ELK RIVER EYE CLINIC, P.A.
19022 Freeport Ave NW, Ste H
Elk River, MN 55330
P: 763-441-1055

NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Elk River Eye Clinic PA uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Elk River Eye Clinic PA will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Elk River Eye Clinic PA may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Elk River Eye Clinic PA may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. You have a right to request a restriction report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer Gary M. Hoffard and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Elk River Eye Clinic PA must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints, please contact Gary M. Hoffard at 763-441-1055.

Signature_____ Date_____

INSURANCE INFORMATION

- I authorize and request my insurance company to pay directly to the doctor of clinic insurance benefits otherwise payable to me.
- If I have no insurance or if my insurance plan has no formal agreement with the Elk River Eye Clinic, P.A., I understand that I am responsible for my entire account balance when services and/or materials are delivered to me.
- I authorize the release of any information, including the records of any treatment or examination rendered to me or my child during the period of such care, to the third party payers and/or other health practitioners.
- I understand that my insurance carrier may pay less than the total amount due for services rendered. I also understand that I am responsible for any portion of my account not paid by insurance within 60 days.

Signature_____ Date_____