Acknowledgement of Receipt of the Notice of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information (PHI). 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 the treatment directly and indirectly
- Obtain payment from third-party payers

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I understand that Precision Eyecare Centers has the right to change its Notice of Privacy Practices from time to time and that I may contact Precision Eyecare Centers at any time to obtain a current copy of their Notice of Privacy Practices.

Please Print

Name: _____

Signature: _____

Date: _____

For Office Use Only

_____

We attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement, but were unable to do so as documented below.

Date: _____

Reason: _____

_____

_____

Signature: _____