

Total EyeCare and Aesthetics
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Notice of Privacy Practices Acknowledgement

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

- 1. Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly**
- 2. Obtain payment from third party payers**
- 3. Conduct normal healthcare operations such as quality assessments and physician certifications**

I have read and understood the posted Notice of Privacy Practices containing a more complete description of the users and disclosures of my health information.

I understand that the 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 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 information. I also understand you are not required to agree to my requested restrictions, but if you agree that you are bound to abide by such restrictions.

Patient Name (printed) and date

Patient Signature
