NOTICE OF PRIVACY PRACTICES

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FLORIDA EYE HEALTH • SUNCOAST SURGERY CENTER, L.L.C.

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.

Our practice is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Our practice is required by law to abide by the terms of this Notice.

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.

Our office is 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 at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. To request a revised notice you may call the office and request that a revised copy be sent to you in the mail, ask for one at the time of your next appointment, or print one from our website www.bettervision.net.

HOW YOUR MEDICAL INFORMATION WILL BE USED/DISCLOSED:

Treatment: We will use your information to provide, coordinate, and manage your care and treatment. For example, a clinic physician may share your medical information with another physician for a consultation.

Payment: We will use your information to receive payment for the services we provide. For example, we will disclose information in order to submit bills and claims to insurance companies and /or Medicare or Medicaid.

Health Care Operations: We will use your information for certain activities related to the functioning of our clinic. For example, we may use or disclose information for quality assurance activities, legal services, underwriting, and other business management and administrative activities

Appointment Reminders and Other Health Information: We may contact you to provide appointment reminders, treatment information or any other details related to your visit. This contact may be by telephone, mail, email or otherwise which could (potentially) be received or intercepted by others.

OUR CLINIC MAY ALSO USE OR DISCLOSE YOUR HEALTH INFORMATION FOR THE FOLLOWING PURPOSES:

1. If you are not available to provide your authorization, we may disclose to a family member, a close personal friend, or any other person you have identified who is responsible for your care, medical information that is directly relevant to your care or to help pay your medical bills, and/or medical information pertaining to your location or general medical condition; provided that we believe it is in your best interest to so disclose such medical information. For example, we may provide limited medical information to a family member or friend to pick up a prescription, explain medications, or help with pre-operative or post-operative instructions.
2. Under emergency conditions, or to government or other groups that assist in emergencies or disasters.
3. By law, our clinic may disclose or use your information without your consent in the following cases: when required by law; for public health activities; relating to victims of abuse/neglect/domestic violence, if required/authorized by law and /or if you agree; for health oversight activities; for judicial and administrative proceedings to the extent permitted by law; for law enforcement purposes, as permitted or required by law; to coroners/medical examiners/funeral directors, as permitted by law; for organ donation purposes; for research purposes under certain circumstances; to avert a serious threat to health or safety; for certain specialized government functions, such as military discharge, and national security and intelligence; and for workers' compensation purposes.

AUTHORIZATIONS:

We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. You may contact:

Attention: Privacy Officer
Jonathan M. Frantz, M.D., P.A.,
12731 New Brittany Blvd., Fort Myers, FL 33907
Telephone: 239-418-0999 Fax: 239-418-0091 Website: www.bettervision.net

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

You have the following rights with respect to your medical information:

- You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
- You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
- You have the right to receive an accounting of the disclosures of your medical information made by our practice during the last six years, except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.
- You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.
- You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, or if you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact the Privacy Officer at the address listed above.

THIS NOTICE IS EFFECTIVE AS OF MAY 1, 2011.

REVISION OF NOTICE OF PRIVACY PRACTICES

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at our office and will make paper copies of the revised Notice of Privacy Practices available upon request.

Acknowledgement of Receipt: I hereby acknowledge that I have received and had an opportunity to ask questions concerning this Notice of Privacy Practices.

_____ _____
Patient or Patient's Representative Signature Date

PRINT Patient Name _____

If signed by Representative, please state:

Name of Representative: _____

Relationship to Patient: _____

AUTHORIZATION FOR USE OR DISCLOSURE

In the event you are unavailable at a future date to provide a release of your medical information, you may now identify below a family member or other person to receive medical information from us that is directly relevant to: (a) your medical care, or (b) your location or general medical condition, if we believe it is in your best interests to release such medical information to the person you identify below.

Name:_____ Relationship: _____

Address:_____

City:_____ State:_____ Zip:_____

Phone: _____