SUMMARY NOTICE OF PRIVACY PRACTICES
Effective Date: 4/30/2026

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO IT. PLEASE READ CAREFULLY. THIS IS AN ABBREVIATED VERSION OF OUR MORE COMPREHENSIVE NOTICE OF PRIVACY PRACTICES, WHICH IS AVAILABLE ON OUR WEBSITE OR UPON REQUEST.

INTRODUCTION
Visionary Ophthalmology, LLC (the "Practice") is committed to using your health information responsibly. This summary Notice of Privacy Practices ("Notice") describes the nature of your protected health information ("PHI"), and how and when we use or disclose that PHI. It also describes your rights as they relate to your PHI.

We are required by the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") to maintain the security and confidentiality of PHI obtained or created by us in any form. As required by HIPAA, we prepared this Notice to explain how we maintain the privacy of your PHI and how we may disclose your PHI. We are required by HIPAA to abide by the terms of this Notice. We reserve the right to amend this Notice at any time, and such amended Notice shall apply to all PHI maintained by the Practice at that time. We will post a copy of the revised Notice in our offices, and you may request a written copy for your records.

UNDERSTANDING YOUR PHI
PHI is any information that relates to your past, present or future physical or mental health, including treatment and payment therefore. Each time you come to the Practice, we create a record of your visit. This record may contain information about your personal demographics, medical exam, diagnoses, test results, treatment and other pertinent data.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research

- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement and other government requests
- Respond to lawsuits and legal actions

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

FOR MORE INFORMATION OR TO REPORT A PROBLEM
To make a complaint or request additional information regarding this Notice or our privacy practices, please contact:

Visionary Ophthalmology, LLC
11300 Rockville Pike, Suite 1202
Rockville, MD 20852
info@voeyedr.com
301-896-0890

If you believe your privacy rights have been violated, please contact the Practice's HIPAA Compliance Officer listed above. You may also file a complaint with the U.S. Department of Health and Human Services – Office for Civil Rights. **There will be no retaliation for filing a complaint with either the Practice's HIPAA Compliance Officer or with the Office for Civil Rights.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have read and understand the contents of this document. I understand that this is an abbreviated version of the Practice's more comprehensive Notice of Privacy Practices, which is available to me on the Practice's website or upon request.

____ _______________________
Patient / Responsible Party - Signature Date

____
Patient / Responsible Party – Printed Name

Personal Representative, Family or Other Entities Authorized Access to Your Protected Health Information

If you wish to authorize any other person or entity to see, use or share your Protected Health Information, please list their names below. For the avoidance of doubt, by listing the name of any person or entity below, you are authorizing the Practice to share your Protected Health Information with them (including information related to your treatment, billing and general healthcare administration).

Name of Authorized Person / Entity	Phone Number	Date
Name of Authorized Person / Entity	Phone Number	Date