RETINA ASSOCIATES OF HAWAII, INC.
Uses and Disclosures of Protected Health Information

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

THIS NOTICE OF PRIVACY PRACTICE SHALL TAKE EFFECT on February 1, 2012.

Understanding Your Health Record/Information:
RETINA ASSOCIATES OF HAWAII, INC. must keep information about your health care confidential. Information regarding your health care is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. §132d *et seq.*, 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. §290dd-2, 42 C.F.R. Part 2. Under these laws, RETINA ASSOCIATES OF HAWAII, INC. may not tell anyone or give out any other health information about you without your authorization, except as described in this notice or required by law. In addition, State laws and Administrative Rules under H.R.S. §334-5 and HAR 11-175-31 may give more protection to PHI maintained by RETINA ASSOCIATES OF HAWAII, INC. In such situations, RETINA ASSOCIATES OF HAWAII, INC. will follow the more stringent laws. Your health record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information serves as a:

- Basis for planning your care and treatment;
- Means of communication among the many health professionals who contribute to your care;
- Legal document describing the care you received;
- Means by which you or a third party payer can verify that services billed were actually provided;
- A tool in educating health care professionals;
- A source of data for health research;
- A source of information for public health officials charged with improving the health of the nation;
- A source of data for facility planning; and
- A tool with which your treatment provider can assess and continually work to improve the care he or she renders and outcomes he or she achieves.

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy;
- Better understand who, what , when, where and why others may access your health information;
- Make more informed decisions when you agree to give information to others.

Your Health Information Rights:
Although your health record is the physical property of RETINA ASSOCIATES OF HAWAII, INC. , the information belongs to you. You have the right to review your complete health information. You have the right to ask RETINA ASSOCIATES OF HAWAII, INC. to:

- Limit the use and/.or disclosure of your medical information as provided by 45 C.F.R. §164.522;
- Obtain a paper copy of this notice of information practices upon request;
- Inspect and copy your health record as provided for in 45 C.F.R. §164.524;
- Amend your health record as provided in 45 C.F.R. §164.526;
- Obtain an accounting of the disclosure of your health information during the six year prior to your request as provided in 45 C.F.R. §164.528;
- Request communications of your health information by alternative means or at alternative locations;
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

You also have the right to give permission for most uses of your health information. There are stricter Federal and State requirements for use and disclosure for some types of protected health information, for example, mental health, substance a use, development disabilities, and Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and AIDS – Related Complex (ARC) information. However, there are still limited circumstance in which these types of information may be used or disclosure without your authorization.

RETINA ASSOCIATES OF HAWAII, INC. Responsibilities:

- Maintain the privacy of your health information by law;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Obtain your specific authorization in writing before disclosing your information for marketing purposes;
- Notify you in the event of a breach if it is believed your health information may have been compromised;
- Abide by the terms of this notice.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the program that provided your treatment within sixty (60) days.

Example of Disclosures for Payment and Health Operations:

RETINA ASSOCIATES OF HAWAII, INC. may use your health information for day-to-day treatment program operations.

For example: RETINA ASSOCIATES OF HAWAII, INC. staff may use information in your health record to assess the care and outcomes in your case and other like it. This information will then be used in an effort to improve continually the quality and effectiveness of the healthcare and service your treatment program provides.

Other Uses and Disclosures Not Requiring Your Permission:

Business Associates: There are some services provided for RETINA ASSOCIATES OF HAWAII, INC. through contracts with business associates. Examples include an auditor who reviews RETINA ASSOCIATES OF HAWAII, INC. records for financial accountability.

Public Health: As required by law, we may disclose your health information to public health or legal authorities preventing or controlling disease, injury or disability.

Health Oversight: Federal and State laws allow for your health information to be released to investigate fraud and abuse, for licensing and for program quality.

For More Facility or Provider Information or to Report a Problem:
If you have questions or would like to report a problem, you may contact the RETINA ASSOCIATES OF HAWAII, INC. Privacy Coordinator at (808) 521-8483.

If you believe your privacy rights (under 45 C.F.F.) have been violated, you can file a written complaint with the RETINA ASSOCIATES OF HAWAII, INC. Privacy Coordinator or with the United States Department of Health and Human Services—Office of Civil Rights, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, DC 20201. There will be no retaliation for filing a complaint.

My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices.

_____ _____

Signature of Client or Legal Representative Date
If signed by Legal Representative, relationship to client:

_____

Signature of staff giving Notice of Privacy Practices _____ Date _____
(with/without client signature/acknowledgement)

THIS NOTICE IS AVAILABLE IN BIGGER PRINT UPON REQUEST.

Revised Version: 2/1/2012

CONSENT TO RELEASE
PROTECTED HEALTH INFORMATION PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

Authorization is hereby given to Retina Associates of Hawaii, Inc., to disclose, fax and be furnished any and all health care information including medical records, reports, x-rays, diagnostic test results, bills, and payment records with respect to medical treatment or qualified healthcare operations provided to:

a) any health insurance plan or company that provides insurance coverage for me for the purpose of payment of charges;
b) any insurance company that provides liability insurance coverage for Retina Associates of Hawaii, Inc., for the purpose of evaluating the treatment rendered to me;
c) any workers' compensation, no-fault or administrative proceeding for the purpose of evaluating my medical condition;
d) mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results. If this medical record contains information about HIV testing and/or AIDS diagnosis or treatment, separate consent must be given to have this information released.
   _____ (Initial) I consent to have my HIV testing, AIDS diagnosis, drug and/or alcohol abuse and/or mental health records released.
   _____ (Initial) I do not consent to have my HIV testing, AIDS diagnosis, drug and/or alcohol abuse and/or mental health records released.
   or
e) to (specify individual/group/organization) _____ for the purposes of _____.

This authorization also gives Retina Associates of Hawaii, Inc., permission to leave messages regarding my appointments or health information on my answering machine/voice mail. Retina Associates of Hawaii, Inc., has my permission to speak to the following spouse, family member, relative, friend or parties regarding my medical information and treatment:

Name	Relationship	Name	Relationship

I understand that if my PHI is disclosed to a party who is not required to comply with the federal privacy protection policies, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

This authorization shall cover the period of time from my first visit to my last visit. I understand that I can revoke this authorization in writing at any time, except to the extent that the practice has already made disclosures in reliance upon my prior consent. This authorization shall end two years after the date of my last visit. I release Retina Associates of Hawaii, Inc., and staff from all legal responsibility that may arise from this authorization.

_____ _____
Patient Signature Date

_____ _____
Print Patient Name Date of Birth

_____
Signature of Parent or Legal Guardian if Minor

Revised 8/2018