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 IT CAREFULLY. WE ARE REQUIRED TO PROVIDE THIS NOTICE PURSUANT TO FEDERAL LAW, SPECIFICALLY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA").

This Notice of Privacy Practices (the "Notice") describes the privacy practices of Eyecare Plus ("ECP" "we" or "us") as they relate to maintaining the privacy of your health information ("Protected Health Information" or "PHI"), which is important to us. PHI is information about you, including basic information that may identify you and relates to your past, present, or future health or condition and the dispensing of pharmaceutical products to you. We take the responsibility for maintaining the privacy of your PHI very seriously.

Our Pledge Regarding Your Health Information

We are required by federal and applicable state law, regulations, and other authorities to protect the privacy of your PHI and to provide you with this Notice. Our staff is required to protect the confidentiality of your PHI and will disclose your PHI to a person other than you or your personal representative only when permitted under federal or state law. This protection extends to any PHI that is oral, written, or electronic, such as prescriptions transmitted by facsimile, modem, or other electronic device. This Notice describes how we may use and disclose your PHI. In some circumstances, as described in this Notice, the law permits us to use and disclose your PHI without your express permission. In all other circumstances, we will obtain your written authorization before we use or disclose your PHI.

This Notice also describes your rights and the obligations we have regarding the use and disclosure of your PHI. Under federal and applicable state law, we are required to follow the terms of the Notice currently in effect.

How We May Use and Disclose Your PHI Without Your Permission

Treatment, Payment or Health Care Operations

Below are examples of how Federal law permits use or disclosure of your PHI for these purposes without your permission:

1. **Treatment:** Dispensing medications. PHI obtained by ECP will be used to dispense prescription medications. We will document information related to the medications dispensed and services provided in your record. Patient Contacts. We may contact you to provide treatment-related services, such as refill reminders, treatment alternatives (e.g., available generic products), and other health related benefits and services that may be of interest to you.

2. **Payment:** We may contact your insurer, payor, or other agent and share your PHI with that entity to determine whether it will pay for your prescription and the payment amount. We may also contact you about a payment or balance due for prescriptions dispensed to you at ECP.

3. **Health care operations:** Service. Your PHI may be used to monitor the effectiveness of our services. Transfer. Your PHI may be transferred for purposes of carrying out the services if we buy another group practice or sell the group. Benefits/Research. We may also use your PHI to tell you about opportunities that may be of interest to you.

I HAVE RECEIVED A COPY OF THE "NOTICE OF PRIVACY PRACTICES" FROM EYECARE PLUS, WHICH EXPLAINS HOW MY MEDICAL INFORMATION WILL BE USED AND DISCLOSED. I UNDERSTAND THAT I AM ENTITLED TO RECEIVE A COPY OF THIS DOCUMENT.

SIGNATURE ______________________________ DATE ______________

RELEASE OF HEALTH INFORMATION

IF YOU WISH TO HAVE YOUR SPOUSE, FAMILY MEMBER, OR OTHER TO HAVE ACCESS TO YOUR PROTECTED HEALTH INFORMATION, PLEASE PROVIDE USE WITH THE NAME(S) OF THE PERSON(S) OR ENTITY.

1. NAME: ______________________________ RELATIONSHIP: ______________
2. NAME: ______________________________ RELATIONSHIP: ______________

PLACE AN (X) NEXT TO THE INFORMATION YOU ARE AUTHORIZING TO BE RELEASED TO THE ABOVE NAMED PERSON.

_____ ANY AND ALL INFORMATION
_____ MEDICAL RECORDS
_____ APPOINTMENT DATE AND TIME
_____ LAB TEST RESULTS
_____ FINANCIAL HISTORY

SIGNATURE OF PATIENT ______________________________

BY SIGNING THIS FORM, I AUTHORIZE EYECARE PLUS TO USE AND DISCLOSE THE PROTECTED HEALTH INFORMATION AS DESCRIBED ABOVE. THIS AUTHORIZATION SHALL BE IN FORCE AND EFFECTIVE, UNTIL I REVOKE THIS AUTHORIZATION IN WRITING TO THE COMPLIANCE OFFICER.