Notice of Privacy Practices (Updated 10/1/2013)

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. SUNY College of Optometry, including the University Eye Center (UEC), is required by law to protect the privacy of health information that may reveal your identity and to provide you with our notice of our legal duties and privacy practices with respect to your health information. This notice describes the health information privacy practices of SUNY College of Optometry. Workforce members include all employees, optometry or other students, trainees, residents, volunteers and contracted personnel. It is provided to patients on behalf of all SUNY College of Optometry and the UEC employees who are involved in your care and perform payment activities and/or business operations for you within the UEC. This notice also describes how we may use and disclose your health information and your rights to access and control your health information. A copy of our current notice will always be posted in our reception area. You will also be able to obtain a hard copy of this policy at the reception area, on our website site at UniversityEyeCenter.org or by calling us at 212-938-4001. If you have questions about any part of this notice or would like to discuss our privacy practices, please contact us at SUNY College of Optometry, ATTN: Clinical Administration, 33 West 42nd Street, New York, NY 10036 or by calling 212-938-4030.

SUNY College of Optometry and the UEC have the right to use and disclose your health information for treatment, payment or operations once you have signed a consent form as required by New York State law. Once you sign this general written consent form, it will be in effect indefinitely until you revoke your general written consent. You may also initiate the transfer of your records to another person by completing an authorization form. You may revoke your general written consent at any time (in writing), except to the extent that we have already relied on it. For example, if we provide you with treatment before you revoke your general written consent, we may still share your health information with your insurance company in order to obtain payment for that treatment. To revoke your general written consent, please contact us at 33 West 42nd Street, New York, NY 10036 or at (212) 938-4030.

IMPORTANT WORDS USED IN THIS NOTICE

We: Means SUNY College of Optometry including the staff and doctors within the University Eye Center.

You: Means the patient. If you are the parent of a child or legal guardian of a child or adult then "you" means the child's or adult's information. Disclose: To share with those outside SUNY College of Optometry or the UEC.

Use: To share with those within SUNY College of Optometry.

Health Information: Any information we receive or create that could be used to identify you, your health condition, the health care services you receive or payment for health care services you receive, whether in the past, present or future.

PROTECTING THE PRIVACY OF YOUR HEALTH INFORMATION - We understand that the medical information contained in the medical record about you and your health is personal. We are committed to protecting the privacy of the health information we gather about you while providing health care services. When you check in, prior to receiving any health care services, we will ask you to sign a HIPAA consent permitting us to use and disclosure your health information for the purposes of Treatment, Payment, and Health Care Operations. We are not allowed by law to refuse to treat you if you do not sign the HIPAA consent form.

WHERE IS YOUR HEALTH INFORMATION KEPT? Health information collected from you is stored in a medical record. The medical record may be partly on paper and partly electronic. The record belongs to the SUNY College of Optometry/University Eye Center but the health information belongs to you. Your rights to access this information are reviewed later in this booklet.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION - In some cases, the law allows us to use and disclose your health information with others without your authorization. Below is a description of how your health information may be used or disclosed. Although not every specific use or disclosure will be listed, the ways in which we are permitted to share your health information will fall within one of the following categories: Treatment, Payment, and Health Care Operations

We may use and disclose your health information in order to treat your condition, obtain payment for treatment and conduct our operations. Your health information may also be shared with other health care providers so that we may jointly perform certain payment activities and business operations. You will be asked to sign a general consent at your first visit to the UEC allowing us to use and disclose your health information for the purposes outlined below.

I. Treatment: We may use your health information to provide you with health care services and to coordinate your health care with other health care providers who need to be involved in your treatment. Your health information may be shared with doctors, nurses, students, technicians and other members of the health care team who are involved in taking care of you. For example, our health care providers may share medical information about you in order to coordinate the different parts of your treatment such as prescriptions, lab work and x-rays, make referrals to other doctors outside of the UEC. We may also disclose your health information to manufacturers when we order eyeglasses, contact lenses or low vision devices for you. Sometimes we may ask for copies of your health information from another professional that you may have seen before us.

II. Payment: We may use your information or share it with others so that we can bill and obtain payment for services we provided to you. For example, we may share your health information with your insurance company. This would be done to determine if your insurance company will cover the cost of your treatment or to obtain approval from your insurance company before you have treatment. This also applies to programs that provide benefits for work-related injuries such as worker's compensation.

III. Health Care Operations: We may use your health information or disclose it to others to conduct our business operations. For example, we may use your health information to evaluate our treatment and services or to educate our staff to improve the care

they provide to you. Your health information may also be used to educate health care students and providers. We may also share your health information with other companies that perform services for us. If so, we will have written agreements with these companies to make sure that the privacy of your health information is protected.

IV. Communications: We may use your health information when we contact you for an appointment for health care services at the UEC. We may also contact you to follow-up on the care you have received, to discuss test results or make referrals to other health care providers. We may contact you to provide appointment reminders for treatment or medical care. The reminder system is automated and messages with the necessary information pertaining to your appointment may be left on voice mail. You will have the opportunity to request that you do not receive automated appointment reminders.

V. Treatment Alternatives, Benefits and Services: We may use and disclose your health information in order to recommend possible treatment options, health-related benefits or services that may be of interest to you.

VI. Fundraising Activities: We may use certain information (i.e. name, address, telephone number or email information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information, etc.) to contact you for the purpose of raising money for SUNY College of Optometry and you will have the right to opt out of receiving such communications with each solicitation. For the same purpose, we may provide your name to our institutionally related foundation, the Optometric Center of New York. The money raised will be used to expand and improve the services and programs we provide to the community. You are free to opt out of fundraising solicitation, and your decision will have no impact on your treatment or payment for services.

DISCLOSURES TO OTHER INDIVIDUALS

We may share your health information with your personal representative, family member, friend or others involved in your care without your written authorization, unless you object. If we are providing health care to you because of a medical emergency, we will allow you the opportunity to object as soon as you are stable.

• Notification and Communication with Other Individuals: We may disclose some of your health information to your appointed personal representative, family member or friend who is involved in your care. We may also use your health information to notify or assist in notifying a family member, your personal representative or another individual responsible for your care about your location, general condition or in the event of your death.

• Individuals Involved in Payment for Your Care: We may disclose your health information related to treatment and services provided by us to an individual or health plan responsible for payment or maintenance of your health insurance.

PUBLIC NEED TO DISCLOSURE INFORMATION

We may disclose your health information to others in order to meet important public needs or other legal requirements. In some situations the disclosure may be required by law for specific purposes. We are not required to obtain your written authorization before using or disclosing your health information for the purposes outlined below:

• Public Health Activities: We may disclose your health information to authorized public health officials and agencies for the purpose of public health activities. These activities may include controlling or preventing disease, injury, or disability, reporting of births and deaths, reporting reactions to medications, products, or medical devices or communicable disease reporting.

• Abuse or Neglect: We are required by law to disclose health information to a public health authority that is authorized to receive reports of suspected child abuse and/or neglect.

• Health Oversight Activities: We may disclose your health information to agencies authorized to perform health oversight activities. These activities may include audits, investigations, inspections and licensure. These activities are necessary to monitor the operation of the health care system, government benefit programs such as Medicaid and Medicare and compliance with civil rights laws.

• Lawsuits, Disputes and Other Legal Matters: We may disclose your health information if we are ordered to do so by a court that is handling a lawsuit or other dispute or if we are required to do so in response to other legal orders.

• Law Enforcement: We may disclose your health information to law enforcement officials to comply with a legal order or law we are required to follow. In certain circumstances we are required to disclose your health information to law enforcement agencies.

• Product Monitoring, Repair and Recall: We may disclose your health information to an agency or individual that is required by law to report problems or reactions to medical products. This information will be used to track, recall, repair or replace a defective or dangerous product or device or to monitor the performance of an approved product or device.

• National Security and Intelligence Activities or Protective Services: We may disclose your health information to authorized federal officials for intelligence or national security activities, to conduct special investigations, or to provide protective services to the President or other government officials.

• Inmates and Correctional Institutions: We may disclose your health information to correctional officers and law enforcement officials if necessary to provide you with health care, to protect your health and safety or the health and safety of others, to protect the safety and security of the correctional institution or if we determine that you escaped from lawful custody.

• Military and Veterans: If you are in the armed forces, we may disclose your health information to appropriate military authorities for activities they determine are necessary to carry out their military mission. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.

RESEARCH - Part of the mission of SUNY College of Optometry and the UEC is the improvement of health care, in part, through research involving human subjects. You may be asked to participate in such research. If you decide to do so, you will sign a consent form for participation in the study. At that time, you will also be asked to provide your written authorization permitting the use or

disclosure of your health information for the research activity. However, certain research activities can include your health information without your written authorization if the researcher is approved through a special review process where it is determined that the use or disclosure of your health information in the research activity poses minimal risk to your privacy. This is achieved, in part, by removing most, if not all, of the information that has the potential to identify you. In some instances, the researcher must sign an agreement that further protects your privacy. Examples of such circumstances include research using your health information to determine if you are a candidate for a research study, to determine whether there will be an adequate number of potential research candidates for a future study or after your death. In any case, researchers are not permitted to use your name or identify you publicly.

OTHER USES AND DISCLOSURES OF YOUR HEALTH INFORMATION - Special privacy protections may apply to certain categories of health information such as: HIV/AIDS related information, Alcohol and substance treatment information, Mental health information and Genetic health information. If your treatment involves any of these specialized services, you will be asked to sign an authorization permitting us to disclose this information. You have the right to revoke the authorization at any time. If you revoke the authorization we will not further use or disclose your health information for the purposes documented on the authorization.

SALE OF PROTECTED HEALTH INFORMATION (PHI) Your PHI cannot be sold to other entities without your prior authorization. Exceptions to this include disclosures for public health, research, treatment and payment purposes, sale of the practice, transfer of PHI to a Business Associate providing services to you, etc. Authorizations will also be required for all treatment and health care operations where we receive financial remuneration from a third party whose product or service is being marketed.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION - The health information contained in your medical record belongs to you. You have been granted several rights by law that allow you to control the way we use your health information, share it with others, communicate with you about your health care and treatment and maintain the accuracy of your health information. In certain circumstances we may deny your request. If we do, we will provide you with an explanation of our reason for denying the request and a complete description of your rights and the process for requesting a review of the denial.

YOUR RIGHT TO INSPECT AND RECEIVE A COPY YOUR RECORDS - You have the right to inspect and receive a copy of any of your health information that is used to make decisions about your care and treatment for as long as the health information is retained in our records (paper and electronic.) This includes medical and billing records but does not include psychotherapy notes. If you request a copy of your health information, we will charge a fee per page and may charge additional fees for mailing or copying of the information. All fees must generally be paid before we will release the copies of your health information to you. In cases of demonstrated financial hardship we may waive the charges. We will respond to your request for inspection within 10 days. We will respond to your request for copies of your health information within 30 days. If we need additional time to respond to your request for copies, we will notify you in writing within the 30-day time frame to explain the reason for the delay. If we deny your request to inspect or obtain a copy of your complete health information, we will provide access to the remaining parts after excluding the information we cannot let you inspect or copy. We will accommodate reasonable requests and we will provide you with the ability to mail requested information to an alternate address.

YOUR RIGHT TO AMEND YOUR RECORDS - You have the right to request an amendment to your health information if you believe that the information we have about you is incomplete or incorrect. You have the right to request an amendment for as long as the information is kept in our records. Your request for an amendment must include a reason why you feel an amendment is necessary. We will respond to your request within 60 days. If we need additional time to respond we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request. We may deny your request in certain circumstances, for example: The health information was not created by us; The information is not part of the medical record which you would be permitted to inspect or copy; We believe the health information is deemed to be complete and accurate
If you disagree with our denial you have the right to have certain information related to your requested amendment included in your records.

YOUR RIGHT TO AN ACCOUNTING OF DISCLOSURES - You have the right to request a list of disclosures we made of your health information and how we shared it with others. This list will not include all of the disclosures we made, such as: Disclosures we made to you; Disclosures we made in order to provide you with treatment, obtain payment for treatment or conduct our normal business operations; Disclosures made to your personal representative, family or friends involved in your care; Disclosures made to federal officials for national security and intelligence activities; Disclosures made as the result of your signed authorization; Unavoidable or unintended disclosures that occur even with reasonable safeguards in place.

Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. We will respond to your request within 60 days from the date of the request. If we cannot provide you with an accounting list within 60 days we will notify you with an explanation and the date when you can expect to receive the accounting list. We are required to provide you with an accounting list within 90 days from the date of your original request. The first list you request within the first 12-month period will be free. For additional lists, we may charge you for the costs of providing the lists. We will notify you of the cost involved so that you can choose whether to withdraw or modify your request. If you want to exercise any of the rights, as explained above, you must put your request in writing and direct it to: University Eye Center, ATTN: Medical Records Department, SUNY College of Optometry, 33 West 42nd Street, New York, NY 10036

BREACH NOTIFICATION - A breach refers to the acquisition, access, use or disclosure of unsecured PHI in violation of the Privacy Rule; exceptions by law if: The PHI is secured or destroyed; The breach was unintentional, in good faith and with no further use within the UEC; The breach was inadvertent and within the UEC's job scope; The information cannot be retained.

YOUR RIGHT TO REQUEST ADDITIONAL PRIVACY PROTECTION - You have the right to request a restriction or limitation on the way we use and disclose your health information for treatment, payment for treatment and the running of our normal business operations. You may request that no information be shared with an insurance plan if you pay in full out of pocket. You also have the right to request that we limit how we share your health information with family and friends involved in your care or the payment for your care. Your request must include: (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others or both; and (3) to whom you want the limits to apply. We are not required by law to agree to your request for restrictions, and in some cases the restriction or limitations you request may not be permitted by law or may not be feasible or possible to honor. If we do agree to your request, we will be bound by our agreement unless your health information is needed to provide you with emergency care or comply with the law. Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under special circumstances we will also have the right to revoke the restriction as long as we notify you before doing so. In some cases we are required to obtain your permission before we can revoke the restriction.

YOUR RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION - You have the right to request that we communicate with you about your health care or medical matters through a reasonable alternative way or at an alternative location. Your request must specify how and/or where you wish to be contacted, and how payment for your health care will be handled if we communicate with you through this alternative way or location. You do not need to tell us the reason for the request. We will not deny your request unless the alternative means or location poses a potential significant risk to the privacy of your health information or is otherwise not feasible. If you want to exercise your right to request additional privacy protection or confidential communication, you must put your request in writing and direct it to the address listed above.

YOUR RIGHT TO A PAPER COPY OF OUR NOTICE OF PRIVACY PRACTICE - You have the right to a paper copy of our current Notice of Privacy Practices at any time. A copy of our most current notice will always be posted in clinical areas of the UEC and a copy for you to take will be readily available. You will be given a copy of our current notice the first time you come to the UEC for care. Any revised notices will be provided to you at the first visit after the changes become effective. You will be asked to sign that you have received a copy of our notice. You will also be able to obtain your own copy from our website at UniversityEyeCenter.org, by asking a member of our staff or by calling us at 212-938-4001. If we change our privacy practices we will revise our Notice of Privacy Practices. The revised notice will apply to all of your health information we currently have as well as all future information. The effective date of our most current Notice of Privacy Practices will be noted in the top right hand corner of the first page.

HOW TO FILE A COMPLAINT RELATED TO OUR PRIVACY PRACTICES OR NOTICE OF PRIVACY PRACTICES - If you believe your privacy rights have been violated, you may file a written complaint with us. Your complaint should describe the act that you believe was a violation of our Notice of Privacy Practices or the privacy of your health information. To file a complaint with us please contact: SUNY College of Optometry, Attn: Clinical Administration, 33West 42nd Street, New York, NY 10036.

The law also grants you the right to file a privacy complaint directly with the Secretary of the Department of Health and Human Services. The complaint must be in writing, name the person or organization that is the subject of the complaint and describe the acts or omissions that you believe violated your privacy. The complaint should be filed within 180 days of when you knew or should have known that a potential privacy violation occurred. In some cases the Secretary of the Department of Health and Human Services will waive the time limit if you explain good cause in your complaint. SUNY College of Optometry will take no action against you for filing a complaint.

Send your written complaint to: Secretary of the Department of Health and Human Services, John F. Kennedy Federal Building Room 1875, Boston, MA 02203. Phone: 617-565-1340 Fax: 617-565-3809 TDD: 617-565-1343

Need more information?

Our websiteUniversityEyeCenter.org contains a wide variety of information about the UEC and the services we provide. In addition, the clinic managers in each of the clinical areas can assist you on the day of your visit if you have any questions and/or concerns. Thank you for choosing the University Eye Center for your eye and vision care needs. As part of our continuous effort to improve the quality of our services, we'd like to hear about your experience at the UEC. Please take a few moments to complete our survey conveniently located at the reception desk or online at www. UniversityEyeCenter.org