HILL VISION SERVICES, LLC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

Uses and Disclosures
Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Health care operations: Your health information may be used when necessary to support day-to-day activities and management of Hill Vision Services, LLC. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
Appointment reminders: Your health information will be used by our staff to call or send you appointment reminders.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- the right to request restrictions in the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Hill Vision Services, LLC Duties

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

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in your policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist(s) or the Privacy Official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Attn: Privacy Official
Hill Vision Services, LLC
522 North New Ballas Rd. Suite 113
St. Louis, MO 63141

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date: This notice is effective on or after **July 4, 2007.**

HILL VISION SERVICES, LLC

Acknowledgement of Receipt of Notice of Privacy Practices
&
Authorization to Release Information to Specified Family Members and Close Friends

PATIENT NAME:_____ **D.O.B.:**_____

Acknowledgement of Receipt

Hill Vision Services, LLC reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for **Hill Vision Services, LLC.**

_____ _____
Signature of Parent/Guardian/Patient Date

_____
Relationship of Patient Representative to Patient

Inability to Obtain Acknowledgement of Receipt

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on _____. The acknowledgement was not obtained because:

- ❑ The parent/guardian/patient declined to sign the acknowledgement
- ❑ Other_____

_____ _____
Signature/Printed Name of Staff Member Date

Authorization to Release Health Information to Family Members & Close Friends

I authorize **Hill Vision Services, LLC** to disclose health information to the following family members and/or close friends to the extent necessary to help with your healthcare or with payment for your healthcare.

Name	D.O.B. or S.S.N	Name	D.O.B. or S.S.N

_____ _____
Signature of Parent/Guardian/Patient Date

_____
Relationship of Patient Representative to Patient