EYECARE CENTER OF KEN CARYL

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 a 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 Compliance Officer who is the Privacy Officer for Eyecare Center of Ken Caryl. They can be reached by phone at 303-973-6333. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

Our pledge to protect your privacy:

The Eyecare Center of Ken Caryl 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 Eyecare Center of Ken Caryl 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 Eyecare Center of Ken Caryl 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 the Eyecare Center of Ken Caryl; to support our standing as a federally qualified health center; and as required or permitted by law.

ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY NOTICE OF PRIVACY PRACTICES

March 8, 2024

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. The Eyecare Center of Ken Caryl 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_____(initial)

COMMUNICATION PREFERENCES:

From time to time Eyecare Center of Ken Caryl may wish to use or disclose your protected health information to individuals involved in your care for notification purposes after we have obtained your verbal or written permission.

The Eyecare Center of Ken Caryl is authorized to: (Please check all that apply.)

□ Notify or speak with my spouse or my family members, i.e., children, siblings, mother, father regarding treatment or proposed treatment
Family Member:_____ Phone Number: _____

□ Notify or speak to my caregiver regarding treatment or proposed treatment
Caregiver Name: _____ Phone Number: _____

□ Notify or speak to my friend regarding treatment or proposed treatment
Friend Name: _____ Phone Number:_____

□ Notify my transportation service regarding my delivery or pick-up to or upon completion of my treatment
Transport Service: _____ Phone Number: _____

□ Other (please specify Name, Relation, and Phone Number)
_____

How may we contact you with reference to your appointment, proposed treatment, follow-up appointments, lab testing, radiology and other situations regarding your protected health information?

If I am not available Eyecare Center of Ken Caryl may: (please check all that apply)

□ Leave a message with my spouse or those members listed above
□ Leave a message on my answering machine, voice mail or cell phone
□ Leave a message with my interpreter (for foreign speaking patients)
Other_____