



---

200 Canal View Blvd., Suite 102, Rochester, NY 14623-2809  
Phone: 585.461.5330 ~ Fax: 585.461.9895

## NOTICE OF PRIVACY PRACTICES

### THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Federal law provides that we may use your protected health information for your treatment without further specific notice to you or written authorization by you (e.g., if we refer you to a neurosurgeon, we may provide them with your laboratory or test data).

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you or written authorization by you (e.g., if you need a visual field test, we are required to provide to your health care plan a diagnosis code for your visit and a description of the services rendered).

Federal law provides that we may use your medical information for necessary business operations without further notice to you or written authorization by you (e.g., our accountant may see your name, dates of treatment and procedure codes during an audit of our books).

We may use or disclose your medical information, without further notice to you or authorization by you, where required by law:

- for public health purposes;
- to report child abuse, domestic violence and neglect;
- to an authorized health agency such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct;
- in judicial or administrative proceedings;
- by a law enforcement official;
- by a coroner or medical examiner;
- to a funeral director;
- for organ donation purposes;
- to avert a serious threat to health or safety;
- to military authorities (if you are a member of the armed forces)

**New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.**

We may contact you by mail or phone at your residence to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave

a message for you on any answering device or with any person who answers the phone. You may request alternative methods of communication to ensure confidentiality.

Other uses or disclosures of your medical information will be made only with your written authorization. You may revoke that authorization at any time.

You have the right to request restrictions on certain uses and disclosures as described above. We are not required to agree to such restrictions.

**Neuro-Ophthalmology Consultants of Rochester  
200 Canal View Blvd., Suite 102  
Rochester, NY 14623-2895  
Telephone: (585) 461-5330 Fax: (585) 461-9895**

**NOTICE OF PRIVACY PRACTICES -- 2**

**Your Rights**

You have the right to inspect and obtain copies of your medical information. (A fee of \$0.75/page up to a maximum fee of \$20 will be charged. The following charges also apply: OCT reprints are \$1/page; FP reprints are \$2/page and referrals sent FedEx are \$30.)

You have the right to request amendments to your medical information. Requests must be in writing and include the reason for the amendment.

You have the right to request an accounting of any disclosures we make of your medical information, except for: those made to you; to carry out treatment; for payment or health care operations; as requested by your written authorization; as permitted or required under 45CFR§ 164.502; for emergency or notification purposes; for national security or intelligence purposes; to correctional facilities or law enforcement officials; for research or public health purposes after being identified or limited to remove personally identifiable information.

You have the right to file a grievance with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. No retaliatory action will be taken against you.

**Our Obligations**

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is in effect.

We may revise this notice and make it effective for all protected health information we maintain. Any revised notice will be posted.

**I have read this notice.**

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Print Name

\_\_\_\_\_

Date of Birth

I require the following restrictions when contacting me (e.g., home/work phone or address):

\_\_\_\_\_

Neuro-Ophthalmology Consultants of Rochester  
200 Canal View Blvd., Suite 102  
Rochester, NY 14623-2895  
Telephone: (585) 461-5330 Fax: (585) 461-9895

Chart ID: \_\_\_\_\_