

New Hartford Eyecare

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy 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 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 have received, read and understand the New Hartford Eyecare *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that NHE has the right to change its *Notice of Privacy Practices* from time to time and that I may contact NHE at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that NHE restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand NHE is not required to agree to my requested restrictions, but if NHE does agree then NHE is bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Other persons who may have my access to my Protected Health Information
