Schwartz Laser Eye Center, PLLC.
Notice of Patients Privacy Practices

This notice describes how Schwartz Laser Eye Center, PLLC may use or disclose your protected health information ("PHI"). It also describes our legal obligations to you and your rights to access your PHI. PHI is individually identifiable health information, including actual medical information, your name, address, phone number, identification number, insurance information or other identifiers. Please review this notice carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates that patients be provided with advance written notice of the practice's policies regarding the use and/or disclosure of protected health information, whether communicated electronically, on paper or in oral conversations. This notice takes effect on **April 14, 2003**.

Schwartz Laser Eye Center, PLLC reserves the right to decline a patient who elects not to sign this notice and reserves the right to change and to make any new provisions effective under HIPAA Privacy Regulations. This notice explains the rights of the patient and policies followed and implemented by the Schwartz Laser Eye Center, PLLC in accordance with HIPAA and other governing organizations for all non-exempt uses of medical records with no expiration. A patient's health care information may be used and/or disclosed for treatment, payment, administrative or healthcare operation activities.

Treatment – We may use PHI to provide you with medical treatment or services. This includes communications between other healthcare professionals, hospitals and other healthcare facilities, and other providers for administering treatment.

Payment – We may use and/or disclose your PHI so the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. This includes typical payment activities, such as verification of coverage, pre-certifications, referrals and claims processing. Please see your plan documents for a full explanation of your insurance benefits.

Administrative or Healthcare Operation Activities – We may use and/or disclose medical information about you for certain administrative, healthcare and management activities, such as compliance monitoring, quality improvement and business planning. These uses and/or disclosures are necessary to run the practice and to ensure that our patients receive quality care and services. We contract with individuals and entities (business associates) to perform various functions on our behalf which involve the use and/or disclosure of your PHI. These business associates must agree in writing to appropriately protect your PHI.

The patient reserves the right to request restrictions on the policies listed in this notice, receive a copy of all information used and/or disclosed, access, inspect and amend his or her own records, with limited exceptions, by submitting a written request to the Schwartz Laser Eye Center, PLLC. We may deny your request to inspect and copy your PHI as set forth in the HIPAA Privacy Regulations. Written requests for the patients own PHI will only be honored with a photo proof of identification from the patient. There will be a fee of .60 per page copied, mailed or faxed.

Schwartz Laser Eye Center, PLLC reserves the right to contact patients for appointment reminders or to transmit relevant information about other health or administrative services that may be necessary. This may require us to leave a message, which other individuals may have access to. By signing this release you also authorize the Schwartz Laser Eye Center, PLLC to mail to you appointment reminders, information about newly released technology, products or services, promotional and other marketing offers.

All written requests or complaints may be submitted to the Privacy Officer of the Schwartz Laser Eye Center, PLLC and/or with the Secretary of Health and Human Services if you believe your privacy rights with respect to our protection of your PHI has been violated. Call 480-483-3937 or mail to 8416 E. Shea Blvd. Suite C101, Scottsdale, AZ. 85260. Please include all names, dates, relative and detailed information in the complaint. You will not be penalized for filing a complaint.

If you receive this form electronically you have the right to obtain a paper copy, only upon your written request.

I hereby agree and understand the information in this notice and understand that I have the right to revoke this consent in writing at any time and all future use or disclosures will cease, with limited exceptions and only in accordance with HIPAA Privacy Regulations.

Print Patient Name (first) _____ (mi) _____ (last) _____

Patient Signature _____ Date _____