ASHLAND EYECARE

James R. Patterson, O.D.
Daniel P. Denbow, O.D.
Brianna N. Buckley, O.D.
2212 Mifflin Avenue
Suite 110
Ashland, OH 44805
419-289-0808
419-281-1200 (fax)

PRIVACY NOTICE

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.

Note: This Notice of Privacy Practices is provided for educational and informational purposes only. This Notice is not intended as legal advice, and is not provided for adoption or publication by any party. The publication of any such notice may create legal obligations or liabilities, which may vary depending upon the legal status and business operations of different organizations. The form and consent of any Notice of Privacy Practices should be determined only upon informed consultation with qualified legal counsel.

Right to Notice: As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA), Ashland Eyecare, Inc. can use your protected health information for treatment, payment and health care operations. a) Treatment - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. b) Payment - We may use and disclose your health information to obtain payment for services we provide you. c) Health Care Operations - We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: Most uses and disclosures that do not fall under treatment, payment or health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations: In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

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ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Ashland Eyecare's Privacy Notice.

Patient Name _____

Signature _____ Date _____