HIPAA- Balancing your healthcare with your privacy.

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 Contact.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain both before and after the change. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. A current copy of this Notice will be available on our website, www.visionassociates.net.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

You will be asked by your physician to sign an acknowledgement of receipt of this Notice of Privacy Practices. We will make a good faith effort to obtain a written acknowledgement that you received this Notice of Privacy Practices for Protected Health Information the first time we provide services to you after April 14, 2003 or as soon as reasonably practicable under the circumstances. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to obtain payment for your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment. We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party that may need access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment. Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations. We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or

disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures that may be made without Your Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you

identify, your protected health information 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. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies. We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your acknowledgement of our Privacy Practices as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your acknowledgement, but is unable, he or she may still use or disclose your protected health information for treatment, payment, and health care operations.

Communication Barriers. We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain an acknowledgement of our Privacy Practices from you, but is unable to do so due to substantial communication barriers.

Other Permitted and Required Uses and Disclosures that may be made without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your acknowledgement or authorization. These situations include:
* Required by Law * Legal Proceedings * Military Activity and
* Public Health * Law Enforcement National Security
* Communicable Diseases * Coroners, Funeral * Workers'
* Health Oversight Directors and Organ Compensation
* Abuse or Neglect Donation * Inmates
* Food and Drug * Research * Required Uses and
Administration * Criminal Activity Disclosures

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however; you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by submitting a written request to our Privacy Contact.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations and valid authorizations or incidental disclosures as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact at 419-578-2020 for further information about the complaint process.

This notice was published and becomes effective on April 14, 2003.

I have received the Practice’s Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Patient Name:

Patient Signature: Date:

I, , hereby authorize Alliance Retina, LLC to (check the following that apply):

0 use the following protected health information, and/or
0 disclose the following health information to:

(Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors, such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

This protected health information is being used or disclosed for the following purposes:

(List specific purposes above.)

This authorization shall be in force and effect until
(SPECIFY DATE OR EVENT THAT RELATES TO THE PATIENT OR THE PURPOSE OF THE USE OR DISCLOSURE) at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Mr. David J. Sobczak at Vision Associates, Inc. I understand that a revocation is not effective to the extent that Vision Associates, Inc has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Vision Associates, Inc will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:
· Inspect or copy the protected health information to be used or disclosed as

permitted under federal law (or state law to the extent the state law provides greater access rights).
· Refuse to sign this authorization.
· Receive a signed copy of this authorization.

Signature of Patient or Personal Representative Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

I, , hereby authorize Alliance Retina, Inc to:

0 Use the following protected health information, and/or
0 Disclose the following information to REQUESTING ENTITY:

(Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors, such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

This protected health information is being used or disclosed for the following purposes:

(List specific purposes above.)

In addition, this protected health information may be used to carry out treatment, payment and health care operations of Alliance Retina, LLC in the following manner:

(Describe how the protected health information will be used to carry out treatment, payment and health care operation purposes.)

We will not make the following disclosures that may be permitted under federal law:

This authorization shall be in force and effect until
(SPECIFY DATE OR EVENT THAT RELATES TO THE PATIENT OR THE PURPOSE OF THE USE OR DISCLOSURE) at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Cathy Clark, our Administrator at Alliance Retina, LLC. I understand that a revocation is not effective to the extent that Alliance Retina, Inc has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Alliance Retina, LLC will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:
· Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
· Refuse to sign this authorization.
· Receive a signed copy of this authorization.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to Alliance Retina, LLC from a third party, if applicable.

Signature of Patient or Personal Representative Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

DATE

VENDOR
OFFICE ADDRESS

Dear VENDOR:

In an effort to comply with the business associate contract requirements of the Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we have enclosed a supplement to our agreement as outlined by the Department of Health and Human Services in the Final HIPAA privacy standards dated August 14, 2002. This supplement serves and an addendum to agreements currently in place or any agreements that may be signed in the future.

During the terms of our agreements, VENDOR may receive from Alliance Retina, LLC or may create on behalf of the Practice, certain confidential health information (PHI) that is protected under state or federal law including the Health Insurance Portability and Accountability Act of 1996. Through this addendum, VENDOR represents that you have policies and procedures in place that will adequately safeguard any PHI you receive or create, consistent with applicable laws and regulations, specifically HIPAA.

If you have any questions, please feel free to contact us at 419-873-6800.

Sincerely,

Alliance Retina, LLC

a) VENDOR agrees to not use or disclose Protected Health Information (PHI) other than as permitted or required under our Agreement(s) or as required by Law.
b) VENDOR agrees to use appropriate safeguards to prevent use or disclosure of PHI other than provided for by our Agreement(s).
c) VENDOR agrees to mitigate, to the extent practicable, any harmful effect that is known by VENDOR of a use of disclosure of PHI by us in violation of

the requirements of our Agreement(s).
d) VENDOR agrees to report to the Practice any use or disclosure of the PHI not provided for by our Agreement(s).
e) VENDOR agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by VENDOR on behalf of the Practice, agrees to the same restrictions and conditions that apply through our Agreement(s) to VENDOR with respect to such information.
f) VENDOR agrees to provide access, at the request of the Practice, and in the time and manner designated by the Practice, to PHI in a Designated Record Set, to the Practice.
g) VENDOR agrees to make any amendment(s) to PHI in a Designated Record Set that the Practice directs or agrees to at the request of the Practice or an Individual, and in the time and manner designated by the Practice.
h) VENDOR agrees to make internal practices, books and records relating to the use and disclosure or PHI received from, or created or received by VENDOR on behalf of, the Practice available to the Practice, or at the request of the Practice to the Department of Health and Human Service's Secretary, in a time and manner designated by the Practice or the Secretary, for purposes of the Secretary determining the Practice's compliance with the Privacy Rule.
i) VENDOR agrees to document such disclosures of PHI and information related to such disclosures as would be required by the Practice to respond to a request by an Individual for an accounting of disclosures of PHI.
j) VENDOR agrees to provide to the Practice, in time and manner designated by the Practice, information collected to permit the Practice to respond to a request by an Individual for an accounting of disclosures for PHI.
k) To the extent possible, upon termination of this agreement, VENDOR shall return or destroy all PHI received from the Practice, or created or received by VENDOR on behalf of the Practice. This provision shall apply to PHI that is in the possession of subcontractors or agents of VENDOR.

However, VENDOR may determine that returning or destroying the PHI is infeasible due to professional requirements. Therefore, VENDOR extends the protections of our Agreement(s) to such PHI and limits further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as VENDOR maintains such PHI.

Permitted Uses and Disclosures by VENDOR:
a) Except as otherwise limited in this Agreement, VENDOR may use PHI for the proper management and administration of VENDOR or to carry out the legal responsibilities of VENDOR.

b) Except as otherwise limited in our Agreement(s), VENDOR may use or disclose PHI to perform functions, activities, or services for, or on behalf of, the Covered Entity as specified in our Agreement(s) provided that such use or disclosure would not violate the Privacy Rule if done by the Practice.
c) Except as otherwise limited in our Agreement(s), VENDOR may disclose PHI for the proper management and administration of VENDOR, provided that disclosures are required by law, or VENDOR obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies VENDOR of any instances which it is aware in which the confidentiality of the information has been breached.

BY: DATE: