SUMMARY NOTICE OF PRIVACY PRACTICES

THIS IS A SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains Patient rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. You may obtain a copy by asking the front desk or Privacy Officer. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

Our pledge to protect your privacy:

Skyline Vision Clinic and Laser Center is committed to protecting the privacy of your medical information. Your care and treatment is recorded in a medical record. So that we can best meet your medical needs, we share your medical record with the providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

Patient Rights - You have the following rights regarding your medical information:

- to request to inspect and obtain a copy of your medical records, subject to certain limited exceptions;
- to request to add an addendum to or correct your medical record;
- to request an accounting of Skyline Vision Clinic and Laser Center disclosures of your medical information;
- to request restrictions on certain uses or disclosures of your medical information; to request that we communicate with you in a certain way or at a certain location; and to receive a copy of the full version of our Notice of Privacy Practices.

We may use and disclose medical information about you for the following purposes:

- to provide you with medical treatment and services;
- to bill and receive payment for the treatment and services you receive;
- for functions necessary to run Skyline Vision Clinic and Laser Center and assure that our Patients receive quality care;
- to provide basic contact information (no medical information is provided) to our development office for purposes of fundraising for Skyline Vision Clinic and Laser Center; to support our standing as a federally qualified health center; and as required or permitted by law.

SKYLINE VISION
clinic & laser center

ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY NOTICE OF PRIVACY PRACTICES

Revised May 17, 2018

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Skyline Vision Clinic and Laser Center provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____ _____

Name of Patient (print) Signature of Patient Date

_____ _____ _____

Signature of Patient Representative Relationship to Patient Date

(Required if Patient is a minor or an adult who is unable to sign this form)

I understand that my health care and the payment for my health care will not be affected if I do not sign this form _____ initials

Communication Preferences:

Home phone number: _____ Mobile phone number: _____

In caring for our patients, it may be necessary for Skyline Vision Clinic and Laser Center staff to contact you by phone. When we are not able to speak to you directly, we like to leave messages when possible. In order to protect your privacy, it is Skyline Vision Clinic and Laser Center's policy to not leave messages with anyone except the patient or legal guardian, nor leave specific information on an answering machine/voicemail system unless we have your written permission to do so.

☐ Yes, I want you to leave a voice mail. (Please circle) Home Mobile
☐ No, I do not want you to leave a voice mail.

Skyline Vision Clinic and Laser Center may disclose your medical information such as exams, labs/radiology results, appointments and your insurance or billing information to the following people:

_____ _____

Name Relationship Phone Number Name Relationship Phone Number

_____ _____

Name Relationship Phone Number Name Relationship Phone Number

☐ No, I do not want you to discuss my medical care with anyone other than me.
☐ I request removal from lists that initiate promotional or marketing communications Yes: _____ initials