Washington Eye Doctors
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Public Information Officer: Diane

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 internal quality assessments and financial or billing audits.

I have received, read and understand Klessman and Rosenblatt, OD, PC's (DBA. Washington Eye Doctors) *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Washington Eye Doctors has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Washington Eye Doctors at any time at the address above to obtain a current copy of the *Notice of Privacy 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 _____

Signature _____

Date _____

Relationship to patient (If signed by personal representative of Patient) _____

Print Name_____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

_____	_____	_____
Date	Initials	Reason