ASSOCIATES IN EYECARE, P.C.
DISEASES AND SURGERY OF THE EYE
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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and 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:

- Provide and coordinate my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health.
- Conduct normal health care operations such as quality assessment and improvement activities.

I hereby acknowledge that I have been given the right to review and receive a copy of this medical practice's *Notice of Privacy Practices*. I further acknowledge that my provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request form. I further understand that Associates in Eyecare, P.C. is not required to accept my restriction request.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____