STEPHEN J. LAQUIS MD, FACS

OPHTHALMIC AND FACIAL PLASTIC SURGERY SPECIALISTS

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At the office of Dr. Stephen Laquis, we will always keep your health information secure and confidential. We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. If you have any questions about this Notice, please contact our Privacy Officer. This medical practice collects health information about you and stores it in a chart or in an electronic health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. A law requires us to maintain your privacy, to give you this notice and to follow the terms of this notice. The law permits us to:

- Use or disclose your health information to those involved in your treatment. For example, your file may be reviewed by a physician specialist whom we involve in your care.
- Use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- Use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- Share your medical information with our business associates, such as a service that performs administrative services for us. We have a written contract with each business associate that requires them to protect your privacy.
- Use your information to contact you. For example, we may send newsletters or call and remind you of your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a designated family member or another person authorized by you who is responsible for your care.
- Having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
- Use your information for marketing purposes. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in.
- We may use your information for marketing purposes. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization.
- We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
- Release some or all of your health information when required by law.
- Disclose your health information to public health authorities. For example, reporting to the Food and Drug Administration problems with products and reactions to medications.
- Share your medical information if this practice is sold. Your information will become the property of the new owner.
- Use your information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
- Use your health information as necessary to comply with workers' compensation laws. For example, to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
- In the case of a breach of unsecured protected health information; we will notify you as required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You reserve the right to transfer copies of your health information to another practice. We will mail your files for you. You have the right to see and receive a copy of your health information with a few exceptions. You must give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request that you receive your health information in a specific way or at a specific location. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, treatment, payment, health care operations, notification and communication with family and specialized government functions.

You may request an amendment or change to your health information. You must give us your request in writing in order to make changes. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

Dr. Laquis reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If we change any of the details of this notice, we will notify you of the changes in writing. You have the right to receive a copy of this notice by contacting Dr. Laquis' office at 7331 College Parkway, Suite 200, Fort Myers, Florida, 33907 or calling 239.947.4042.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington DC, 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our privacy officer at 239.947.4042.

I consent to the use or disclosure of my protected health information by Dr. Laquis for the purpose of the reasons stated above. I understand that diagnosis or treatment of me by Dr. Laquis may be conditioned upon my consent as evidenced by my signature on this document. I understand that I have the right to request a restriction as to how my protected health information is used or disclosed. Dr. Laquis is not required to agree to the restrictions that I may request. However, if Dr. Laquis agrees to a restriction that I request, the restriction is binding on Dr. Laquis' practice and on Dr. Laquis. I have the right to revoke this Consent, in writing at any time, except to the extent that Dr. Laquis' practice has taken action in reliance on the Consent.

My "Protected Health Information" means health information, including my demographic information collected from me and collected or received from another health care provider, a health plan, my employer or a health care clearinghouse. This protected information relates to my past, present, future physical or mental health condition and identifies me, or there is reasonable evidence which leads you to believe the information may identify me.

Acknowledgement

I have read and understand the Notice of Privacy Practices for the office of Dr. Stephen Laquis.

____ ______________________

Signed Date

____

Print Name

____

If signing as a parent or guardian, please note the name of the patient

Ophthalmic Plastic and Orbital Surgery
Stephen J. Laquis, MD, FACS

Patient Authorization to Use or Disclose Protected Health Information For Purposes Other than Treatment, Payment or Healthcare Operations

I, ________________________________, understand Ophthalmic Facial Plastic Surgery Specialists, P.A. is
(Print Name)
authorized by me to use or disclose my protected health information for treatment, payment or health care operations only. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I specifically authorize any current employee or owner at Ophthalmic Facial Plastic Surgery Specialists, P.A. or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization.

I understand, and authorize my health care provider to use my name, address and phone number; the name of my scheduled treating physician; and the time and place of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information regarding pending appointments and to leave a reminder message on my voice mail system or answering machine.

Do you give us permission to discuss your medical and financial information with family members and/or friends?

- ○ Yes
- ○ No

If yes, please list the friends/ family members that you would like to authorize us to speak to:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Patient's Signature ____ Date: ______________

9/6/2011