

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full length Notice is available upon request.

Date of Last Revision 01-30-2008

Effective Date: Immediately

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.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As your patient, we are required to make sure that your protected health information is kept private. How will we use or disclose your information? Here are a few examples (for more details please refer to the Notice of privacy Practices that follow this summary):

- For medical treatment
- For research
- To obtain payment for our services
- To avert a serious threat to health or safety
- In emergency situations
- For organ and donor situation
- For appointment and patient recall reminders
- For worker's compensation programs
- To run our Practice more efficiently and to ensure that our patients receive quality care
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint. You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to request restrictions
- The right to amend
- The right to a paper copy of this notice
- The right to an accounting of disclosures
- The right to request confidential communications

For information about these rights please see the detailed Notice of Privacy practices

592 Springfield Avenue, Westfield, N.J. 07090 (908)789-8999 · Fax (908)789-1379

10 Mountain Boulevard, Warren, N.J. 07059 (908) 754-4800 · Fax (908)754-4803

517 Route 1 South, Iselin N.J. 08830 (732) 636-7355 · Fax (732)636-7497

Website www.newjerseyvision.com

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. This Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our Office.

You have the right to request that we restrict how protected health information about you is disclosed for treatment, payment of health care operations. We are not required to agree to this restriction, but if we do so, we shall honor that agreement.

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 this 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 Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (**HIPPA**).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of privacy Policies
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke the Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This consent was signed by: _____
Signature – Patient or Representative

Print Name **Date: mo/day/year**

Relationship to patient (if other than patient): _____

In front of: _____
Printed name – Practice Representative

The Eye Care and Surgery Center

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

The practice will disclose information about patient status to persons other than the patient only in limited circumstances. The practice understands that patients often wish for family members or representatives to be able to learn information about the patient's status. As a result, the practice will disclose information about patient status to family members and others as authorized by you only in limited situation where the patient agrees, or if the patient is unable to agree, where the disclosure is determined to be in the best interest of the patient. As a general principle, if the patient is competent, the Practice will not disclose information regarding such patient unless the patient has expressly agreed to such disclosure.

Please list below the relatives or spouse that may receive information regarding your health status. This authorization may be revoked by you (the patient) at anytime.

Name	Relationship
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Name	Relationship
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Name	Relationship
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Name	Relationship
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Name	Relationship
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Name	Relationship
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Signature of Patient	Date
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In front of:	Printed name-Practice Representative
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