XAVIER EYECARE

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HIPPA NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand, under the Health Insurance Portability & Accountability Act of 1996(HIPPA), I have certain rights 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 multiple health care providers who may be involved in that treatment directly or indirectly.**
- **Obtain payment for third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I acknowledge that I have received Notice of Privacy Practices concerning 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 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 operation. I also understand that you are not required to agree to my requested restrictions, but if you do agree to them you are bound to abide by such restrictions.

Patients Name: ____

Relationship to Patient: ____

Signature: ____

Date:____

OFFICE USE ONLY

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

Date:__________ Initials:______________ Reason:_________________________