provided to us, provide notice of our legal duties and privacy practices, and abide by the terms of this notice.

INFORMATION COLLECTED ABOUT YOU In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as your name, address, phone number, medical history, insurance information, and information regarding other medical providers. In addition, we will be collecting data about you during our examinations which will be contained within your medical record. Some information may also be provided to us by other individuals or organizations that are part of your "circle of care", such as the referring physician, other doctors, your health plan and close friends and family.

HOW INFORMATION MAY BE DISCLOSED We may use and disclose personal and identifiable health information for a variety of purposes including treatment planning, billing and health care operations (such as internal audits). We sometimes work with outside business associates. We may disclose your health information so they can perform the tasks that we hire them to do. They must promise to respect the confidentiality of your personal and identifiable health information. We are required by law to provide information in cases of review by the Secretary of Health and Human Services in determining our compliance with privacy laws or when served a subpoena, court order or warrant. We also may disclose information in cases of public health issues, child or other abuse cases, or if necessary to prevent a serious health and safety threat to yourself or others. Your information may be released to workers' compensation or similar programs, which provide benefits for work related injuries or illnesses without regard to fault. If you are an inmate, we may release protected information to the correctional institution if it is deemed necessary for your treatment or the health and safety to yourself or others. Your personal information may be used by the office to contact you regarding upcoming or missed appointments, give updates on insurance issues, test results and treatment options. We may disclose information to the individuals involved in your care including your spouse, your doctors or an aide who may be providing services to you. In case of an emergency situation, we may make disclosures without your agreement. If you sign an authorization to disclose information to another individual or company, you may revoke it in writing and stop any future uses and disclosures.

INDIVIDUAL RIGHTS You have the right to ask for restrictions on the way we use and disclose your health information for treatment, payment and health care operation purposes. You may also request that we limit our disclosures to persons assisting in your care or payment for your care. We will consider your request, but are not required to accept it. You have the right to request that you receive communications containing your personal information by alternative means or locations (such as only by mail or only at home). Such requests must be made in writing. If you believe information in your record is incorrect or incomplete, you have the right to ask us to correct or amend the information. Under certain circumstances, we may deny your request, such as when the information is accurate and correct. Except under certain circumstances, you have the right to inspect and obtain copies of your medical records and billing information. You may be charged a fee for copying and mailing. You have the right to receive a list of certain instances when we have used or disclosed your medical information. We are not required to include in the list uses and disclosures for your treatment, payment for services furnished to you, our health care operations, disclosures to you, disclosures you give us authorization to make, and used and disclosed before April 12, 2003, among others. If you ask for this information more than once every 12 months, you may be charged a fee. You have the right to a copy of this notice in paper form at any time. You have the right to be notified if and when a breach has occurred containing your PHI. To exercise any of your rights, please notify us in writing at Retina Specialists of Michigan, 5030 Cascade Road SE, Grand Rapids, MI 49546.

COMPLAINTS If you have any complaints regarding our privacy practices, you may contact our privacy officer at the above address, or the Secretary of the Department of Health and Human Services at 200 Independence Ave. Room 509F, HHH Bldg, Washington DC, 20201. YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.

We reserve the right to make changes to this notice at any time. In the event of a change, the revised notice will be posted. You may also request a copy.