WILLIAMS EYE INSTITUTE, P.C.

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices is contains a condensed version of our Notice of Privacy Practices. The full-length Notice is available at the front desk of all locations.

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 our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, 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 medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- 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 Secretary of 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 amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential Communications

For more information about these rights, please see the full notice posted in the office or request the detailed Notice of Privacy Practices from the front desk. This notice applies to all clinics, optical shops, surgery centers and providers of Williams Eye Institute, P.C.

_____
Signature of Patient or Representative

_____
Print Name

_____
Relationship to Patient (if other than patient)

_____
Date

I hereby grant permission to disclose my health information to the following individual(s). I understand that I may revoke permission at any time and that I must notify the practice in writing of my intent to revoke this permission.

Name of Individual	Relationship to Patient
_____	_____
_____	_____
_____	_____