

**I.U. DEPARTMENT OF OPHTHALMOLOGY/I.U. EYE  
CARE, INC.  
NOTICE OF PRIVACY PRACTICES**

Effective Date: \_\_\_\_\_

**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.**

If you have any questions about this Notice, please contact **I.U. Department of Ophthalmology/Administration, 317-274-2698**, for further information.

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. This Notice also describes your rights to access and control your protected health information, as well as certain obligations we have regarding the use and disclosure of your protected health information. "Protected health information" ("PHI") is medical 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.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. We are also required to abide by the terms of this Notice as currently in effect.

This Notice describes **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.**, practices and that of all services and units of **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.**, as well as all of the physicians, employees, staff and other **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** personnel. All of these covered entities, sites and locations follow the terms of this Notice. In addition, these covered entities, sites and locations may share PHI with each other for treatment, payment or health care operations purposes as described in this Notice. This notice also covers our third party "business associates" who perform various activities for us to provide you treatment or to administer our business. Before we disclose any of your PHI to one of our business associates, we will enter into a written contract with them that contains terms to protect the privacy of your PHI.

**USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:**

This Notice sets forth different reasons for which we may use and disclose your protected health information ("PHI"). The Notice does not list every possible use and disclosure, however, all the reasons for which we are permitted to use and disclose your PHI are listed.

**For Treatment.** We may use your PHI to provide you with medical treatment or services. We will use or disclose your PHI to provide, coordinate and manage your health care. We may disclose your PHI to physicians, nurses, technicians, medical students, or other personnel who are involved in taking care of you. For example, a physician treating you for a knee injury may need to know if you have diabetes because diabetes may affect the rate of your healing process. Your physician may provide your PHI to a referral physician in order for you to receive appropriate health care. Different departments of **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** may share PHI in order to coordinate your needs, such as prescriptions, lab work and x-rays. We may also disclose PHI to people outside of **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** who may be involved in your health care, such as others who provide you with health care services or your family members.

**For Payment.** We may use and disclose your PHI so that the treatment and services you receive at **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** may be billed to, and payment may be collected from, you, an insurance company, or a third party. For example, we may need to get a pre-authorization from your health plan to determine if the plan covers the treatment you are seeking. We may also need to disclose PHI to your health plan in order to get paid for services we have provided to you.

**For Health Care Operations.** We may use and disclose your PHI for purposes of health care operations. These uses and disclosures are necessary to manage **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** and to make sure that all of the patients receive quality health care. For example, we may use your PHI, as needed, to evaluate the quality of health care you are receiving. Your PHI may also be used to evaluate the service our staff has provided to you. In evaluating the services we provide to our patients, we may combine your PHI with others to get a practical idea of services we may need to offer, tailor, or eliminate. We may also disclose your PHI to staff for learning purposes. For this purpose, we may de-identify your PHI so that those who study the health care process do not know of specific patients.

**Appointment Reminders.** We may use and disclose your PHI in order to contact you and remind you of an upcoming appointment for treatment or health care services.

**Treatment Alternatives.** We may use and disclose your PHI to inform you of or recommend possible treatment alternatives that may be available to you.

**Health-Related Benefits and Services.** We may use and disclose your PHI to inform you of health-related benefits or services that may be available to you.

**Fundraising.** We may use your PHI to contact you in an effort to raise money for the **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** and its operations. We may disclose your PHI to an organization related to

**Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** so that the organization may contact you in raising money for **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** We would only disclose contact information, such as your name, address and phone number and the dates you received treatment or services from **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** If you do not want **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** to contact you for fundraising efforts, you must notify: **I.U. Department of Ophthalmology/Administration, 702 Rotary Circle, #337, Indianapolis, Indiana 46202-5175 with a copy indicated directly to your Ophthalmologist by name to the same address in writing.**

**Facility Directories.** We may disclose, unless you object to such disclosure, your name, location in the facility, your general condition (*e.g.*, fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, will be disclosed to people, such as family and friends, who ask for you by name. Your religious affiliation will be given to members of the clergy, such as priests or rabbis. **[This purpose for the use and disclosure of PHI is applicable to covered health care providers that operate facilities.]**

**Emergencies.** We may use or disclose some or all of your PHI in an emergency treatment situation. As soon as practicable, you will be given the opportunity to object. The PHI will be disclosed only if it is thought to be in your best interest.

**Individuals Involved in Your Health Care or Payment for Your Health Care.** We may disclose your PHI to a family member or friend who is involved in your medical treatment or care. We may also disclose this information to a person who is involved in the financing of your health care. We may inform your family or friends as to your condition, location, or death. If you are present, you will be given the opportunity to object to all of these disclosures. However, if you are not present, only a disclosure that is in your best interest and directly relevant to the inquiring person's involvement in your health care will be made. In addition, we may disclose PHI to a public or private entity assisting in a disaster relief effort so that your family can be notified as to your condition, location, or death, or so that care or rescue efforts can be coordinated.

**As Required By Law.** We will use and disclose your PHI when required to do so by federal, state, or local law, to the extent that such use and disclosure is limited to the relevant requirements of such law.

**Public Health Activities.** We may disclose your PHI for purposes of public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;

- to report the conduct of public health surveillance, investigations, and interventions;
- to report child abuse or neglect;
- to report adverse events relating to product defects, problems, or biological deviations;
- to track FDA-regulated products;
- to notify people and enable product recalls, repairs, replacement, or lookback;
- to conduct post marketing surveillance;
- to notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition;
- to conduct an evaluation relating to the medical surveillance of the workplace; and
- to evaluate whether an individual has a work-related illness or injury.

**Abuse, Neglect, or Domestic Violence.** We may notify the appropriate government authority if we reasonably believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities.** We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, by way of example, audits; civil, administrative or criminal investigations and proceedings; inspections; and licensure and disciplinary actions. These activities are necessary for the government to monitor the health care system, government benefit programs, compliance with program standards, and compliance with civil rights laws.

**Judicial and Administrative Proceedings.** If you are involved in a legal proceeding, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by another person involved in the dispute, but only if we believe that the party seeking the PHI has made reasonable efforts to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may disclose your PHI, within limitations, if asked to do so by a law enforcement official for a law enforcement purpose, if it is:

- in response to a court order, subpoena, warrant, summons or similar process, or required by law;

- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if the individual agrees to the disclosure, or due to incapacity or emergency, we are unable to obtain the individual's agreement;
- about a death we suspect may have resulted from criminal conduct;
- about criminal conduct we believe in good faith to have occurred on our premises; and
- in an emergency situation, in order to report the commission and nature of a crime; the location of the crime or its victims; or the identity, description or location of the individual who committed the crime.

**Coroners, Medical Examiners and Funeral Directors.** We may disclose your PHI to a coroner or medical examiner. This disclosure may be necessary in order to identify a deceased person or determine the cause of death. We may also disclose your PHI, as necessary, in order for the funeral directors to carry out their duties.

**Organ, Eye and Tissue Donation.** If you are an organ donor, we may disclose your PHI to an organ procurement organization or other entity involved in the procurement, banking, or transplantation of organs, eyes, or tissue for the purpose of facilitating the donation and transplantation process.

**Research.** We may use and disclose your PHI for certain limited research purposes. All research projects, however, are subject to a special approval process. The research project must be approved by an Institutional Review Board. This Board reviews the research proposal and ensures that the PHI for which access is desired is necessary for research purposes.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose your PHI when we believe in good faith, it is necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public. Any disclosure, however, would only be to a person able to help prevent the threat.

**Military and Veterans.** We may disclose the PHI of individuals who are members of the Armed Forces, as required by appropriate military command authorities. PHI may be disclosed for purposes of determining an individual's eligibility for or entitlement to benefits under appropriate military laws. We may also disclose the PHI of foreign military personnel to the appropriate foreign military authority.

**National Security and Intelligence Activities.** We may disclose your PHI to authorized federal officials for lawful intelligence, counterintelligence, and other national security activities as authorized by law.

**Protective Services for the President and Others.** We may disclose your PHI to authorized federal officials, so they may adequately provide protection to the President, other authorized persons, or foreign heads of state. PHI may also be disclosed to conduct special investigations.

**Medical Suitability.** We may use your PHI to make medical suitability determinations. We may then disclose our findings to Department officials who need access to such information. **[This purpose for the use and disclosure of PHI is applicable to a Covered Health Care Provider that is a component of the United States Department of State.]**

**Inmates.** We may disclose your PHI, as long as you are an inmate of a correctional institution or under the custody of a law enforcement official, to the correctional institution or law enforcement official. The disclosure must be necessary: (1) for the institution or law enforcement official to provide you with health care; (2) to protect your health and safety or the health and safety of others in and employed by or in connection with the correctional institution; and (3) for the safety and security of the correctional institution.

**Government Programs Providing Public Benefits.** We may disclose your PHI to other government agencies that provide public benefits, if the programs serve the same or similar populations and the disclosure of PHI is necessary to coordinate the functions of such programs or to improve administration and management of such programs. **[This purpose for the use and disclosure of PHI is applicable to a Covered Health Care Provider that is a government agency.]**

**Workers' Compensation.** We may disclose your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Other Uses and Disclosures Of Your Protected Health Information.** Other uses and disclosures of your protected health information not covered by this Notice or the laws that apply to us, will be made only with your written authorization. If you have given us your authorization, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose the PHI for the reasons covered by your written authorization, except to the extent that we have taken action in reliance on your authorization. Please note that we are unable to withdraw any disclosures we have already made with your written authorization, and that we are required by law to maintain our records as to the health care that we have provided to you.

## **YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION**

You have the following rights regarding your protected health information ("PHI") which we maintain, as required by law:

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for purposes of treatment, payment, or health care operations. You also have the right to request that we restrict the disclosure of your PHI from those involved in your health care or the payment for your health care, such as a family member or friend. For example, you may request that we not use or disclose your PHI relating to a procedure you may have had.

*We are not required to agree with your request for restrictions.* However, if we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions, you must make your request in writing by filling out the appropriate form provided by **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** and submitting it to **[I.U. Department of Ophthalmology/Administration, 702 Rotary Circle, #337, Indianapolis, Indiana 46202-5175 with a copy indicated directly to your Ophthalmologist by name to the same address]**. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse or children.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about your personal health matters in a particular way or at a particular location. For example, you can request that we only contact you at work or at a friend's house.

To request confidential communications, you must make your request in writing by filling out the appropriate form provided by **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** and submitting it to **[insert name, title, and telephone number of a person or office to contact]**. We will not ask you the reason for your request. We will accommodate all reasonable requests. However, we may condition granting your request on receiving appropriate information regarding payment, as well as, you specifying how or where you would like us to contact you.

**Right to Inspect and Copy.** You have the right to inspect and copy your PHI that is kept in a designated record set. This may include medical and billing records, but does not include: (1) psychotherapy notes; (2) information compiled in anticipation of or for use in legal actions or proceedings; or (3) protected health information that is maintained by the **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** to which access is prohibited by law.

To inspect and copy your PHI, you must make your request in writing by filling out the appropriate form provided by **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** and submitting it to **[I.U. Department of Ophthalmology/Administration, 702 Rotary Circle, #337, Indianapolis,**

**Indiana 46202-5175 with a copy indicated directly to your Ophthalmologist by name to the same address**]. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or preparing the requested documents.

We may deny your request to inspect and copy in certain very limited circumstances:

- the PHI you are requesting to inspect is specifically prohibited by law;
- you are an inmate and providing you with a copy of your PHI could be dangerous to your health, safety, security, custody, or rehabilitation, or that of others;
- the PHI you are requesting may have been created or obtained by a covered health care provider in the course of research;
- denial in accordance with the Privacy Laws; or
- the information you are requesting was confidentially obtained from a source other than a health care provider and if you were granted access you could find out the identity of the source.

If you are denied access to your PHI, for reasons other than those listed above, you may request that the denial be reviewed. A licensed health care professional chosen by **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** will review your request, as well as the basis for the denial. The person conducting the review will not be the person who denied your request the first time. The outcome of the review will be the final decision.

**Right to Amend.** You have the right to request that we amend your PHI if it is incorrect or incomplete. You have the right to request an amendment for as long as the information is kept by or for **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** within a designated record set.

To request an amendment, you must make your request in writing by filling out the appropriate form provided by **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** and submitting it to **I.U. Department of Ophthalmology/Administration, 702 Rotary Circle, #337, Indianapolis, Indiana 46202-5175 with a copy indicated directly to your Ophthalmologist by name to the same address** in writing **insert name, title, and telephone number of a person or office to contact**. You must be prepared to provide a reason to support your request for an amendment.

We may deny your request for an amendment if the request does not include a reason to support the request for an amendment. Furthermore, we may deny your request for an amendment if you request that we amend PHI that:

- was not created by us, unless the person or covered entity that created the PHI is no longer available to make the amendment;
- is not part of the health information kept by or for **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** within the designated record set;
- is not part of the information that you would be permitted to inspect and copy by law; or
- is accurate and complete.

**Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures made by **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** This is a list of the disclosures we have made of your PHI.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** and submitting it to **[I.U. Department of Ophthalmology/Administration, 702 Rotary Circle, #337, Indianapolis, Indiana 46202-5175 with a copy indicated directly to your Ophthalmologist by name to the same address]**. Your request must state a time period **which may not be longer than six years**, but which may be shorter, and may not include dates before **April 14, 2003**. The first accounting you request within a 12 month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

You have a right to receive an accounting of disclosures made by **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.**, within the past six years from the date of your request, except for disclosures that have been made:

- to carry out treatment, payment or health care operations;
- to you;
- incident to a use or disclosure permitted or required by law;
- pursuant to an authorization;
- to facility directories;
- to those involved in your care or for notification purposes;
- for national security or intelligence purposes;

- to correctional institutions or law enforcement of officials;
- as part of a limited data set; and
- prior to **April 14, 2003**.

**Right to a Paper Copy of this Notice.** You have the right to receive a paper copy of this Notice. You may request that we give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to receive a paper copy.

You may obtain a copy of this Notice at our website, [www.iueye.iu.edu](http://www.iueye.iu.edu)

In the alternative, to obtain a paper copy of this Notice, please contact **I.U. Department of Ophthalmology/Administration, 317-274-2698**.

### **CHANGES TO THIS NOTICE**

We reserve the right to change the terms of this Notice. We reserve the right to make the new Notice provisions effective for all protected health information we currently maintain, as well as any information we receive in the future. We will post a copy of the current Notice in the **website, [www.iueye.iu.edu](http://www.iueye.iu.edu)**. Please note, on the first page, in the top right-hand corner of the Notice, you will find the effective date. A Notice with a more recent date supercedes a Notice with an older date.

### **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.** or with the Secretary of the Department of Health and Human Services. You will not be retaliated against or penalized for filing the complaint. To file a complaint with **Indiana University Department of Ophthalmology/I.U. Eye Care, Inc.**, contact: **I.U. Department of Ophthalmology/Administration, 702 Rotary Circle, #337, Indianapolis, Indiana 46202-5175 with a copy indicated directly to your Ophthalmologist by name to the same address** in writing *All complaints must be submitted in writing.*