

## Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge that this Primary Eye Care Practice has given you a copy of its Notice of Privacy Practices. This notice explains how your health information will be handled. HIPPA, the new Federal law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. This Practice has given me the opportunity to ask questions about this notice and all my questions have been answered.

If you would like to give permission for others to have access to your health information (i.e. parents, spouse), please list them here.

\_\_\_\_\_

\_\_\_\_\_

Patient/Guardian's Signature \_\_\_\_\_ Date signed \_\_\_\_\_

### Provider Use Only

If patient was not able to sign due to an emergency, or did not want to sign, please document if patient was given the notice and the reason why the patient did not sign below.

Patient was given the notice Yes/No

Reason Patient did not sign

\_\_\_\_\_

\_\_\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_