Marko Habekovic MD Ophthalmology

1000 East Paris SE, Suite 111
Grand Rapids, MI 49546

NOTICE OF INFORMATION/PRIVACY PRACTICES

Understanding Your Health Record/Information

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. We use this information, often referred to as your health or medical record, as a basis for planning your care or treatment, a means to obtain payment for treatment, for administrative purposes, and to elevate the quality of care that you receive. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future users and disclosures. 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 protected health information (PHI) and to make more informed decisions when authorizing disclosure to others.

We may contact you by phone, mail or through the portal (My Health) to provide appointment reminders or to offer you information about other health related benefits and services that may be of interest to you.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person below.

Individual Rights

In most cases, you have the right to look at or obtain a copy of health information about you that we use to make decisions regarding your health. If you request copies, a reasonable, cost-based fee can be charged. You also have the right to receive a list of instances in which we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact: Office Manager/Privacy Officer at (616) 222-4111

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

Acknowledgment

I acknowledge receipt of this notice of information/privacy practices. I understand that I may request additional restrictions on the use and disclosure of my protected health information or for additional confidential treatment of communications.

I understand that I have the right to choose family members, friends or others to be involved in discussions about my health care. The people listed below may receive any verbal information needed to be involved in my care or help me make decisions about my care. By signing this form, I give my permission for staff of Marko Habekovic MD, PLLC to discuss information about me with the people listed below. This may include diagnoses, test results, medicine, treatment options and information from previous services I have had at other locations or in hospitals.

- I understand that information may be discussed with family members or others without this form as allowed by federal and state laws.
- I understand that listing a person on this form does not allow them to receive or copy my medical records.
- I understand that people listed on this form are not allowed to give consent for me.
- If patient is a minor, parents are assumed to be designated except in cases where the minor has given consent under Michigan law.

NAME OF PERSON	RELATIONSHIP TO PATIENT	PHONE NUMBER	MAY RECEIVE VERBAL INFORMATION	MAY PICK UP ALL PRESCRIPTIONS

_____ I do not wish to name anyone

I understand that I can update this form at any time by notifying a staff member of Marko Habekovic MD, PLLC and by filling out a new form. I have reviewed this form and understand it. Any questions have been answered.

_____ _____

Patient name Date

_____ _____

Patient Signature Date

_____ _____

Parent or Guardian Signature Date