Privacy Notice

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. THIS NOTICE IS EFFECTIVE 3/1/2024 UNTIL FURTHER NOTICE.

Right to Notice

As a patient, you have the right to adequate notice of the uses and disclosures or your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA), Sunset Eye Clinic / Sunset Vision Center LLC, can use your protected health information for treatment, payment, and healthcare operations. a) Treatment- We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. b) Payment- We may use and disclose your health information to obtain payment for services we provide you. c) Health care operations- we may use and disclose your health information in connection with our healthcare operations.
Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization

Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations

In the event of your incapacity or an emergency, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

Marketing

We will not use your health information for marketing communications without your written authorization.

Required by Law

We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to you or other people's health or safety.

National Security

We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence, and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders

We may use or disclose your health information to provide you with appointment reminders via phone, text, e-mail, or letter.

Your Rights as a Patient

You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the Information Is required for treatment, payment, or health care operations. -You have the right to receive confidential communications regarding your protected health information. -You have the right to inspect and copy your protected health Information. -You have the right to amend your protected health information. -You have the right to receive an account of disclosures of your protected health information. -You have the right to a paper copy of this notice of privacy practices.

Legal Requirements

Sunset Eye Clinic LLC / Sunset Vision Center LLC is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted to this site or are available within our office.

Complaints

If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

Contact Information

For further information about Sunset Eye Clinic / Sunset Vision Center LLC's privacy policies, please contact us at the following address or phone number. Sunset Eye Clinic, 1865 SW 169th Pl Ste. 105, Beaverton, OR 97006, (503) 533-8441.

SUNSET EYE CLINIC, LLC
SUNSET VISION CENTER, LLC

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

Patient name_____

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose your health information for treatment purposes. This not only includes care and services provided here, but also may be necessary for you to receive follow-up care from another health professional.
Similarly, the use and disclosure of your health information may be needed for processing claims, determining benefits, and/or obtaining payment from a third party.

When you sign this consent document, you agree that Sunset Eye Clinic may use and disclose your health information to treat you, to obtain payment for our services, and to perform health care referrals. You agree that in the event you are sent to collections, you are subject to 30-40% of the total amount owed as a collection service fee depending on circumstances. By signing, you also agree that a copy of the **Notice of Privacy Practice** was available for you to read. If you have any questions regarding the Notice of Privacy Practice, please ask the receptionist.

If you sign this authorization, you may revoke this consent in writing at any time unless we have already performed actions in reliance with this consent.

I _____**,** HAVE READ AND UNDERSTAND THIS CONSENT DOCUMENT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. I HAVE READ AND UNDERSTAND SUNSET EYE CLINIC / SUNSET VISION CENTER'S NOTICE OF PRIVACY PRACTICE.

Date_____ Signature Patient/Guardian_____