NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT
ACHIEVE EYE & LASER SPECIALISTS

This Notice of Privacy Practices Acknowledgment is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Your signature is also a requirement.

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting your physician, the office manager, or medical records department.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

PLEASE LIST THE INDIVIDUALS YOU WISH TO PARTICIPATE IN YOUR CARE:
This will be someone we can talk to or leave messages with in regards to your medical or vision care, appointments, insurance and account information. We will not give out or take in any information from a contact unless the person is listed below. If more space is needed, please add to notation area at bottom of page, or on the back of this sheet.

- _____ _____
  Contact Name Relation: _____ Phone Number
- _____ _____
  Contact Name Relation:_____ Phone Number

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Patient or legally authorized individual's signature Date Time

_____ _____
Printed name if signed on behalf of the patient Relationship
(Parent, legal guardian, personal representative)

(Notation, if any, by staff)

This form will be retained in your medical record.

Last Update: 04-01-2003/10-09-2003/4-2008 name change