315 Hospital Drive, Barbourville, KY 40906 | Phone: (606) 546-4166 | Fax: (606) 546-4167
Email: bfvision@accesshealthky.com | accesshealthky.com

NOTICE OF PRIVACY PRACTICES — ACKNOWLEDGMENT

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 COMMITMENT TO YOUR PRIVACY

Access Health Vision is dedicated to maintaining the privacy of your protected health information (PHI). We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices. This Notice of Privacy Practices describes how we may use and disclose your PHI to carry out treatment, payment, or health care operations, and for other purposes permitted or required by law.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your PHI may be used and disclosed by Access Health Vision, our staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of our practice.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. For example, we may share your PHI with a specialist, laboratory, or other health care provider who is involved in your care.

Payment: Your PHI will be used, as needed, to obtain payment for the health care services we provide. This may include activities such as billing, claims management, and collection activities. For example, we may send a bill for your visit to your insurance company, which would contain your diagnosis and procedure codes.

Health Care Operations: We may use or disclose your PHI for our own health care operations, including quality assessment, employee review activities, licensing, training, accreditation, and other business-related activities.

OTHER PERMITTED USES AND DISCLOSURES

We may use or disclose your PHI in the following situations without your authorization:

- **As Required by Law:** We may disclose PHI when required to do so by federal, state, or local law.
- **Public Health:** As required by law, we may disclose PHI to public health authorities for purposes related to preventing or controlling disease, injury, or disability.
- **Law Enforcement:** We may disclose PHI for law enforcement purposes as required by law or in response to a valid subpoena or court order.
- **Judicial and Administrative Proceedings:** We may disclose PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- **Health Oversight:** We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure.
- **Abuse or Neglect:** We may disclose PHI to appropriate authorities if we reasonably believe a patient is a victim of abuse, neglect, or domestic violence.
- **Emergencies:** We may use and disclose PHI when necessary to prevent a serious and imminent threat to your health and safety or the health and safety of the public or another person.
- **Workers' Compensation:** We may disclose PHI as authorized by and to comply with laws relating to workers' compensation or other similar programs.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you:

- **Right to Inspect and Copy:** You have the right to inspect and copy your PHI that we maintain. You must submit your request in writing.
- **Right to Amend:** You may ask us to amend your health information if you believe the information is incorrect or incomplete. Requests must be made in writing.
- **Right to an Accounting of Disclosures:** You may request a list of instances in which we disclosed your PHI for purposes other than treatment, payment, or health care operations.
- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the PHI we use or disclose about you.
- **Right to Request Confidential Communications:** You may request that we communicate with you about health matters in a certain way or at a certain location.
- **Right to a Paper Copy:** You have the right to a paper copy of this Notice at any time, even if you have agreed to receive the notice electronically.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint. To file a complaint, contact our Privacy Officer at (606) 546-4166 or write to us at 315 Hospital Drive, Barbourville, KY 40906.

ACKNOWLEDGMENT OF RECEIPT

By signing below, I acknowledge that I have received and/or been given the opportunity to review Access Health Vision's Notice of Privacy Practices. I understand that this Notice describes the ways in which my protected health information may be used and disclosed. I understand that I may contact Access Health Vision if I have questions about its privacy practices.

☐ I acknowledge receipt of the Notice of Privacy Practices

☐ I declined to sign this acknowledgment

PATIENT NAME (PRINTED)

DATE OF BIRTH

PATIENT / GUARDIAN SIGNATURE

DATE

RELATIONSHIP TO PATIENT (IF SIGNED BY REPRESENTATIVE)

Do we have your permission to:

☐ Leave a message on your answering machine/voicemail? Yes / No

☐ Confirm appointments by leaving messages or speaking with family? Yes / No

☐ Speak to household members concerning your care? Yes /

IF YES, LIST NAMES OF THOSE WE MAY SPEAK WITH REGARDING YOUR CARE