

TRUWAY VISION CARE PA.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct plans 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 quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this origination 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 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 request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

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

Date:

/Initials:

/Reason: