PATIENT INFORMATION

(PLEASE PRINT CLEARLY)

FOR OFFICE USE ONLY

DATE: ___/____/__________ **BELLAIRE EYE CARE** CHART#________________________

PATIENT NAME ____________________ ____________________ ____________________
LAST FIRST MIDDLE

ADDRESS ______________________________ CITY ____________________

STATE ____________________ ZIP CODE ________________ HOME PHONE (_____) _____-_______

E-MAIL ADDRESS ____

SOCIAL SECURITY # _______ - _____ - _________ AGE ___ CELL # (_____) _____-_______

DATE OF BIRTH ________ / ________ / __________ SEX: MALE _______ FEMALE _______
MONTH DAY YEAR

EMPLOYER/ SCHOOL ____________________ OCCUPATION/GRADE ____________________

MARITAL STATUS: ____________________

SPOUSE OR PARENT'S NAME ____

SPOUSE OR PARENT'S OCCUPATION ____________________ EMPLOYER ____________________

DATE OF BIRTH ________ / ________ / __________ PHONE (_____) _____-__________

SOCIAL SECURITY # _________ - ______ - _________ CELL # (_____) _____-__________

INSURANCE INFORMATION

PLEASE NOTE THAT "EYE EXAM" COVERAGE DOES NOT AUTOMATICALLY COVER THE **CONTACT LENS FEE**.

VISION INSURANCE ____

SUBSCRIBER NAME ____

SUBSCRIBER SSN ____

SUBSCRIBER D.O.B ____

PRIMARY MEDICAL INSURANCE ____

SUBSCRIBER NAME ____

SUBSCRIBER SSN ____

SUBSCRIBER D.O.B. ____

DO YOU PARTICIPATE IN A FLEX SPENDING ACCOUNT? ( ) YES ( ) NO
HOW WILL YOU SETTLE YOUR ACCOUNT TODAY? ( ) CASH ( ) CHECK ( )CREDIT CARD ( ) CARE CREDIT

______________________________ ____________ ____________________
SIGNATURE OF PATIENT OR GUARDIAN DATE WITNESS

REVIEW OF SYSTEMS

Bellaire Eye Care

PLEASE FILL OUT NAME & DATE ON EACH PAGE AND BE SURE TO SIGN THE LAST PAGE!

♦ **ALLERGIES:** ______________________

____

DESCRIBE REACTION: ______________________

♦ **IMMUNIZATIONS/VACCINES** (OVER THE LAST 6 MONTHS)

DATE ________ **TYPE** ______________________

____

♦ **CURRENT MEDICATIONS** (INCL OTC, VITAMINS, BCP, INJECT)

PILLS			STRENGTH	FREQUENCY
EYE-DROPS/OINTMENTS	**R**	**L**	FREQUENCY	LAST USED

♦ **PAST MEDICATIONS** (12 MONS) INCL VITAMINS/ANTIBIOTICS

PILLS
EYE-DROPS/OINTMENTS

♦ **SOCIAL HISTORY:**

OCCUPATION: ______________________

OCCUPATIONAL HAZARDS: ______________________

EDUCATION: ______________________

MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED OTHER

____

HOBBIES (INCL. CAMPING)**:** ______________________

PETS (CATS?)**:** ____________ **RECENT SCRATCH?** YES NO

TRAVELS: ______________________

DO YOU EAT RAW MEAT? YES NO

TOBACCO: CIGARETTES CIGARS PIPE CHEWING TOBACCO

CURRENT USE? YES NO **HOW MUCH?** ______ **HOW LONG?** ______

PAST USE? YES NO **HOW MUCH?** ______ **HOW LONG?** ______

STOPPED? YES NO **WHEN?** ______________________

ALCOHOL: BEER WINE WHISKEY OCCASIONALLY

CURRENT USE? YES NO **HOW MUCH?** ______ **HOW LONG?** ______

PAST USE? YES NO **HOW MUCH?** ______ **HOW LONG?** ______

STOPPED/WHEN? ____________ **REHAB?** ____________

RECREATIONAL DRUGS: TYPE ______________________

CURRENT USE? YES NO **HOW MUCH?** ______ **HOW LONG?** ______

PAST USE? YES NO **HOW MUCH?** ______ **HOW LONG?** ______

STOPPED/WHEN? ____________ **REHAB?** ____________

NAME: ______________________

DATE: ____ / ____ / ______ **CHART#:** ____________

♦ **HOSPITALIZATIONS/SURGERY:**

HOSPITALIZATION NON-SURGICAL:

DATE PLACE & REASON

______ ______________________

______ ______________________

______ ______________________

______ ______________________

______ ______________________

HOSPITALIZATION SURGICAL:

DATE PLACE & REASON

______ ______________________

______ ______________________

______ ______________________

______ ______________________

______ ______________________

EMERGENCY ROOM VISITS:

DATE PLACE & REASON

______ ______________________

______ ______________________

______ ______________________

OUT-PATIENT SURGERY (NON-OCULAR)**:**

DATE PLACE & REASON

______ ______________________

______ ______________________

______ ______________________

OUT-PATIENT SURGERY (OCULAR)**:**

DATE PLACE & REASON

______ ______________________

______ ______________________

______ ______________________

♦ **INJURIES** (SPECIFY IF OCULAR)**:**

DATE PLACE & REASON

______ ______________________

______ ______________________

______ ______________________

♦ **SPECIAL TREATMENTS** (RADIATION OR CHEMOTHERAPY)**:**

DATE PLACE & REASON

______ ______________________

______ ______________________

______ ______________________

♦ **EXPOSURES** (CHEMICALS, GAS, POISON, DRUGS, ETC.)**:**

DATE PLACE & REASON

______ ______________________

______ ______________________

© BELLAIRE EYE CARE 2007

BELLAIRE EYE CARE
Past Medical &
Family History

NAME: ______________________________

DATE: ____ /____ /________ CHART#: ______________

HAVE YOU OR A MEMBER OF YOUR FAMILY EVER AT ANY TIME HAD ANY OF THE PROBLEMS LISTED BELOW ?

***OCULAR HISTORY*:**	***PATIENT ONLY***				***FAMILY ONLY***			
	Patient		Date	Explain	Family		Age	Family Member
	Yes	No			Yes	No		
BLINDNESS			____	____________			____	____________
DIABETIC RETINOPATHY			____	____________			____	____________
EYE TRAUMA		List Under Injuries						
EYE / LID / ORBITAL SURGERY		List Under Surgeries						
GLAUCOMA			____	____________			____	____________
MACULAR DEGENERATION			____	____________			____	____________
MISALIGNED EYES			____	____________			____	____________
OPTIC NEURITIS			____	____________			____	____________
RETINITIS PIGMENTOSA			____	____________			____	____________
UVEITIS (IRITIS)			____	____________			____	____________
WEAK / LAZY EYE			____	____________			____	____________

***MEDICAL HISTORY*:**	***PATIENT ONLY***				***FAMILY ONLY***			
	Patient		Date	Explain.	Family		Age	Family Member
	Yes	No			Yes	No		
ALZHEIMER'S			____	____________			____	____________
ASTHMA/COPD			____	____________			____	____________
BLOOD CLOTS/PHLEBITIS			____	____________			____	____________
CANCER			____	____________			____	____________
CAROTID ARTERY/BRUITS			____	____________			____	____________
COLLAGEN DISEASE / LUPUS			____	____________			____	____________
DIABETES			____	____________			____	____________
GOUT			____	____________			____	____________
HEMOPHILIAC			____	____________			____	____________
HEART DISEASE (ASCVD, CHF)			____	____________			____	____________
HEART SURGERY			____	____________			____	____________
HEPATITIS / LIVER DISEASE			____	____________			____	____________
HIV/AIDS			____	____________			____	____________
HYPERTENSION			____	____________			____	____________
KIDNEY DISEASE / STONES			____	____________			____	____________
MENINGITIS			____	____________			____	____________
MIGRAINE			____	____________			____	____________
MULTIPLE SCLEROSIS			Date of last exacerbation ____				____	____________
MYASTHENIA			____	____________			____	____________
RHEUMATIC FEVER			____	____________			____	____________
SEIZURES			____	____________			____	____________
SICKLE CELL			____	____________			____	____________
STROKE / TIA			____	____________			____	____________
SYPHILIS / V.D.			____	____________			____	____________
THYROID / GOITER			____	____________			____	____________
TUBERCULOSIS			____	____________			____	____________
ULCER			____	____________			____	____________

Other:

FAMILY HISTORY:

	ALIVE	AGE	Health Status	DEAD	AGE	Cause of Death	Any Other Illness
MOTHER		______	______________		____	____________	______________
FATHER		______	______________		____	____________	______________
BRO SIS		______	______________		____	____________	______________
BRO SIS		______	______________		____	____________	______________
BRO SIS		______	______________		____	____________	______________
SON DAUG		______	______________		____	____________	______________
SON DAUG		______	______________		____	____________	______________
SON DAUG		______	______________		____	____________	______________

© BELLAIRE EYE CARE 2007

Bellaire Eye Care

REVIEW OF SYSTEMS

Do you have a problem with...

NAME: ______________________________

DATE: ____ /____ /______ **CHART#:** ____________

EYES	Yes	No
Blindness	[ ]	[ ]
Loss of vision	[ ]	[ ]
Distorted vision	[ ]	[ ]
Blurred vision	[ ]	[ ]
Double vision	[ ]	[ ]
Cataracts	[ ]	[ ]
Crossed eyes	[ ]	[ ]
Flashes or floaters	[ ]	[ ]
Dry eyes	[ ]	[ ]
Watery eyes	[ ]	[ ]
Red eyes	[ ]	[ ]
Mucous discharge	[ ]	[ ]
Burning or itching	[ ]	[ ]
Sandy or gritty feeling	[ ]	[ ]
Eye pain or soreness	[ ]	[ ]
Glare/Light sensitivity	[ ]	[ ]
Chronic eye infections	[ ]	[ ]
Tired eyes	[ ]	[ ]
Halos	[ ]	[ ]
Vision therapy	[ ]	[ ]
Eye surgery	[ ]	[ ]
Eye injury	[ ]	[ ]
Retinal detachment	[ ]	[ ]
Glaucoma	[ ]	[ ]

Allergic/Immunologic	Yes	No
Hay fever	[ ]	[ ]
Medicine allergies	[ ]	[ ]

Constitutional Symptoms	Yes	No
Fever [ ]	[ ]	
Weight loss	[ ]	[ ]

Cardiovascular	Yes	No
Heart pain	[ ]	[ ]
High blood pressure	[ ]	[ ]
Vascular disease	[ ]	[ ]

Ears/Nose/Mouth/Throat	Yes	No
Allergies/Hay Fever	[ ]	[ ]
Sinus problems	[ ]	[ ]
Chronic cough	[ ]	[ ]
Dry throat/mouth	[ ]	[ ]
Chronic ear infections	[ ]	[ ]

Endocrine	Yes	No
Thirsty all the time	[ ]	[ ]
Frequent urination	[ ]	[ ]
Diabetes	[ ]	[ ]
Thyroid problems	[ ]	[ ]
Other glands	[ ]	[ ]

Gastrointestinal	Yes	No
Diarrhea	[ ]	[ ]
Constipation	[ ]	[ ]
Ulcers	[ ]	[ ]

Genitourinary	Yes	No
Genitals	[ ]	[ ]
Kidneys	[ ]	[ ]
Bladder	[ ]	[ ]

Hematologic/Lymphatic	Yes	No
Anemia	[ ]	[ ]
Bleeding problems	[ ]	[ ]
Swelling	[ ]	[ ]

Integumentary	Yes	No
Skin	[ ]	[ ]
Breast	[ ]	[ ]

Musculoskeletal	Yes	No
Arthritis	[ ]	[ ]
Rheumatoid Arthritis	[ ]	[ ]
Muscle pain	[ ]	[ ]
Joint pain	[ ]	[ ]

Neurological	Yes	No
Headaches	[ ]	[ ]
Migraines	[ ]	[ ]
Seizures	[ ]	[ ]

Psychiatric	Yes	No
Nervous disorders	[ ]	[ ]
Depression	[ ]	[ ]
Compulsive behavior	[ ]	[ ]

Respiratory	Yes	No
Asthma	[ ]	[ ]
Shortness of breath	[ ]	[ ]
Emphysema	[ ]	[ ]
Lung cancer	[ ]	[ ]

REVIEWED BY DOCTOR...

____

SIGNATURE

------- IMPORTANT! PLEASE READ, COMPLETE AND SIGN BELOW! ------

☐ I UNDERSTAND THAT DR. ____________________ MY ____________ IS ATTENDING TO ALL POSITIVELY MARKED PROBLEMS ADDRESSED HERE IN THIS REVIEW OF SYSTEM THAT ARE NOT OCULAR IN NATURE.

☐ I WILL MAKE AN APPOINTMENT WITH DR. ___________________ MY _____________ TO ATTEND ALL POSITIVE MEDICAL PROBLEMS ADDRESSED HERE IN THIS REVIEW OF SYSTEMS THAT ARE NOT OCULAR IN NATURE.

☐ MARK HERE IF YOU WANT A COPY OF THIS COMPLETED REVIEW OF SYSTEM.

______________________________ ____________

PATIENT'S SIGNATURE **DATE**

------- IMPORTANT! PLEASE READ, COMPLETE AND SIGN ABOVE! -------

© BELLAIRE EYE CARE 2007

PATIENT MEDICAL HISTORY

The information in this confidential case history form is critical to the evaluation of your vision and health.

CHIEF COMPLAINT

HOW CAN WE HELP YOU TODAY? IN THIS SPACE PLEASE BRIEFLY TELL US ANY SIGNS AND SYMPTONS YOU ARE EXPERIENCING. (MEDICAL INSURANCE WILL ONLY COVER IF THERE IS A MEDICAL REASON FOR THE EXAM SUCH AS LOSS OF VISION, HEADACHES, EYE REDNESS, EYE PAIN, EYE ITCHING OR BURNING, GLAUCOMA, CATARACTS, FLOATERS, DRY EYE.)

( ) Y ( ) N ARE YOU THINKING OF NEW GLASSES TODAY?
( ) Y ( ) N ARE YOU THINKING OF NEW CONTACT LENSES TODAY?

AGE OF CURRENT GLASSES? ____________________

BRAND/ PRESCRIPTION OF CURRENT CONTACT LENSES?

R: ____________________

L: ____________________

HISTORY OF PRESENT ILLNESS

LOCATON	WHICH EYE HAS THE PROBLEM?	RIGHT EYE- LEFT EYE-BOTH EYES
QUALITY	DOES THE PROBLEM CAUSE VISION LOSS OR BLUR?	LOSS- BLUR
CONTEXT	DID THE PROBLEM OCCUR SUDDENLY OR GRADUALLY?	SUDDEN- GRADUAL
SEVERITY	HOW SEVERE IS THE PROBLEM?	MILD- MODERATE- SEVERE
MODIFYING FACTORS	IS IT WORSE AT ANY SPECIFIC DISTANCE?	DISTANCE- NEAR- BOTH
DURATION	HOW LONG DOES THE PROBLEM LAST?	INTERMITTENT- CONSTANT
TIMING	HOW LONG HAS THE PROBLEM BEEN OCCURRING?	SHORT TERM- LONG TERM
ASSOCIATED SYMPTOMS	ARE THERE ASSOCIATED SYMPTOMS?	NO- HEADACHE- NAUSEA
PREVIOUS INTERVENTIONS	DOES ANYTHING HELP THE PROBLEM?	NOTHING HELPS- NOTHING HAS BEEN TRIED

REVIEW OF SYMTOMS- DO YOU HAVE A PROBLEM WITH....

EYES	Y	N
BLINDNESS	( )	( )
LOSS OF VISION	( )	( )
DISTORTED VISION	( )	( )
BLURRED VISION	( )	( )
DOUBLE VISION	( )	( )
CATARACTS	( )	( )
CROSSED EYE/ EYE TURN	( )	( )
FLASHES	( )	( )
FLOATERS	( )	( )
DRY EYES	( )	( )
TEARING	( )	( )
RED EYES	( )	( )
MUCOUS DISCHARGE	( )	( )
BURNING OR ITCHING	( )	( )
SANDY OR GRITTY FEELING	( )	( )
EYE PAIN OR SORENESS	( )	( )
GLARE/LIGHT SENSITIVITY	( )	( )
EYE INFECTIONS	( )	( )
HALOS	( )	( )
EYE INJURY	( )	( )
RETINAL DETACHMENT	( )	( )
GLAUCOMA	( )	( )
MACULAR DEGENERATION	( )	( )
HEADACHES	( )	( )

HAVE YOU EVER BEEN EXPOSED TO OR INFECTED WITH:

GONORRHEA	( ) YES	( ) NO
HEPATITIS	( ) YES	( ) NO
HIV	( ) YES	( ) NO
SYPHILIS	( ) YES	( ) NO

NAME OF FAMILY PHYSICIAN ____________________

DATE OF LAST PHYSICAL CHECK-UP ____________________

CURRENT MEDICATION (RX OR OVER THE COUNTER SUCH AS EYE DROPS, VITAMINS, & BIRTH CONTROLPILLS)

____

____

____

ALLERGIES TO MEDICATIONS? ( ) YES ( ) NO

IF SO, WHAT MEDICATIONS? ____________________

____

HAVE YOU HAD ANY SURGERIES? ( ) Yes ( ) No

PLEASE LIST: ____________________

____

DO YOU USE CIGARETTES/TOBACCO, ALCOHOL, OR OTHER SUBSTANCE? ( ) Yes ( ) No

____

SIGNATURE OF PATIENT OR GUARDIAN DATE

PATIENT MEDICAL HISTORY

PLEASE PRINT CLEARLY

The information in this confidential case history form is critical to the evaluation of your vision and health.

REVIEW OF SYMPTOMS- DO YOU HAVE A PROBLEM WITH....

HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR THE FOLLOWING HEALTH PROBLEMS?

	YES	NO	DIAGNOSED WHAT MONTH/YEAR
ALLERGIES	( )	( )	____________
ARTHTITIS (RHEUMATOID)	( )	( )	____________
BLOOD/LYMPH	( )	( )	____________
BRONCHITIS	( )	( )	____________
CANCER	( )	( )	____________
CHOLESTEROL	( )	( )	____________
DIABETES	( )	( )	____________
DIGESTIVE	( )	( )	____________
EARS/NOSE/THROAT	( )	( )	____________
ENDOCRINE	( )	( )	____________
ECZEMA/RASHES	( )	( )	____________
FATIGUE	( )	( )	____________
FEVERS	( )	( )	____________
GENITOURIARY	( )	( )	____________
HOGH BLOOD PRESSURE	( )	( )	____________
INTEGUMENTARY (SKIN)	( )	( )	____________
KIDNEY	( )	( )	____________
MUSCLE/ BONE	( )	( )	____________
NEUROLOGICAL	( )	( )	____________
PSYCHOLOGICAL	( )	( )	____________
SINUS	( )	( )	____________
THROAT INFECTION	( )	( )	____________
THYROID INFECTIONS	( )	( )	____________
UNUSUAL WEIGHT LOSSES/GAINS	( )	( )	____________

FAMILY MEDICAL/ EYE HISTORY (CHECK ALL THAT APPLY)

	YES	NONE	RELATIONSHIP MATERNAL/PATERNAL
BLINDNESS	( )	( )	____________
CATARACTS	( )	( )	____________
CORNEAL PROBLEMS	( )	( )	____________
DIABETES	( )	( )	____________
GLAUCOME	( )	( )	____________
HEART DISEASE	( )	( )	____________
LAZY EYE	( )	( )	____________
MACULAR DEGENERATION	( )	( )	____________
RETINAL PROBLEMS	( )	( )	____________

____________________ ____________ ____________________

SIGNATURE OF PATIENT OR GUARDIAN DATE WITNESS

BELLAIRE EYE CARE

IMPORTANT
NOTICE TO THE PATIENT

PAYMENT FOR ALL MEDICAL SERVICES RENDERED IS THE RESPONSIBILITY OF THE PATIENT.

BELLAIRE EYE CARE WILL SUBMIT CLAIMS TO THE PATIENT'S INSURANCE AS A **COURTESY**.

IF NOT PROMPTLY PAID BY THE INSURER, PAYMENT WILL BE SOUGHT DIRECTLY FROM THE PATIENT.

ANY AMOUNT *NOT PAID* BY THE PATIENT'S INSURANCE IS STILL THE RESONSIBILITY OF THE PATIENT TO PAY.

_______________________________________ _______________

SIGNATURE **DATE**

BELLAIRE EYE CARE

FAX PRIVACY WAIVER

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur I absolve **Bellaire Eye Care** of all liability. I give my consent to fax my records for the purpose of treatment, payment of healthcare operations and understand that I may withdraw this consent at any time in writing.

____ ________________

SIGNATURE OF PATIENT OR REPRESENTATIVE **DATE**

____

PRINTED NAME OF PATIENT OR REPRESENTATIVE

Bellaire Eye Care

ACKNOWLEDGEMENT
OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES OF:

BELLAIRE EYE CARE

By signing this document, I acknowledge that I have received a copy of the Notice of Privacy Practices of *Bellaire Eye Care*.

______________________	______________________	______________
NAME (PRINT)	**SIGNATURE**	**DATE**

FOR BELLAIRE EYE CARE OFFICE USE ONLY

DATE ACKNOWLEDGEMENT RECEIVED: ______________________

-OR-

REASON ACKNOWLEDGEMENT ***WAS NOT*** OBTAINED:

____

____

____

BELLAIRE EYE CARE

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.

Bellaire Eye Care uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of The University Eye Institute.

How Bellaire Eye Care May Use or Disclose Your Health Information

For Treatment. **Bellaire Eye Care** may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as an optometrist, physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions. If you have been referred into our facility from a healthcare provider outside of **Bellaire Eye Care**, that referring doctor may have sent information about you in advance to help in our treatment of you. We will provide your referring healthcare provider with copies of your record or reports that will assist him/her in your treatment and health care after you have completed your management from our facility.

For Payment. **Bellaire Eye Care** may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations. **Bellaire Eye Care** may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- evaluate the performance of our staff;
- assess the quality of care and outcomes in your cases and similar cases;
- learn how to improve our facilities and services; and
- determine how to continually improve the quality and effectiveness of the health care we provide.

Appointments. **Bellaire Eye Care** may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You or a family member may be contacted by postcard and/or by telephone at the number you have provided for contact to remind you of an upcoming appointment.

Notification. **Bellaire Eye Care** may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care of your general condition. You have the right to restrict who we may disclose information to.

Marketing. **Bellaire Eye Care** in compliance with both Federal and State restrictions cannot disclose your health information to 3rd parties for marketing purposes unless an authorization to do so is obtained from you in advance. However, **Bellaire Eye Care** may directly market to you by face-to-face or by mail for research opportunities, services, procedures or materials offered by **Bellaire Eye Care** that may be of benefit to you. If you do not wish to receive this information, you have the right to be removed from our mailing list.

Required by law. **Bellaire Eye Care** may use and disclose information about you as required by law. For example, **Bellaire Eye Care** may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence; and
- to assist law enforcement officials in their law enforcement duties;

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Research. **Bellaire Eye Care** may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research. You may be contacted by telephone or by mail asking to participate in specific studies at **Bellaire Eye Care** or receive general information about research opportunities.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

Workers' Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Other uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent **Bellaire Eye Care** has taken action in reliance on such.

Your Health Information Rights

You have the right to:

- request a restriction on certain uses and disclosures or your information as provided by 45 C.F.R. §164.522; however, **Bellaire Eye Care** is not required to agree to a requested restriction;
- obtain a paper copy of the notice of information practices upon request;
- inspect and obtain a copy of your health record as provided for in 45 C.F.R. §164.524;
- request that your health record be amended as provided in 45 C.F.R. §164.526;
- request communications of your health information by alternative means or at alternative locations; and
- receive an accounting of disclosures made of your health information as provided by 45 C.F.R. §164.528.

Complaints

You may complain to **Bellaire Eye Care** and to the Department of Health and Human Services (Office of Civil Rights) if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Obligations of Bellaire Eye Care

Bellaire Eye Care is required by law to:

- maintain the privacy of protected health information;
- provide you with this notice of its legal duties and privacy practices with respect to your health information;
- abide by the terms of this notice;
- notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and

Bellaire Eye Care reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you by upon your next visit.

Contact Information

If you have any questions or complaints, please contact:

Privacy Officer
Bellaire Eye Care
Bellaire, Texas
Office: 713-942-2187