

Notice of Privacy Practices Acknowledgement Primary Eyecare Associates, P.C.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your notice of privacy practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its notice of privacy practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the notice of private practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

Office Use Only

I attempted to obtain the patients signature in acknowledgement on this notice of privacy practices acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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