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 healthcare 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 _______________