

# Privacy Policy



WE ARE REQUIRED BY LAW TO PROVIDE YOU WITH THIS NOTICE AND TO MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION AS OUTLINED HEREIN.

WE WILL NOT DISCLOSE YOUR HEALTH INFORMATION TO ANYONE WITHOUT YOUR PRIOR WRITTEN AUTHORIZATION EXCEPT AS REQUIRED BY LAW IN THE FOLLOWING SITUATIONS:

- An FDA request for information on adverse effects.
- A public health agency request for information to prevent epidemics, disease or a threat to public safety.
- To report abuse, neglect or domestic violence.
- To comply with an audit of healthcare delivery performed by governmental agencies such as medicare.
- Under a court order or subpoena.
- To cooperate with law enforcement officials or the medical examiner in the investigation of a crime.

YOU HAVE THE RIGHT TO:

- Request restrictions on the health information we disclose.
- Inspect or copy your health information.
- Request us to ammend your health information.
- Request we contact you only according to your specific instructions.
- Receive an accounting of disclosures of your health information.
- Revoke the Authorization(s) indicated below.

ALL REQUESTS MUST BE MADE IN WRITING TO CAROLINA VISION CENTER.

IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED, YOU MAY FILE A COMPLAINT WITH THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

I AUTHORIZE CAROLINA VISION CENTER TO RELEASE MY HEALTH INFORMATION TO:

_____	_____	_____
Person	Relationship	Telephone #

_____	_____	_____
Person	Relationship	Telephone #

_____	_____	_____
Person	Relationship	Telephone #

_____	_____
Patient or Guarantor Signature	Date